The Member States in the WHO European Region met at the WHO European Ministerial Conference on Mental Health in Helsinki in January 2005 to tackle one of the major threats to the well-being of Europeans: the epidemic of psychosocial distress and mental ill health. These countries took mental health from the shadow of stigma and discrimination and brought it to the centre of the public health policy arena. By adopting the Mental Health Declaration and Action Plan for Europe, they set the course for mental health policy for the next 5–10 years.

Member States now face the challenge of acting on the principles of the Declaration and accomplishing the goals in the Action Plan's 12 areas of work. This book contributes to the achievement of this task by describing the current situation in the Region, presenting the Declaration and Action Plan, offering brief discussions of the areas of work (with examples of initiatives already underway in each) and describing WHO's plans to assist Member States in improving mental health in the European Region.

The commitments in the Declaration and the Action Plan are based on information and evidence from across the WHO European Region. Together, they form a solid and inspiring foundation on which governments, policy-makers, nongovernmental organizations and other stakeholders, along with WHO, can build solutions to improve the quality of life of all citizens.

Mental health:
facing the challenges, building solutions

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Report from the WHO European
Ministerial Conference

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Contents

Abbreviations

Organizations and programmes

EU	European Union
IMHPA	Implementing Mental Health Promotion Action (network)
NIS	newly independent states of the former USSR
NGOs	nongovernmental organizations
VVGG	Flemish Mental Health Association
WHO-AIMS	WHO Assessment instrument for Mental Health Systems
WHO-CHOICE	CHOosing Interventions that are Cost Effective

Technical terms

ADHD	attention-deficit hyperactivity disorder
ASD	autism spectrum disorders
DALYs	disability-adjusted life years
GPs	general practitioners
PHC	primary health care
PO	personal ombudsman (Sweden)
PTSD	post-traumatic stress disorder
SSRIs	selective serotonin reuptake inhibitors
YLD	years lived with disability

Acknowledgements

Foreword

The Member States in the WHO European Region met at the WHO European Ministerial Conference on Mental Health in Helsinki in January 2005 to tackle one of the major threats to the well-being of Europeans: the epidemic of psychosocial distress and mental ill health. Thanks to the long-term investment and work of many actors in many fora, it is now possible to state that mental health no longer belongs to the area of shameful and unspeakable things. Instead, it has been brought to the centre of the public health policy arena.

During the Ministerial Conference, we found strength in each other's views and experiences, and the road forward is already paved with evidence from individual countries' success stories. Our common future encompasses investments in mental health promotion and ill health prevention, and in the development of community-based, integrated mental health services for empowered citizens. The Conference illustrated the creative partnerships between researchers, professionals, users, family members and policy-makers that are needed to bring forward this too long neglected field.

The Conference was not an end-point, but the starting point for developing a multitude of mental health actions in a public health framework. The Mental Health Action Plan for Europe is a challenge for all Member States. The work outlined in the Action Plan will need many actors, and I hope that the newly established Finnish WHO Collaborating Centre for Mental Health Promotion, Prevention and Policy Development, hosted by the Finnish National Research and Development Centre for Welfare and Health (STAKES), will be able to provide solid support to WHO in its implementation.

The Government of Finland extends its thanks for a successful Ministerial Conference not only to the WHO Regional Office for Europe but also to the European Commission, the Council of Europe, the Member States that made this turning point possible by supporting the preparations for this meeting and – finally – to all the countries that participated and made a commitment to a new era in mental health.

Liisa Hyssälä,
Minister of Health and Social Services, Finland

Foreword

At the WHO European Ministerial Conference on Mental Health, held in Helsinki in January 2005, the Mental Health Declaration for Europe and the Mental Health Action Plan for Europe were signed and endorsed on behalf of ministers of health of the 52 Member States in the WHO European Region.

The signing symbolizes a strong commitment by governments to work to solve the daunting challenges facing mental health in Europe. Member States, representatives of professional organizations and nongovernmental organizations all demonstrated a powerful and unique commitment to take the action set out in the Declaration and to work together in its spirit. The European values of equality, fairness and solidarity, reflecting both the WHO constitution and its policy for health for all, stand at the heart of the mental health agenda for the next 5–10 years.

The present circumstances motivate all of us for the hard work that lies ahead. Improving mental health is one of the biggest challenges facing every country in the Region, where mental health problems affect at least one in four people at some time in their lives. Although much is known about what works in mental health care and treatment, and how to prevent mental disorders and promote well-being, many people receive little or no treatment or support.

Too often, prejudice and stigma hamper the development of mental health policies, and these are reflected in the lack of respect for the human rights of mentally ill people, the low status of the services provided and the lack of support given to work for mental health. All countries must work with limited resources, but their mental health budgets constitute on average only 5.8% of their total health expenditure, even though mental health problems are responsible for nearly 20% of the burden of disease. Depression alone is responsible for 6.2% of the total burden of disease in the WHO European Region.

Nevertheless, hopeful signs are appearing. Many countries are restructuring their services to reflect the latest learning and experience. Recognition of mental health as a public health priority is growing. The Conference showed that mental health activities no longer exclusively focus on treating and institutionalizing people with severe and enduring mental illness. The Declaration recognizes that policy and services need to address the needs of the population as a whole, groups at risk and people suffering from a wide range of mental health problems. Activities therefore need to be comprehensive and integrated, covering mental health promotion, early intervention in crises, in-novative community-based care and policies to achieve social inclusion.

The commitments in the Declaration and the Action Plan are based on information and evidence from across the WHO European Region. Together, they form a solid and inspiring foundation on which governments, policy-makers and nongovernmental organizations, along with WHO, can build solutions to improve the quality of life of all citizens in the European Region. I look forward to the progress that will be made.

Marc Danzon
WHO Regional Director for Europe

1. Mental health in Europe – The context

Countries in the WHO European Region face enormous challenges in working to promote the mental well-being of their populations, to prevent mental health problems in marginalized and vulnerable groups and to treat, care for and support the recovery of people with mental health problems. Mental health has growing priority across the Region, owing to the awareness of both the human and economic costs to society and the suffering of individuals. The WHO European Ministerial Conference on Mental Health, held in Helsinki in January 2005, identified the main issues to be tackled, and viable solutions that can be implemented in all countries, regardless of their stage of mental health development.

This book presents the two main results of the Conference: the Mental Health Declaration and Action Plan for Europe, which were adopted by the Member States in the Region and enshrine their commitment to improve mental health. Then follow 14 briefings on the areas of work in the Action Plan, including examples of successful interventions, and a brief description of the way forward for the mental health programme of the WHO Regional Office for Europe in assisting Member States to reach the ambitious goals they have set for themselves. This chapter, however, describes the current situation in the Region – and the challenge to which countries are responding through the Declaration and Action Plan.

Burden

Mental health is currently one of the biggest challenges facing every country in the Region, with mental health problems affecting at least one in four people at some time in their lives. The prevalence of mental health disorders is very high in Europe. Of the 870 million people living in the European Region, at any one time about 100 million people are estimated to suffer from anxiety and depression; over 21 million to suffer from alcohol use disorders; over 7 million from Alzheimer's disease and other dementias; about 4 million from schizophrenia; 4 million from bipolar affective disorder; and 4 million from panic disorders.

Neuropsychiatric disorders are the second greatest cause of the burden of disease on the Region after cardiovascular diseases. They account for 19.5% of all disability-adjusted life-years (DALYs – years lost to ill health and premature death). Depression alone is the third greatest cause, accounting for 6.2% of all

DALYs. Self-inflicted injuries are the eleventh leading cause of DALYs, accounting for 2.2%. Alzheimer's disease and other dementias are the fourteenth leading cause of DALYs, accounting for 1.9%. The number of people with these disorders is likely to increase further as the population ages.

Neuropsychiatric disorders also account for over 40% of chronic disease and are the greatest cause of years lived with disability. Depression is the single most important cause. Five of the highest fifteen contributors are mental disorders. In many countries, mental health problems account for 35–45% of absenteeism from work.

One of the most tragic results of mental health problems is suicide. Nine of the ten countries in the world with the highest rates of suicide are in the European Region. The most recent available data show that about 150 000 people, of whom 80% are male, commit suicide every year. Suicide is a leading and hidden cause of death among young adults, second only to traffic accidents among those aged 15–35 years.

Stigma and discrimination

Too often, the widespread stigma attached to mental health problems jeopardizes the development and implementation of mental health policy. Stigma is the main cause of discrimination and exclusion: it affects people's self-esteem, helps to disrupt their family relationships, and limits their ability to socialize and get housing and jobs. It also contributes to the abuse of human rights in some large institutions.

Mental health promotion

Governments now recognize the importance of mental well-being for all citizens. It is fundamental to the quality of life, enabling people to experience life as meaningful and to be creative and active. Public mental health reinforces lifestyles conducive to mental well-being. Mental health promotion needs to target the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.

Prevention of harmful stress and suicide

People in many countries are exposed to harmful stress that leads to an increase in anxiety and depression, alcohol and other substance use disorders, violence and suicidal behaviour. Countries are now aware of the potential benefits of activities to reduce harmful stress and the importance of reducing suicide rates.

The social causes of mental health problems are manifold, ranging from individual causes of distress to issues that affect a whole community or society. They can be induced or reinforced in many different settings, including the home, educational facilities, the workplace and institutions. Marginalized and vulnerable

groups – such as refugees and migrant populations, and people who are unemployed, in or leaving prisons, have different sexual orientations, have disabilities or are already experiencing mental health problems – can be at particular risk.

Services

In many instances, care based in the community has been shown to offer a better quality of life and greater satisfaction for service users and their families than traditional hospital care. Across the Region, bed numbers are falling and institutions are being closed down, but the pace of change is uneven. Institutional care still dominates in most parts of the Region. In a quarter of European countries, mental health services are not available in the community. In some countries, over 50% of all patients are treated in large mental hospitals. Indeed, more than two thirds of all mental hospital beds in Europe are in psychiatric hospitals. In some countries, 85% of the money devoted to mental health is spent on maintaining large institutions. In over one third, treatment for severe mental health disorders is not available from family doctors and there are no mental health training programmes for family doctors or other primary health care professionals. One fifth of countries do not make the three essential psychotropic drugs (amitriptyline, chlorpromazine and phenytoin) available in primary health care. One fifth also do not have a therapeutic drug policy or an essential drug list.

The quality of care depends heavily on the quality of the workforce. The significant variations between countries in the number of mental health professionals arouses concern:

* the number of psychiatrists ranges from 1.8 to 25 per 100 000 population;
* the number of psychiatric nurses ranges from 3 to 104 per 100 000 population;
* the number of psychologists ranges from 0.1 to 96 per 100 000 population.

Treatment gap

A vast gap exists between the need for treatment and the services available. In a European Union survey published in 2003, 90% of people who said they had mental health problems reported they had received no care or treatment in the previous 12 months. Only 2.5% of them had seen a psychiatrist or psychologist. Even in developed countries with well-organized health care systems, between 44% and 70% of patients with mental health disorders do not receive treatment. For example, in western Europe alone, evidence indicates that about 45% of people suffering from depression get no treatment.

Cost and financing

Mental health disorders cost national economies billions of dollars in terms of expenditure and loss of productivity. Human and economic costs also fall on

people with mental health disorders and their families, whose lives can be severely affected.

All countries in the European Region must work with limited resources, but their mental health budgets constitute on average only 5.8% of their total health expenditure, while ranging from about 0.1% to 12%. A large proportion of these budgets is allocated to services, and only negligible amounts invested in promotion and prevention.

Empowerment

Empowerment and advocacy are important mechanisms to address these issues. Poor advocacy and a lack of financial support for service users' and carers' organizations hinder the design and implementation of policies and activities that are sensitive to their needs and wishes. The absence of the voices of users and carers from the process reflects the stigma of mental health problems, and can reinforce negative attitudes.

These are the challenges that the WHO European Region is facing in mental health. The Mental Health Declaration for Europe (see pp. 9–15) and the Mental Health Action Plan for Europe (see pp. 17–30), both endorsed at the Conference, are a signal that gives hope to service users, carers and families – to everyone working for better mental health in Europe.

2. Main issues and challenges

Introduction

On 12–15 January 2005, delegations from the 52 Member States in the WHO European Region gathered in Helsinki, Finland for the first WHO European Ministerial Conference on Mental Health, organized by the WHO Regional Office for Europe and hosted by the Finnish Ministry of Social Affairs and Health. Ministers and other high-level decision-makers met to make decisions about future policies on mental health across the Region. The delegations also included medical and technical experts, and representatives of service users' groups. The ministers agreed on a Mental Health Declaration and Action Plan for Europe, which will drive policy on mental health in the Region for at least the next five years.

The Conference proved to be an historic moment in the history of mental health policy in Europe, following many years of painstaking work. It was remarkable, too, for the overwhelming endorsement by Member States of the Declaration and Action Plan.

Countries in the European Region face a considerable challenge. Poor mental health affects one in four people at some time in life. As a major source of lost productivity across the Region, it also has high economic costs. Action is needed, not just from individuals, but from society as a whole, especially when the public remains prejudiced against people with mental health problems, and stigma impedes progress.

Reaching agreement is one thing; delivering on the commitments made and reaching the goals set are another. The Declaration and the Action Plan demand nothing less than a paradigm shift in the nature and delivery of mental health policy and services across the European Region. This will be easier for some countries than for others, but the Conference demonstrated that everyone has signed up for the journey – Member States, nongovernmental organizations and WHO – no matter its length. All European Member States now share the principles and priorities that will underlie future mental health policy and all have agreed on the direction of travel to act on them.

The Conference marked the end of the beginning – a vital first step. This chapter focuses on some of the challenges that lie ahead.

Health

Considerable emphasis was given throughout the Conference to the need to rebalance mental health policy to give a higher priority to promotion and, where

possible, prevention. Like public health policy more generally, mental health suffers from the emphasis given to acute, hospital-based care, which continues to receive most of the resources and attention. Of course, treatment is essential and gaps remain throughout the European Region. Nevertheless, treatment on its own is not the answer, since its benefits are often marginal and any treatment entails risk. Treatment can also lead to the medicalization of social problems.

The Conference participants (Annex 1) did not seek to divert resources from hard-pressed acute care services, but made the importance of evidence-based policy that promotes mental health a central theme of the Conference and of the Declaration.

Ensuring success will require determination and political commitment. Many countries can testify to the production of many worthy, attractive-looking public health policy statements over the years that failed to be implemented. Now that countries have declared their commitment to the Declaration and the Action Plan, delivery needs to follow.

Empowerment

Conference participants heard a great deal about the notion of empowering service users and their families and friends. Complex issues are involved, but making rhetoric into reality remains the challenge.

The notion of empowerment receives a great deal of lip service, but deep-seated issues of power and professional status are at stake and should not be ignored. Bringing service users and their families into hitherto closed decision-making practices and arenas can be threatening for professionals and disempowering for the users and families. The process should be transparent and designed to benefit everyone concerned. The users of mental health services are experts about their conditions and states of health. It is only right that they become co-producers of their health alongside professionals, and equal partners in that endeavour.

At the strategic and managerial levels, users and their carers help to shape policies and services. There is a long way to go before this becomes accepted routine practice. Successful initiatives were cited throughout the Conference, are mentioned in the body of this book and now need to become part of mainstream mental health policy and practice.

Innovation and solidarity

No single model of care is perfect, although some are clearly more attractive and effective than others. Different countries have different models to offer, and they should embrace diversity as an advantage. Countries should be open to and invest in innovation and change, and search for new ways to tackle familiar problems. Countries have expressed their wish to exchange information and models of good practice, and to provide active support to those that lack the requisite expertise.

Knowledge

There is a need for better information about developments in the Region and for comparative data on European countries where appropriate. Collecting them may be a task for public health observatories, for which a European movement now exists. More research is not needed to describe the problems – there is already an abundance of this. More research is urgently needed, however, to evaluate interventions for their cost–effectiveness and to identify what works.

Nevertheless, there is also a need to apply the considerable knowledge that already exists. While gaps in knowledge will always occur and need to be filled, they should not become an excuse for inaction. Action can be taken on the basis of "good enough" information about what works, rather than waiting for perfect data to appear. Much is known already; the greater problem is often a failure to act on that knowledge.

Learning

The need for and importance of learning within and more particularly between countries in the Region was stressed at the Conference several times. WHO is well-placed and -equipped to undertake the task of education and to help countries transform knowledge into action.

For example, research and development often focus too much on research at the expense of development. A European strategy is needed on the dissemination of knowledge and the development of evidence-based mental health care. Part of this should entail more investment in learning opportunities as a central component of development. Mental health services need to become learning organizations, open to new ideas and new ways of delivering care and support. The Region is rich in its diversity, and much can be learned from the various practices and models of care followed.

Intersectoral policy and practice

Health ministries are behind the Declaration and Action Plan, but other government ministries need to lend their support if change is to occur. Finance ministries and those dealing with housing, education, social care and employment all need to become as committed as the health ministries. Indeed, they may sometimes be more important in bringing about change.

Health ministers have a key role to play in influencing the agendas of other ministries, and in raising their awareness of the importance of the Declaration and Action Plan. This will require a vigorous struggle against the compartmentalized thinking that is the scourge of all governments and other large organizations. Cooperative work must also extend to the voluntary and private sectors.

Sustainability

In adopting the Declaration and Action Plan, countries have pledged to maintain their commitment beyond the duration of the Conference. Creating policies and

services that promote mental health, prevent ill health and provide treatment and recovery care will be a long haul, not a quick sprint. Although ministers and governments in countries will change, political commitment to the Declaration and Action Plan must be sustained if their goals are to be achieved.

Implementation

Implementation is the final and most important challenge. Indeed, it covers all the other points mentioned. For implementation to occur, countries must translate the Declaration and the Action Plan into achievable policy objectives within their respective systems, and build in monitoring and evaluation from the start, to show what progress has been made or what obstacles hinder it. Important first tasks for countries will include customizing implementation to their particular circumstances and pacing it to match the resources available.

Setting ambitious but achievable goals, and ensuring that leadership and management skills are in place and that the workforce can play its part are vital tasks. It is encouraging that several countries have offered their assistance with such practical issues, so that countries that lack appropriate infrastructure can be supported in filling this need.

Conclusion

The key themes mentioned here are the critical issues that emerged from discussions during the Conference. There is no room for complacency. It is time to move from words to action, and the Declaration and the Action Plan provide the vehicle for doing so, at a pace that is agreed by and is realistic for each country.

3. Mental Health Declaration for Europe

Preamble

1. We, the Ministers of Health of Member States in the European Region of the World Health Organization (WHO), in the presence of the European Commissioner for Health and Consumer Protection, together with the WHO Regional Director for Europe, meeting at the WHO Ministerial Conference on Mental Health, held in Helsinki from 12 to 15 January 2005, acknowledge that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens. We believe that the primary aim of mental health activity is to enhance people's well-being and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors.

2. We recognize that the promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority for WHO and its Member States, the European Union (EU) and the Council of Europe, as expressed in resolutions by the World Health Assembly and the WHO Executive Board, the WHO Regional Committee for Europe and the Council of the European Union. These resolutions urge Member States, WHO, the EU and the Council of Europe to take action to relieve the burden of mental health problems and to improve mental well-being.

3. We recall our commitment to resolution EUR/RC51/R5 on the Athens Declaration on Mental Health, Man-made Disasters, Stigma and Community Care and to resolution EUR/RC53/R4 adopted by the WHO Regional Committee for Europe in September 2003, expressing concern that the disease burden from mental disorders in Europe is not diminishing and that many people with mental health problems do not receive the treatment and care they need, despite the development of effective interventions. The Regional Committee requested the Regional Director to:
   - give high priority to mental health issues when implementing activities concerning the update of the Health for All policy;
   - arrange a ministerial conference on mental health in Europe in Helsinki in January 2005.

4. We note resolutions that support an action programme on mental health. Resolution EB109.R8, adopted by the WHO Executive Board in January 2002, supported by World Health Assembly resolution WHA55.10 in May 2002, calls on WHO Member States to:

- adopt the recommendations contained in *The world health report 2001*;
- establish mental health policies, programmes and legislation based on current knowledge and considerations regarding human rights, in consultation with all stakeholders in mental health;
- increase investment in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations.

5. Resolutions of the Council of the European Union, recommendations of the Council of Europe and WHO resolutions dating back to 1975 recognize the important role of mental health promotion and the damaging association between mental health problems and social marginalization, unemployment, homelessness and alcohol and other substance use disorders. We accept the importance of the provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms, of the Convention on the Rights of the Child, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and of the European Social Charter, as well as the Council of Europe's commitment to the protection and promotion of mental health, which has been developed through the Declaration of its Ministerial Conference on Mental Health in the Future (Stockholm, 1985) and through its other recommendations adopted in this field, in particular Recommendation R(90)22 on protection of the mental health of certain vulnerable groups in society and Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder.

Scope

6. We note that many aspects of mental health policy and services are experiencing a transformation across the European Region. Policy and services are striving to achieve social inclusion and equity, taking a comprehensive view of the balance between the needs and benefits of diverse mental health activities aimed at the population as a whole, groups at risk and people with mental health problems. Services are being provided in a wide range of community-based settings and no longer exclusively in isolated and large institutions. We believe that this is the right and necessary direction. We welcome the fact that policy and practice on mental health now cover:

i.   the promotion of mental well-being;
ii. the tackling of stigma, discrimination and social exclusion;

iii. the prevention of mental health problems;
iv. care for people with mental health problems, providing comprehensive and effective services and interventions, offering service users and carers[1] involvement and choice;
v. the recovery and inclusion into society of those who have experienced serious mental health problems.

Priorities

7. We need to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

i. foster awareness of the importance of mental well-being;
ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
iv. address the need for a competent workforce, effective in all these areas;
v. recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

Actions

8. We endorse the statement that there is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. Therefore we, ministers responsible for health, commit ourselves, subject to national constitutional structures and responsibilities, to recognizing the need for comprehensive evidence-based mental health policies and to considering ways and means of developing, implementing and reinforcing such policies in our countries. These policies, aimed at achieving mental well-being and social inclusion of people with mental health problems, require actions in the following areas:

i. promote the mental well-being of the population as a whole by measures that aim to create awareness and positive change for individuals and families, communities and civil society, educational and working environments, and governments and national agencies;

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[1] The term "carer" is used here to describe a family member, friend or other informal caregiver.

ii.   consider the potential impact of all public policies on mental health, with particular attention to vulnerable groups, demonstrating the centrality of mental health in building a healthy, inclusive and productive society;

iii.   tackle stigma and discrimination, ensure the protection of human rights and dignity and implement the necessary legislation in order to empower people at risk or suffering from mental health problems and disabilities to participate fully and equally in society;

iv.   offer targeted support and interventions sensitive to the life stages of people at risk, particularly the parenting and education of children and young people and the care of older people;

v.   develop and implement measures to reduce the preventable causes of mental health problems, comorbidity and suicide;

vi.   build up the capacity and ability of general practitioners and primary care services, networking with specialized medical and non-medical care, to offer effective access, identification and treatments to people with mental health problems;

vii.   offer people with severe mental health problems effective and comprehensive care and treatment in a range of settings and in a manner which respects their personal preferences and protects them from neglect and abuse;

viii. establish partnership, coordination and leadership across regions, countries, sectors and agencies that have an influence on the mental health and social inclusion of individuals and families, groups and communities;

ix.   design recruitment and education and training programmes to create a sufficient and competent multidisciplinary workforce;

x.   assess the mental health status and needs of the population, specific groups and individuals in a manner that allows comparison nationally and internationally;

xi.   provide fair and adequate financial resources to deliver these aims;

xii.   initiate research and support evaluation and dissemination of the above actions.

9. We recognize the importance and the urgency of facing the challenges and building solutions based on evidence. We therefore endorse the Mental Health Action Plan for Europe and support its implementation across the WHO European Region, each country adapting the points appropriate to its needs and resources. We are also committed to showing solidarity across the Region and to sharing knowledge, best practice and expertise.

Responsibilities

10. We, the Ministers of Health of the Member States in the WHO European Region, commit ourselves to supporting the implementation of the following

measures, in accordance with each country's constitutional structures and policies and national and subnational needs, circumstances and resources:

i.   enforce mental health policy and legislation that set standards for mental health activities and uphold human rights;

ii.   coordinate responsibility for the formulation, dissemination and implementation of policies and legislation relevant to mental health within government;

iii.   assess the public mental health impact of government action;

iv.   eliminate stigma and discrimination and enhance inclusion by increasing public awareness and empowering people at risk;

v.   offer people with mental health problems choice and involvement in their own care, sensitive to their needs and culture;

vi.   review and if necessary introduce equal opportunity or anti-discrimination legislation;

vii.   promote mental health in education and employment, communities and other relevant settings by increasing collaboration between agencies responsible for health and other relevant sectors;

viii. prevent risk factors where they occur, for instance, by supporting the development of working environments conducive to mental health and creating incentives for the provision of support at work or the earliest return for those who have recovered from mental health problems;

ix.   address suicide prevention and the causes of harmful stress, violence, depression, anxiety and alcohol and other substance use disorders;

x.   recognize and enhance the central role of primary health care and general practitioners and strengthen their capacity to take on responsibility for mental health;

xi.   develop community-based services to replace care in large institutions for those with severe mental health problems;

xii.   enforce measures that end inhumane and degrading care;

xiii. enhance partnerships between agencies responsible for care and support such as health, benefits, housing, education and employment;

xiv.   include mental health in the curricula of all health professionals and design continuous professional education and training programmes for the mental health workforce;

xv.   encourage the development of specialized expertise within the mental health workforce, to address the specific needs of groups such as children, young people, older people and those with long-term and severe mental health problems;

xvi.   provide sufficient resources for mental health, considering the burden of disease, and make investment in mental health an identifiable part of overall health expenditure, in order to achieve parity with investments in other areas of health;

    xvii. develop surveillance of positive mental well-being and mental health problems, including risk factors and help-seeking behaviour, and monitor implementation;

    xviii. commission research when and where knowledge or technology is insufficient and disseminate findings.

11. We will support nongovernmental organizations active in the mental health field and stimulate the creation of nongovernmental and service user organizations. We particularly welcome organizations active in:

    i.   organizing users who are engaged in developing their own activities, including the setting up and running of self-help groups and training in recovery competencies;

    ii.   empowering vulnerable and marginalized people and advocating their case;

    iii. providing community-based services involving users;

    iv. developing the caring and coping skills and competencies of families and carers, and their active involvement in care programmes;

    v.   setting up schemes to improve parenting, education and tolerance and to tackle alcohol and other substance use disorders, violence and crime;

    vi. developing local services that target the needs of marginalized groups;

    vii. running help lines and Internet counselling for people in crisis situations, suffering from violence or at risk of suicide;

    viii. creating employment opportunities for disabled people.

12. We call upon the European Commission and the Council of Europe to support the implementation of this WHO Mental Health Declaration for Europe on the basis of their respective competences.

13. We request the WHO Regional Director for Europe to take action in the following areas:

    (a) partnership:

        i. encourage cooperation in this area with intergovernmental organizations, including the European Commission and the Council of Europe;

    (b) health information:

        i. support Member States in the development of mental health surveillance;

        ii. produce comparative data on the state and progress of mental health and mental health services in Member States;

    (c) research:

        i. establish a network of mental health collaborating centres that offer opportunities for international partnerships, good quality research and the exchange of researchers;

    ii. produce and disseminate the best available evidence on good practice, taking into account the ethical aspects of mental health;

(d) policy and service development:
    i. support governments by providing expertise to underpin mental health reform through effective mental health policies that include legislation, service design, promotion of mental health and prevention of mental health problems;
    ii. offer assistance with setting up "train the trainer" programmes;
    iii. initiate exchange schemes for innovators;
    iv. assist with the formulation of research policies and questions;
    v. encourage change agents by setting up a network of national leaders of reform and key civil servants;

(e) advocacy:
    i. inform and monitor policies and activities that will promote the human rights and inclusion of people with mental health problems and reduce stigma and discrimination against them;
    ii. empower users, carers and nongovernmental organizations with information and coordinate activities across countries;
    iii. support Member States in developing an information base to help empower the users of mental health services;
    iv. facilitate international exchanges of experience by key regional and local nongovernmental organizations;
    v. provide the media, nongovernmental organizations and other interested groups and individuals with objective and constructive information.

14. We request the WHO Regional Office for Europe to take the necessary steps to ensure that mental health policy development and implementation are fully supported and that adequate priority and resources are given to activities and programmes to fulfil the requirements of this Declaration.

15. We commit ourselves to reporting back to WHO on the progress of implementation of this Declaration in our countries at an intergovernmental meeting to be held before 2010.

Minister of Health and Social Services of Finland   WHO Regional Director for Europe

4. Mental Health Action Plan for Europe

This Action Plan is endorsed in the Mental Health Declaration for Europe by ministers of health of the Member States in the WHO European Region. They support its implementation in accordance with each country's needs and resources.

The challenges over the next five to ten years are to develop, implement and evaluate policies and legislation that will deliver mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems. The priorities for the next decade are to:

i.   foster awareness of the importance of mental well-being;
ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
iv. address the need for a competent workforce, effective in all these areas;
v.   recognize the experience and knowledge of service users and carers[2] as an important basis for planning and developing services.

This Action Plan proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries of the WHO European Region, requiring action in the 12 areas as set out below. Countries will reflect these policies in their own mental health strategies and plans, to determine what will be delivered over the next five and ten years.

1. Promote mental well-being for all
Challenge
Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is

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[2] The term "carer" is used here to describe a family member, friend or other informal caregiver.

an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies. Public mental health and lifestyles conducive to mental well-being are crucial to achieving this aim. Mental health promotion increases the quality of life and mental well-being of the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.

Actions to consider

i. Develop comprehensive strategies for mental health promotion within the context of mental health, public health and other public policies that address the promotion of mental health across the lifespan.

ii. Adopt promotion of mental health as a long-term investment and develop education and information programmes with a long time frame.

iii. Develop and offer effective programmes for parenting support and education, starting during pregnancy.

iv. Develop and offer evidence-based programmes that foster skills, provide information and focus on resilience, emotional intelligence and psycho-social functioning in children and young people.

v. Improve access to healthy diets and physical activity for older people.

vi. Promote community-based multilevel interventions involving public awareness campaigns, primary care staff and community facilitators such as teachers, clergy and the media.

vii. Integrate mental health promotion components into existing generic health promotion and public health policies and programmes, such as those supported by WHO health promoting networks.

viii. Encourage the consumption of healthy products and reduce the intake of harmful products.

ix. Create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles.

x. Offer effective mental health promotion activities to groups at risk such as people with enduring mental or physical health problems and carers.

xi. Identify clear mechanisms for empowering the population to take responsibility for health promotion and disease prevention targets, for example by heightening public awareness of the importance of life choices.

2. Demonstrate the centrality of mental health

Challenge

Mental health is central to building a healthy, inclusive and productive society. Sound and integrated public policies, such as those on labour, urban planning and

socioeconomic issues, also have a positive impact on mental health and reduce the risk of mental health problems. The mental health implications of all public policy, and particularly its potential impact on groups at risk, therefore need to be considered. Mental health policy requires intersectoral linkages and should incorporate multisectoral and multidisciplinary approaches.

Actions to consider
i. Make mental health an inseparable part of public health.
ii. Incorporate a mental health perspective and relevant actions into new and existing national policies and legislation.
iii. Include mental health in programmes dealing with occupational health and safety.
iv. Assess the potential impact of any new policy on the mental well-being of the population before its introduction and evaluate its results afterwards.
v. Give special consideration to the relative impact of policies on people already suffering from mental health problems and those at risk.

3. Tackle stigma and discrimination

Challenge
Mental health policy development and implementation must not be jeopardized by the widespread stigma attached to mental health problems that leads to discrimination. In many instances, people with mental health problems suffer from a lack of equal opportunities because of such discrimination. Human rights and respect for people with mental health problems must be protected. Empowerment is a crucial step towards meeting these objectives, as it enhances integration and social inclusion. The lack of empowerment of service users' and carers' organizations and poor advocacy hinder the design and implementation of policies and activities that are sensitive to their needs and wishes. The exclusion experienced by mental health service users, whether in asylums and institutions or in the community, needs to be tackled in a variety of ways.

Actions to consider
i. Instigate activities to counter stigma and discrimination, emphasizing the ubiquity of mental health problems, their general good prognosis and treatability, and the fact that they are rarely associated with violence.
ii. Introduce or scrutinize disability rights legislation to ensure that it covers mental health equally and equitably.
iii. Develop and implement national, sectoral and enterprise policies to eliminate stigma and discrimination in employment practices associated with mental health problems.

iv. Stimulate community involvement in local mental health programmes by supporting initiatives of nongovernmental organizations.

v.   Develop a coherent programme of policy and legislation to address stigma and discrimination, incorporating international and regional human rights standards.

vi. Establish constructive dialogue with the media and systematically provide them with information.

vii. Set standards for representation of users and their carers on committees and groups responsible for planning, delivery, review and inspection of mental health activities.

viii. Stimulate the creation and development of local and national nongovernmental and service-user-run organizations representing people with mental health problems, their carers and the communities they live in.

ix. Encourage the integration of children and young people with mental health problems and disabilities in the regular educational and vocational training system.

x.   Establish vocational training for people suffering from mental health problems and support the adaptation of workplaces and working practices to their special needs, with the aim of securing their entry into competitive employment.

4. Promote activities sensitive to vulnerable life stages

Challenge

Infants, children and young people, and older people are particularly at risk from social, psychological, biological and environmental factors. Given their vulnerability and needs, young and older people should be a high priority for activities related to the promotion of mental health and the prevention and care of mental health problems. However, many countries have inadequate capacity in this area, and services and staff are often poorly prepared to deal with developmental and age-related problems. In particular, disorders in childhood can be important precursors of adult mental disorders. Supporting the mental health of children and adolescents should be seen as a strategic investment that creates many long-term benefits for individuals, societies and health systems.

Actions to consider

i.   Ensure that policies on mental health include as priorities the mental health and well-being of children and adolescents and of older people.

ii. Incorporate the international rights of children and adolescents and of older people into mental health legislation.

iii. Involve young people and older people as much as possible in the decision-making process.

iv. Pay special attention to marginalized groups, including children and older people from migrant families.

v. Develop mental health services sensitive to the needs of young and older people, operated in close collaboration with families, schools, day-care centres, neighbours, extended families and friends.

vi. Promote the development of community centres for older people to increase social support and access to interventions.

vii. Ensure that age- and gender-sensitive mental health services are provided by both primary care and specialized health and social care services and operate as integrated networks.

viii. Restrict institutional approaches for the care of children and adolescents and older people that engender social exclusion and neglect.

ix. Improve the quality of dedicated mental health services by establishing or improving the capacity for specialized interventions and care in childhood and adolescence and old age, and by training and employing adequate numbers of specialists.

x. Improve coordination between organizations involved in alcohol and drugs programmes and children's and adolescents' health and mental health at the national and international levels, as well as collaboration between their respective networks.

xi. Ensure parity of funding in relation to comparable health services.

5. Prevent mental health problems and suicide

Challenge

People in many countries are exposed to harmful stress-inducing societal changes that affect social cohesion, safety and employment and lead to an increase in anxiety and depression, alcohol and other substance use disorders, violence and suicidal behaviour. The social precipitants of mental health problems are manifold and can range from individual causes of distress to issues that affect a whole community or society. They can be induced or reinforced in many different settings, including the home, educational facilities, the workplace and institutions. Marginalized and vulnerable groups, such as refugees and migrant populations, the unemployed, people in or leaving prisons, people with different sexual orientations, people with physical and sensorial disabilities and people already experiencing mental health problems, can be particularly at risk.

Actions to consider

i. Increase awareness of the prevalence, symptoms and treatability of harmful stress, anxiety, depression and schizophrenia.

ii.   Target groups at risk, offering prevention programmes for depression, anxiety, harmful stress, suicide and other risk areas, developed on the basis of their specific needs and sensitive to their background and culture.

iii. Establish self-help groups, telephone help-lines and web sites to reduce suicide, particularly targeting high-risk groups.

iv.   Establish policies that reduce the availability of the means to commit suicide.

v.   Introduce routine assessment of the mental health of new mothers by obstetricians and health visitors and provide interventions where necessary.

vi.   For families at risk, provide home-based educational interventions to help proactively to improve parenting skills, health behaviour and interaction between parents and children.

vii. Set up in partnership with other ministers evidence-based education programmes addressing suicide, depression, alcohol and other substance use disorders for young people at schools and universities and involve role models and young people in the making of campaigns.

viii. Support the implementation of community development programmes in high-risk areas and empower nongovernmental agencies, especially those representing marginalized groups.

ix.   Ensure adequate professional support and services for people encountering major crises and violence, including war, natural disasters and terrorist attacks in order to prevent post-traumatic stress disorder.

x.   Increase awareness among staff employed in health care and related sectors of their own attitudes and prejudices towards suicide and mental health problems.

xi.   Monitor work-related mental health through the development of appropriate indicators and instruments.

xii. Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising.

xiii. Involve mainstream agencies responsible for employment, housing and education in the development and delivery of prevention programmes.

6. Ensure access to good primary care for mental health problems

Challenge

For many countries in the European Region, general practitioners (GPs) and other primary care staff are the initial and main source of help for common mental health problems. However, mental health problems often remain undetected in people attending GPs or primary care services and treatment is not always

adequate when they are identified. Many people with mental health problems, particularly those who are vulnerable or marginalized, experience difficulties in accessing and remaining in contact with services. GPs and primary care services need to develop capacity and competence to detect and treat people with mental health problems in the community, supported as required as part of a network with specialist mental health services.

Actions to consider

i. Ensure that all people have good access to mental health services in primary health care settings.

ii. Develop primary care services with the capacity to detect and treat mental health problems, including depression, anxiety, stress-related disorders, substance misuse and psychotic disorders as appropriate by expanding the numbers and skills of primary care staff.

iii. Provide access to psychotropic medication and psychotherapeutic interventions in primary care settings for common as well as severe mental disorders, especially for individuals with long-term and stable mental disorders who are resident in the community.

iv. Encourage primary health care staff to take up mental health promotion and prevention activities, particularly targeting factors that determine or maintain ill health.

v. Design and implement treatment and referral protocols in primary care, establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services.

vi. Create centres of competence and promote networks in each region which health professionals, service users, carers and the media can contact for advice.

vii. Provide and mainstream mental health care in other primary care services and in easily accessible settings such as community centres and general hospitals.

7. Offer effective care in community-based services for people with severe mental health problems

Challenge

Progress is being made across the Region in reforming mental health care. It is essential to acknowledge and support people's right to receive the most effective treatments and interventions while being exposed to the lowest possible risk, based on their individual wishes and needs and taking into account their culture, religion, gender and aspirations. Evidence and experience in many countries support the development of a network of community-based services including hospital

beds. There is no place in the twenty-first century for inhumane and degrading treatment and care in large institutions: an increasing number of countries have closed many of their asylums and are now implementing effective community-based services. Special consideration should be given to the emotional, economic and educational needs of families and friends, who are often responsible for intensive support and care and often require support themselves.

Actions to consider

i.   Empower service users and carers to access mental health and mainstream services and to take responsibility for their care in partnership with providers.

ii. Plan and implement specialist community-based services, accessible 24 hours a day, 7 days a week, with multidisciplinary staff, to care for people with severe problems such as schizophrenia, bipolar disorder, severe depression or dementia.

iii. Provide crisis care, offering services where people live and work, preventing deterioration or hospital admission whenever possible, and only admitting people with very severe needs or those who are a risk to themselves or others.

iv. Offer comprehensive and effective treatments, psychotherapies and medications with as few side effects as possible in community settings, particularly for young people experiencing a first episode of mental health problems.

v.   Guarantee access to necessary medicines for people with mental health problems at a cost that the health care system and the individual can afford, in order to achieve appropriate prescription and use of these medicines.

vi. Develop rehabilitation services that aim to optimize people's inclusion in society, while being sensitive to the impact of disabilities related to mental health problems.

vii. Offer services for people with mental health needs who are in non-specialist settings such as general hospitals or prisons.

viii. Offer carers and families assessment of their emotional and economic needs, and involvement in care programmes.

ix. Design programmes to develop the caring and coping skills and competencies of families and carers.

x.   Scrutinize whether benefit programmes take account of the economic cost of caring.

xi. Plan and fund model programmes that can be used for dissemination.

xii. Identify and support leaders respected by their peers to spearhead innovation.

xiii. Develop guidelines for good practice and monitor their implementation.

xiv. Introduce legal rights for people subject to involuntary care to choose their independent advocate.

xv. Introduce or reinforce legislation or regulations protecting the standards of care, including the discontinuation of inhuman and degrading care and interventions.

xvi. Establish inspection to reinforce good practice and to stop neglect and abuse in mental health care.

8. Establish partnerships across sectors

Challenge

Essential services, which in the past were routinely provided in large institutions or were not considered as relevant to the lives of people with mental health problems, are nowadays often fragmented across many agencies. Poor partnership and lack of coordination between services run or funded by different agencies lead to poor care, suffering and inefficiencies. The responsibilities of different bodies for such a wide range of services need coordination and leadership up to and including government level. Service users and their carers need support in accessing and receiving services for issues such as benefits, housing, meals, employment and treatment for physical conditions, including substance misuse.

Actions to consider

i. Organize comprehensive preventive and care services around the needs of and in close cooperation with users.

ii. Create collaborative networks across services that are essential to the quality of life of users and carers, such as social welfare, labour, education, justice, transport and health.

iii. Give staff in mental health services responsibility for identifying and providing support for needs in daily living activities, either by direct action or through coordination with other services.

iv. Educate staff in other related services about the specific needs and rights of people with mental health problems and those at risk of developing mental health problems.

v. Identify and adjust financial and bureaucratic disincentives that obstruct collaboration, including at government level.

9. Create a sufficient and competent workforce

Challenge

Mental health reform demands new staff roles and responsibilities, requiring changes in values and attitudes, knowledge and skills. The working practices of many mental health care workers and staff in other sectors such as teachers,

benefit officers, the clergy and volunteers need to be modernized in order to offer effective and efficient care. New training opportunities must respond to the need for expertise in all roles and tasks to be undertaken.

Actions to consider

i. Recognize the need for new staff roles and responsibilities across the specialist and generic workforce employed in the health service and other relevant areas such as social welfare and education.

ii. Include experience in community settings and multidisciplinary teamwork in the training of all mental health staff.

iii. Develop training in the recognition, prevention and treatment of mental health problems for all staff working in primary care.

iv. Plan and fund, in partnership with educational institutions, programmes that address the education and training needs of both existing and newly recruited staff.

v. Encourage the recruitment of new mental health workers and enhance the retention of existing workers.

vi. Ensure an equitable distribution of mental health workers across the population, particularly among people at risk, by developing incentives.

vii. Address the issue of lack of expertise in new technologies of present trainers, and support the planning of "train the trainers" programmes.

viii. Educate and train mental health staff about the interface between promotion, prevention and treatment.

ix. Educate the workforce across the public sector to recognize the impact of their policies and actions on the mental health of the population.

x. Create an expert workforce by designing and implementing adequate specialist mental health training for all staff working in mental health care.

xi. Develop specialist training streams for areas requiring high levels of expertise such as the care and treatment of children, older people and people suffering from a combination of mental health problems and substance use disorder (comorbidity).

10. Establish good mental health information

Challenge

In order to develop good policy and practice in countries and across the Region, information has to be available about the current state of mental health and mental health activities. The impact of any implementation of new initiatives should be monitored. The mental health status and the help-seeking behaviour of populations, specific groups and individuals should be measured in a manner that allows comparison across the WHO European Region. Indicators should be standardized and comparable locally, nationally and internationally in order

to assist in the effective planning, implementation, monitoring and evaluation of an evidence-based strategy and action plan for mental health.

Actions to consider

i. Develop or strengthen a national surveillance system based on internationally standardized, harmonized and comparable indicators and data collection systems, to monitor progress towards local, national and international objectives of improved mental health and well-being.

ii. Develop new indicators and data collection methods for information not yet available, including indicators of mental health promotion, prevention, treatment and recovery.

iii. Support the carrying out of periodic population-based mental health surveys, using agreed methodology across the WHO European Region.

iv. Measure base rates of incidence and prevalence of key conditions, including risk factors, in the population and groups at risk.

v. Monitor existing mental health programmes, services and systems.

vi. Support the development of an integrated system of databases across the WHO European Region to include information on the status of mental health policies, strategies, implementation and delivery of evidence-based promotion, prevention, treatment, care and recovery.

vii. Support the dissemination of information on the impact of good policy and practice nationally and internationally.

11. Provide fair and adequate funding

Challenge

Resources dedicated to mental health are often inadequate and inequitable compared to those available to other parts of the public sector, and this is reflected in poor access, neglect and discrimination. In some health care systems, insurance coverage of access and rights to treatment discriminate severely against mental health problems. Within the mental health budget, resource allocation should be equitable and proportionate, i.e. offering greatest relative share and benefits to those in greatest need.

Actions to consider

i. Assess whether the proportion of the health budget allocated to mental health fairly reflects the needs and priority status of the people with needs.

ii. Ensure that people with the most severe problems and the poorest in society receive the largest relative benefits.

iii. Assess whether funding is allocated efficiently, taking into account societal benefits, including those generated by promotion, prevention and care.

iv. Evaluate whether coverage is comprehensive and fair in social and private insurance-based systems, on an equal level to that for other conditions, not excluding or discriminating against groups and particularly protecting the most vulnerable.

12. Evaluate effectiveness and generate new evidence

Challenge

Considerable progress is being made in research, but some strategies and interventions still lack the necessary evidence base, meaning that further investment is required. Furthermore, investment in dissemination is also required, since the existing evidence concerning effective new interventions and national and international examples of good practice are not known to many policy-makers, managers, practitioners and researchers. The European research community needs to collaborate to lay the foundations for evidence-based mental health activities. Major research priorities include mental health policy analyses, assessments of the impact of generic policies on mental health, evaluations of mental health promotion programmes, a stronger evidence base for prevention activities and new service models and mental health economics.

Actions to consider

i. Support national research strategies that identify, develop and implement best practice to address the needs of the population, including groups at risk.

ii. Evaluate the impact of mental health systems over time and apply experiences to the formulation of new priorities and the commissioning of the necessary research.

iii. Support research that facilitates the development of preventive programmes aimed at the whole population, including groups at risk. Research is needed on the implications of the interrelated nature of many mental, physical and social health problems for effective preventive programmes and policies.

iv. Promote research focused on estimating the health impacts of non-health sector policies, as there is a clear potential for positive mental health to be improved through such policies.

v. Bridge the knowledge gap between research and practice by facilitating collaboration and partnerships between researchers, policy-makers and practitioners in seminars and accessible publications.

vi. Ensure that research programmes include long-term evaluations of impact not only on mental health but also on physical health, as well as social and economic effects.

vii. Establish sustainable partnerships between practitioners and researchers for the implementation and evaluation of new or existing interventions.

viii. Invest in training in mental health research across academic disciplines, including anthropology, sociology, psychology, management studies and economics, and create incentives for long-term academic partnerships.

ix. Expand European collaboration in mental health research by enhancing networking between WHO's European collaborating centres and other centres with research activities in the field of prevention.

x. Invest in regional collaboration on information and dissemination in order to avoid the duplication of generally applicable research and ignorance of successful and relevant activities elsewhere.

Mental health for Europe: facing the challenges

Milestones

Member States are committed, through the Mental Health Declaration for Europe and this Action Plan, to face the challenges by moving towards the following milestones. Between 2005 and 2010 they should:

1. prepare policies and implement activities to counter stigma and discrimination and promote mental well-being, including in healthy schools and workplaces;

2. scrutinize the mental health impact of public policy;

3. include the prevention of mental health problems and suicide in national policies;

4. develop specialist services capable of addressing the specific challenges of the young and older people, and gender-specific issues;

5. prioritize services that target the mental health problems of marginalized and vulnerable groups, including problems of comorbidity, i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness;

6. develop partnership for intersectoral work and address disincentives that hinder joint work;

7. introduce human resource strategies to build up a sufficient and competent mental health workforce;

8. define a set of indicators on the determinants and epidemiology of mental health and for the design and delivery of services in partnership with other Member States;

9. confirm health funding, regulation and legislation that is equitable and inclusive of mental health;

10. end inhumane and degrading treatment and care and enact human rights and mental health legislation to comply with the standards of United Nations conventions and international legislation;
11. increase the level of social inclusion of people with mental health problems;
12. ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities.

5. Mental health services in Europe: the treatment gap

"Sometimes they have to be standing on a bridge before we can get help."
– A GP (1)

Facing the challenges

One of the primary functions of mental health services is to provide treatment to all who need it. Mental health services in Europe do not perform well on this criterion. Most individuals with mental disorders in Europe, including many with severe disorders, do not receive treatment for their condition. The treatment gap (the percentage of individuals who require mental health care, but do not receive it) is high for most mental disorders in Europe *(2)*.

Mental disorders impose a heavy burden on individuals, families and societies. According to the most recent available data from the WHO's Global Burden of Disease study, neuropsychiatric disorders are the second cause of DALYs lost in the WHO European Region, amounting to one fifth of DALYs lost due to all health conditions.

In terms of years lived with disability (YLD), the proportion is even higher (more than two fifths) *(3)*. Unipolar depressive disorder alone led to 13.7% of YLD and was the first cause of YLD in the European Region.

Four of the top fifteen contributors to DALYs in Europe are neuropsychiatric conditions: depression (in third place), alcohol use disorder (sixth), self-inflicted injuries (eleventh) and dementia (fourteenth).

The burden owing to neuropsychiatric disorders is high in the European Region and will increase in the future because of the continent's ageing population.

One of the most tragic results of mental health problems is suicide. According to WHO data, nine of the ten countries with the highest rates of completed suicide are in the European Region *(3)*.

Gaps in mental health policy and financing

Mental health policy at the national level is considered essential for the comprehensive development of mental health services.

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The existence and quality of policies on mental health care in countries in the European Region is uneven. Data from WHO's atlas on mental health resources in the world *(4)* highlights these deficiencies.

- One third of European countries do not have specified mental health policies.
- More than two fifths of them do not have mental health programmes.
- One fifth do not have a therapeutic drug policy or an essential drug list.
- One fifth of countries have not made the three essential psychotropic drugs – an antidepressant, an antipsychotic and an antiepileptic – available in primary care.
- One sixth do not have substance abuse policies.
- About a tenth do not have mental health legislation.
- Three fifths do not have a national suicide prevention initiative.

Financing of mental health services is also inadequate. Current resource allocation to mental health care does not fully reflect the impact of mental disorders *(5)*.

- The 24 countries in the European Region for which data are available allocate an average of 5.8% of their national or federal health budget to mental health, while mental disorders represent 20% of the burden of disease *(4)*.
- In particular, depression, which is responsible for 6.2% of the total burden of disease, attracts only 0.5–1.0% of national health expenditure, according to information available from the United Kingdom *(6)*.

A mixture of tax and social insurance funding mechanisms dominate general health care in Europe. In principle, these mechanisms promote equity in access to all health care interventions, including those for mental health. However, funding through social insurance, a method that is dominant in 50% of European countries, may not ensure the financing of social care, housing, etc., and services to population groups such as the unemployed, immigrants and the Roma community. Almost all countries also levy user charges, which can potentially affect access. The exemption of specific groups from charges (such as those on low incomes, those with chronic conditions, the unemployed, children and the elderly) varies across Europe.

Large service and treatment gap

The result of inadequate policies and financing is a large service and treatment gap for mental disorders.

- More than one third of countries do not provide treatment for severe mental disorders in the primary care setting or training in mental health for primary care personnel.

- More than one quarter of countries do not provide community care for mental disorders.
- More than two thirds of the beds available in Europe are still in psychiatric hospitals.

The treatment gap for schizophrenia and non-affective psychosis (severe mental illnesses) was 17.8% in studies from western Europe, according to a recent review of all available scientific studies *(2)*.

For other disorders, the gap was as follows:

- generalized anxiety disorder: 62.3%
- panic disorder: 47.2%
- major depression: 45.4%
- dysthymia: 43.9%
- bipolar disorder: 39.9%
- obsessive compulsive disorder: 24.6%.

Alcohol abuse and dependence had the largest treatment gap at 92.4%.

In the WHO-initiated world mental health surveys, which were linked to the European Study on Epidemiology of Mental Disorders, information has recently become available from seven European countries (Belgium, France, Germany, Italy, the Netherlands, Spain and Ukraine) *(7)*.

- Between 8.2% and 20.4% of people in those countries had experienced mental disorders within the previous 12 months and about half of them had disorders of at least moderate severity.
- Substantial loss of productivity was caused by moderate or severe mental disorders.
- The fact that many people with subthreshold disorders are treated, while many with serious disorders are not, shows that unmet need for treatment among serious cases is a result not merely of limited resources for treatment but also of the misallocation of those resources.

The fact that services were sought does not imply that treatment was provided adequately or at all. Data from six western European countries *(8)* showed that:

- among those who sought help in the health sector, one fifth did not receive any treatment;
- psychotropic drug utilization was generally low in individuals with mental disorders (32.6%);
- among individuals with major depression, only 21.2% had received any antidepressants; the exclusive use of antidepressants was even lower (4.6%), while more individuals took only anxiolytics (18.4%) *(9)*;
- psychotherapy was used even less often than pharmacotherapy.

A mature service should be able to provide care to meet existing needs, rather than being based on population-linked formulae. A Nordic study on people with schizophrenia living in the community found that, in general, patients reported a need for help from services clearly exceeding the actual amount of help received. The areas of need related to social and interpersonal functioning demonstrated the highest proportion of unmet to total needs *(10)*.

Health resources and services inequitably distributed

Equitable distribution of resources and services is necessary to ensure their maximum impact, especially for vulnerable groups *(4)*. However, countries in the European Region present a mixed picture on this criterion:

- two thirds of European countries do not provide special programmes for minorities;
- half do not have special programmes for refugees or disaster-affected populations;
- nearly two fifths do not provide special programmes for the elderly;
- one fifth do not provide special programmes for children and adolescents.

Services for the rich and the poor

Examination of a comprehensive and exhaustive psychiatric case register of all psychiatric inpatient care in Belgium in 1997 and 1998 found that such care was associated with socioeconomic status. Lower socioeconomic groups were more likely to be compulsorily admitted, to be cared for in non-teaching or psychiatric hospitals, to be admitted to hospitals with unexpectedly long average lengths of stay and to be admitted to wards with more severe case mixes (all indicators of poor-quality services). They were less likely to receive antidepressants and psychotherapies. The improvements in functioning and in symptoms were also less favourable for these groups. In addition, the lowest socioeconomic group had a higher risk of dying in hospital *(11)*.

A French study of a general population sample and a sample of recipients of a social benefit (Revenu minimal d'insertion) that is not targeted at people with mental health problems showed that mental disorders were significantly more frequent among recipients. Examination of a depressed subsample showed that depressed recipients made less use of available medical care for their depression. On average, the duration of depressive episodes was longer in recipients, especially in women *(12)*.

Ethnic minorities

Low utilization of support services and less desirable or less effective routes taken through psychiatric services are features of ethnic minority use of mental health

services. Failure to access support services at an early stage is linked to worsening mental health outcomes and greater likelihood of involuntary admission, detention in secure psychiatric settings and greater police involvement in the sectioning process. Insufficient accessing of mental health services may increase with repeated contact over time, suggesting that negative experiences of those services by ethnic minorities may contribute to their underutilization *(13)*.

A practice-based cross-sectional survey of the prescription of antidepressants and anxiolytics (daily defined dosages) in 164 general practices in the United Kingdom showed that Asian ethnicity alone accounted for 28% of the variation in antidepressant prescription and 20.5% of the variation in anxiolytic prescription (more than half of the explained variance), suggesting a possibility of practical difficulties in diagnosis and management of patients from these groups within the general practice setting *(14)*. Ethnic minority communities are far less likely to be offered "talking therapies" such as counselling, more likely to be offered chemotherapy, and tend to be prescribed higher drug dosages than their white counterparts *(13)*. The spiritual aspects of patients are rarely seen as a priority and, where health care services address the issue, it is usually from a Christian perspective *(15)*.

Life stages

In 1999, the Swedish Society for Old Age Psychiatry conducted an investigation in all Swedish counties in order to survey existing organizations and resources for medical services intended for elderly people with psychiatric complaints. In some counties, there were no outpatient units specifically aimed at elderly people with psychiatric diseases, while more than half had no outpatient units for the large group of elderly people with psychiatric ailments other than dementia. Less than 5% of the total number of Swedish psychiatrists and geriatricians held positions exclusively for geriatric psychiatry. Access to geriatric psychiatry resources was unevenly distributed and was found mainly in or near cities with universities *(16)*.

An examination of the distribution and key characteristics of child and adolescent psychiatric inpatient units in England and Wales showed that they are unevenly distributed, with a concentration of beds in London and south-eastern England. The independent sector, which provides more than a quarter of beds and manages a high proportion of very specialized services, accentuates this uneven distribution *(17)*.

Prisons

The first full survey of the mental health of prisoners in England and Wales undertaken by the Office for National Statistics showed that psychiatric morbidity was far more common among prisoners than in the general population. Only one prisoner in ten showed no evidence of any mental disorder, and no more than two out of ten had only one disorder. Ten per cent of men on remand and 14% of all

female prisoners had signs of psychotic illness in the year prior to interview in prison, compared with 0.4% in the general population. Over a quarter of female remand prisoners reported attempting suicide in the preceding year and 2% of both male and female remand prisoners reported having attempted suicide in the week before interview *(18)*. Reasons for this high prevalence could be higher risk of arrest for people with mental disorder alleged to have offended, inadequate coverage by court assessment schemes, inadequate psychiatric services and poor identification during reception into prison. Services offered to mentally ill offenders were not equivalent to those available to non-offenders in terms of staff training, guidance on policy or practice, and integration with general mental health services in the United Kingdom *(19)*.

Building solutions

The Declaration and the Action Plan aim to achieve healthy societies and to alleviate the suffering of people with mental health problems through actions that can contribute to closing the existing gaps in treatment and services. These actions include:

- developing comprehensive national mental health legislation and policies;
- assessing whether the proportion of the health budget allocated to mental health care fairly reflects the needs and priority status of the people served;
- ensuring that people with the most severe problems and the poorest in society receive the largest relative benefits;
- evaluating whether coverage is comprehensive and fair in social and private insurance-based systems, on an equal level to that for other conditions, not excluding or discriminating against groups and particularly protecting the most vulnerable;
- developing primary care services with the capacity to detect and treat mental health problems, including depression, anxiety, stress-related disorders and substance misuse by expanding the numbers and skills of primary care staff;
- planning and implementing specialist community-based services, accessible 24 hours a day, 7 days a week, with multidisciplinary staff, to care for people with severe problems such as schizophrenia, bipolar disorder, severe depression or dementia;
- providing access to psychotropic medication and simple psychotherapeutic interventions in the primary care setting for common as well as severe mental disorders, especially for individuals with long-term and stable mental disorders who reside in the community;
- guaranteeing access to necessary medicines for people with mental health problems at a cost that the health care system and the individual can afford, in order to achieve appropriate prescription and use of these medicines;
- ensuring an equitable distribution of mental health workers across the population, particularly among people at risk, by developing incentives;

- ensuring that national action plans on mental health include the mental health and well-being of children and adolescents and the elderly as priorities;
- paying special attention to groups at risk, including children and elderly from migrant families;
- developing mental health services sensitive to the needs of young and elderly people, operated in close collaboration with families, schools, day-care centres, neighbours, extended families and friends;
- supporting the implementation of community development programmes in high-risk areas and empowering nongovernmental organizations (NGOs), especially those representing marginalized groups.

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6. Stigma and discrimination against the mentally ill in Europe

"I used to get stones thrown at my window, knocking on the window every night, windows broken. I got name-called: loony, nutter and other names."
– Pauline Lee, interviewed in *Open up (1)*

Facing the challenges

Stigma "is one of the most important problems encountered by people with severe psychiatric disorders. It lowers their self-esteem, contributes to disrupted family relationships and adversely affects their ability to socialize, obtain housing and become employed" *(2)*.

Although mental health problems occur in almost every family at some point, people who experience them still meet fear and prejudice from others and are made to feel ashamed and excluded. The stigma and discrimination associated with having a mental illness are often so devastating that they prevent people from seeking help for fear of being labelled. Effectively reducing stigma and discrimination requires concerted action by all interested parties – service users, carers, professional groups and civil society – with strong government back-up.

At a WHO meeting in Athens in 2001, mental health professionals and members of mental health organizations from the countries of southern and south-eastern Europe signed a declaration encouraging government officials to tackle stigma and discrimination. The declaration was welcomed and supported by the WHO Regional Committee for Europe in resolution EUR/RC51/R5 adopted later that year. During round-table discussions at the World Health Assembly in 2001, health ministers from around the world called for action to fight stigma and discrimination, stating: "More than 50% of all patients in some eastern European countries continue to be treated in large mental hospitals. Stigma and discrimination with regard to mental illness make early intervention extremely difficult, especially in rural areas" *(3)*.

Misconceptions

There are many misconceptions in our societies that create and fuel stigma and turn it into discriminatory behaviour.

Although attitudes towards mental illness are less negative in the cases of dementia and depression, the perception of mentally ill people as violent and

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Some of the common myths about mental health problems
- "People with mental health problems are violent and dangerous."
- "People with mental health problems are poor and less intelligent."
- "Mental health problems are caused by personal weakness."
- "Mental illness cannot be treated."

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aggressive has increased among the general population. People in residential psychiatric care, mentally ill refugees and ethnic minorities with mental disorders are especially vulnerable to discrimination. Importantly, psychiatric treatment and care are also considered to be less effective than other medical treatments *(4)*.

Stigma prevents people with mental health problems seeking mental health services even if there are effective treatments available. A number of studies have found that people with mental health problems often do not attend psychiatric clinics and other mental health facilities even when they have made an appointment.

Building solutions

In 1991, the United Nations General Assembly adopted the *Principles for the protection of persons with mental illness and the improvement of mental health care (5)*. The document sets out principles and rights that work towards combating stigma and discrimination related to mental health illness.

Effective treatment

There are effective treatments for mental disorders that can reduce symptoms and unwanted and disturbing behaviour. These may be pharmaceutical, psychotherapeutic or social interventions, and they need to be backed up by improved services and support.

Good treatment is a cornerstone to removing discrimination. The case of epilepsy is a good example of how providing effective treatment can reduce stigma. Epilepsy is still highly stigmatized, but much less so in countries where there is now access to modern effective treatment. Similarly, the changed treatment and care of mentally retarded people in many of the affluent countries of Europe have radically improved the living conditions of this group, traditionally stigmatized and discriminated against, and brought a dramatic change to their quality of life.

"I am too afraid to mention some of my diagnoses to people, so I just say I have 'depression' as it's not seen as so bad. I have self-harm scars and I don't know what people think of that, but now I don't care because I am a survivor!"

– Catherine, aged 33

Employment and support

Access to meaningful jobs is also considered to be one of the most important ways of empowering people suffering from mental disorders. Promoting job

opportunities for such people changes both the public perception and their own perception of themselves. There are good examples of such initiatives, such as the international Fountain House movement.

> "After I lost my job and acknowledged my illness I thought I could never work again. Mentally ill and over fifty years old, but the miracle happened. After regaining my self-esteem working in the Fountain House for a year, I entered 'the world of the working'. Life took a turn. Now I was in recovery. I was working like any other healthy individual. Life has not been easy. I have had my share of difficulties in my job, perhaps more so than a completely healthy man. The work has nonetheless changed my life for the better and I have enjoyed tackling and conquering difficulties I have faced."
>
> – Jón Sigurgeirsson, member of a Fountain House club in Iceland

The role of patients', service users' and family organizations in fighting stigma is also crucial. In many countries, these organizations have taken a leading role. It is important that they should receive support and cooperation from governments and professional groups – they are usually weak and lacking in economic resources. There are good examples from many countries where strong support has created solid organizations. It is also important that these organizations should be included in policy development consultations.

> "As a health care professional (who suffers from psychotic depression) I would not expect my colleagues to stigmatize. However, after the recent publicity about selective serotonin reuptake inhibitors (SSRIs), at a meeting partly to discuss this, it was suggested by two more senior colleagues that depression was purely due to family problems and that you had to be on antipsychotics to have a true psychiatric disorder. I am, but, needless to say, they do not know this. I found it difficult to contribute to this meeting. I find it hard to believe these people can call themselves health care professionals."
>
> – Anonymous woman

Legislation can also help. Safeguarding human rights, especially the right to adequate treatment and protection against abuse, is particularly important in the case of compulsory treatment, which is sometimes used unnecessarily. In some countries, special rights legislation has been introduced to secure medical treatment and social care for the most vulnerable groups.

The effects of anti-stigma campaigns have been various and their outcomes not always easy to quantify, but they are still an important tool in fighting stigma and discrimination. Many different kinds of programmes have been developed. In the United Kingdom, several long-lasting campaigns have been run by professional organizations and users' and family organizations. The World Psychiatric Association is running a global programme to fight the stigma and discrimination associated with schizophrenia, with local action groups in a number of countries (see examples below).

> "People wouldn't look you in the eye. The mothers at school, they would put their heads down and walk past you, and you would hear the comments: 'She's mad, you know'."
>
> – Alison McDermott, in *Open up (1)*

Role of the media

If our only view of the world were through the lens of the media, would our opinion about people with stigmatized mental health problems be accurate? Research conducted over the past 30 years has convincingly demonstrated that the mass media are one of the most significant influences on belief systems *(6)*. Because people with stigmatized illnesses do not usually announce themselves, others often form their attitudes through the films, television programmes and news reports they see. That is why the media have an important role to play in reducing the stigma of mental health problems, and the media can only report correctly if they are given correct and valid information.

What difference will the Declaration and the Action Plan make?

The Declaration and the Action Plan aim to eliminate the stigma that results in people avoiding or not adhering to care because of fear of victimization and abuse by individuals, communities or the state. The Action Plan acknowledges and aims to change the fact that people with mental health problems suffer from derogatory language and reinforcement of negative stereotypes in the workplace and the media. It also acknowledges and aims to change the suffering from lack of equal opportunities, absence of legislation and the often inadequate enforcement of equality and protection of the human rights of people with mental health problems. The Action Plan sets out to achieve reintegration rather than rejection, thus reversing the exclusion and consequent stigma experienced in the past by mental health service users in asylums and institutions.

To address the challenges posed by stigma and discrimination, the Action Plan proposes the following measures:

- instigate activities to counter stigma, emphasizing the ubiquity of mental health problems, their general good prognosis and treatability;
- introduce or scrutinize disability rights legislation to ensure that it covers mental health equally and equitably;
- encourage return to work and retention of jobs for people with mental health problems;
- provide and mainstream mental health care in other primary care services and in easily accessible settings such as community centres and general hospitals;
- stimulate community involvement in local mental health programmes by supporting initiatives of NGOs.

Some examples

Changing Minds

In 1998, the Royal College of Psychiatrists in the United Kingdom commissioned the Office for National Statistics to undertake a nationwide survey of public opinion concerning people with six types of mental illnesses: anxiety disorders, depression, schizophrenia, Alzheimer's disease and dementia, eating disorders, and alcohol and drug misuse.

> "If only those who think of mentally ill people as weak could see the courage, perseverance and determination needed by patients who cope with these disorders."
> – Jill Siddle, in *Changing minds – Our lives and mental illness (7)*

A random sample of the general adult population was surveyed on its attitudes to people with mental health problems in terms of their dangerousness, their unpredictability, the extent to which they had only themselves to blame, whether they could pull themselves together, whether they were hard to talk to and whether they were hard to empathize with.

The majority of the sample group reported a perception that people with schizophrenia or addictions were dangerous, that eating disorders and addictions were self-inflicted and that people with any kind of mental illness were hard to communicate and empathize with.

Armed with this information, the College launched a five-year campaign called Changing Minds: Every Family in the Land *(8)*. It aimed to address negative attitudes, with particular reference to perceived communication difficulties, and thereby to begin to reduce the stigma surrounding the six most common mental disorders. The target populations were medical practitioners, children and adolescents, the media and the general public. The aim was to improve understanding and communication between patients and doctors and other health care workers. Books, leaflets, reports, articles, CD-ROMs, a film, videos, web sites, lectures and opportunities for dialogue were designed for this purpose.

A second nationwide survey, in July 2003, revealed significant reductions in many negative public opinions.

How Different Is Different?

The How Different is Different? programme brings together young people aged 16–19 years and people with mental illness in Ghent, Belgium *(9)*. Based on an idea from Mental Health Ireland's public speaking project, it was initiated in 1991 by the Flemish Mental Health Association (VVGG). School pupils interact with people with mental illness, in either hospitals or community settings, for at least three days. The aim of the programme is to allow human contact between adolescents and people with mental illness. It is crucial that both parties have fun, learn to know each other and discover their similarities.

Every year, all participating classes are visited by a VVGG worker who provides information on mental illness. Each pupil receives a booklet containing the most important facts, and teachers receive a folder with extra information.

In the second stage of the programme, a patient or relative of a patient visits the class and speaks about personal experiences of mental illness. Next, a group of patients in a psychiatric hospital, sheltered living initiative or community mental health centre is contacted and a project is designed.

At the end of the school year, a conference is held in Brussels for all participants, both patients and pupils, to speak about their activities or show a video of their project. When the programme started in 1991, there were 5 participating schools and 20 pupils. By 2003, 1500 pupils from 46 schools were taking part. All Flemish mental health units (both hospitals and community mental health centres) were involved.

A wide range of activities and projects now takes place. In 2003–2004, projects included basketball games (a school team against a team of patients), the preparation and organization of a Christmas party in a home for sheltered living, a bicycle tour, an exhibition of paintings by patients and pupils, the production of a video, and music and dance events.

The diaries of pupils and teachers show a major change in attitude during the project. At the conference in Brussels on 21 April 2004, one participant told the audience how he had been raised to fear the inmates of the psychiatric hospital in his village, and told never to pass there at night. "Now," he said, "I have lots of friends in there; I like to visit them, even after sunset."

Open the Doors

In 1996, the World Psychiatric Association embarked on an international programme to fight stigma and discrimination because of schizophrenia. Nearly a decade later, the programme, called Open the Doors *(10)*, has been implemented in Austria, Brazil, Canada, Chile, Egypt, Germany, Greece, India, Italy, Japan, Morocco, Poland, Slovakia, Spain, Switzerland, Turkey, the United Kingdom and the United States.

It has involved nearly 200 anti-stigma interventions and achieved demonstrable improvements in knowledge and attitudes.

The programme is designed to dispel the myths and misunderstandings surrounding schizophrenia. Stigma creates a vicious cycle of alienation and discrimination that can lead to social isolation, the inability to work, alcohol or drug abuse, homelessness and excessive institutionalization, all of which decrease the chances of recovery. Prejudice diminishes the quality of life of people with schizophrenia and their families and prevents them from living and working with others.

Four features distinguish Open the Doors from other programmes:

- its focus on schizophrenia;
- close collaboration between mental health professionals and those living with the illness and their families in developing and implementing the interventions;
- interventions focused on specific target groups, including journalists, law enforcement officials, general practitioners, secondary school students and government officials;
- the global nature of the programme, which has allowed new local action groups to learn from the experiences of others with the methodologies and communication materials they use.

The programme web site *(10)* has been translated into seven languages and serves as a resource for efforts to counter stigma in many more countries.

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7. Mental health promotion and mental disorder prevention

"An ounce of prevention is worth a pound of cure."
– Proverb

Facing the challenges

The health and social costs

Positive mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community *(1)*. It is a global public good; it is an essential part of the health and well-being of the citizens of Europe and a fundamental human right; it is a prerequisite for a viable, socially responsible and productive Europe; it enhances social cohesion and social capital and improves safety in the living environment *(2)*.

Mental and behavioural disorders are found in people of all ages, regions, countries and societies, and are present at any point in time in 10% of the adult population *(1)*. More than one person in four will develop a mental disorder during his or her life. In 2002, neuropsychiatric conditions accounted for more than 20% of all European ill health and premature death; unipolar depression alone accounted for over 6% of the burden of disease expressed in DALYs *(3)*. Furthermore, mental ill health is also common in people with physical illness; for example, 22% of people with myocardial infarction, 27% of people with diabetes and 33% of people with cancer suffer from major depression *(4)*.

In addition to the health burden, the social and economic costs of mental ill-health for societies are wide ranging, long lasting and enormous. The economic costs of mental health are estimated to be 3–4% of gross national product *(4)*. However, besides the health and social service costs, lost employment and reduced productivity, the impact on families and caregivers, levels of crime and public safety, and the negative impact of premature mortality, many other immeasurable costs have not been taken into account, such as opportunity costs to individuals and families *(1)*.

The costs of not taking action

A lack of positive mental health is a threat to public health, the quality of life and the stability of Europe. The direct and indirect consequences of mental disorders

lead to enormous health and social burdens, including discrimination and marginalization, reduced social cohesion and negative economic effects *(5)*.

Treatment for mental disorders can be effective, but only after the illness has emerged and individuals and their families have already suffered. Positive mental health cannot be achieved by treatment alone. Two recent WHO publications have presented the evidence that mental health promotion and mental disorder prevention can lead to health, social and economic gains *(6,7)*.

A public mental health policy should include the promotion of mental health and the prevention of mental disorders, in addition to treatment and rehabilitation. This will improve the health and the individual and social capital of European societies. Unfortunately, to date, there has been little implementation of evidence-based approaches to promotion and prevention across Europe.

The challenges

The development of a comprehensive strategy for mental health promotion and mental disorder prevention is essential and the first challenge to be met, if countries are to combat mental health problems and promote the positive mental health of the citizens of WHO's European Region.

A second major challenge relates to the implementation process, which needs to include consideration and promotion of the organizational infrastructure and policies required to ensure the long-term maintenance and sustainability of evidence-based programmes.

Moreover, mental health is everybody's business; it is not only an issue of mental or public health, but also one of public policy. Action for mental health is a shared responsibility, and health and economic gains can be achieved through the support and action of many different sectors in society. The third challenge is therefore to create links with and mobilize support from, among others, the environment, social welfare, labour, education, criminal justice and housing sectors.

Finally, if mental health is to be promoted and mental disorders prevented, there must be a climate of respect for and protection of basic civil, political, economic, cultural and social rights. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of health. The right to mental health is enshrined in a number of international agreements and countries should respect it.

Building solutions

The evidence base

The evidence now exists that, when properly implemented, interventions and approaches aimed at mental health promotion and mental disorder prevention are effective and lead to a range of positive health, social and economic outcomes *(6,7)*.

Such approaches include interventions that target infants and children up to 6 years of age, school-aged children, child abuse and neglect, conduct disorder,

violence and aggression, use of addictive substances across the lifespan, parental support and stress, anxiety and depression. For example, poor parental support, child abuse and parental mental illness during infancy and early childhood can lead to depression and anxiety later in life as well as in subsequent generations, while secure attachment and family social support can reduce such risks. Effective parenting support and education, starting during pregnancy, have led to improvements in children's resilience, educational attainment and mental well-being, as well as reduced the risk of anxiety and depression in later life.

Policy initiatives both within and outside the health sector, including policies on transport, education, urban planning, health care, nutrition and labour, can also result in significant improvements in community mental health *(2)*. For example, both the quantity and quality of work have strong influences on factors related to mental health, including income, social networks and self-esteem. Job insecurity, unemployment and low-quality jobs put mental health at risk and increase both anxiety and depression. Educational and job search training for high-risk groups can bring about increases in re-employment and the quality and pay of jobs obtained, greater achievements in job searching, and reduced depression and mental strain. Government management of the economy to reduce the highs and lows of the business cycle and workplace policies, such as job sharing, reduced hours and job security during times of economic difficulty, reduce the risk of job loss, unemployment and their consequences for mental health.

Planning for prevention and promotion in mental health

Countries in WHO's European Region should develop specific action plans or comprehensive strategies for mental health promotion and mental disorder prevention, to be endorsed by the highest political body at each level. The action taken must cover people's whole lifespan in order to ensure a healthy start in life for children and families, school strategies to enhance resilience, and prevention and promotion in mental health during adulthood and old age. The financial resources could, for example, come from a special mental health fund paid for by tobacco and alcohol taxes. In addition, to meet the challenges ahead, the development of effective policies for mental health should be supported by:

- capacity building and the involvement of other sectors and lay people;
- efficient implementation;
- monitoring and evaluation of implementation and outcomes;
- assurance of the sustainability of practices at local and national levels.

Building capacity and involving other sectors and lay people

Mental disorder prevention and mental health promotion require a broad-based professional workforce as well as informed and active citizens. Countries in the Region should build capacity by ensuring that:

- the education of health care professionals imparts the relevant knowledge, attitudes and skills for mental health promotion and mental disorder prevention;
- the practising health workforce has access to continuing education programmes;
- the education of public health professionals prepares them to act as enablers, mediators and advocates for mental health in all sectors, and to identify and engage in work with a broad set of partners in society;
- the education of professionals in other sectors prepares them to recognize the importance of their policies and actions to the mental health of the population.

Interdisciplinary research training programmes should be made available to develop the research skills needed to conduct evaluations and improve the quality and effectiveness of practice. Finally, lay people must be encouraged to become actively engaged in mental health promotion, not merely as objects for professional treatment, but as competent and highly committed mental health promoters in their families, neighbourhoods, schools and workplaces.

Supporting implementation

As a programme or policy moves to more widespread implementation, programme implementers, in collaboration with programme evaluators, will need to ensure the quality of implementation, providing the supportive elements needed for success and adapting and fitting initiatives to each specific cultural situation.

The action that may be taken to implement a mental health promotion policy may differ according to the level of responsibility and the existing policy environment. More use should be made of administrative, financial and management instruments, and of measures that affect and support implementation, research and training. The further use of quality assurance in implementation and continuous improvement of implemented action will be essential. Much more thought should also be given to mechanisms used to inform, involve and promote the rich networks of influence and development within civil societies. It is here, at a decentralized level within societies, that much of the commitment to and activities for mental health promotion will actually occur.

Evaluating existing programmes and assessing the impact of policies

Countries in the European Region should develop, use and report on a common set of indicators, including indicators of mental health and mental disorders, determinants of mental health, and the infrastructure, policies and programmes that are in place to promote mental health and prevent mental disorders. It is essential to evaluate the costs, benefits and impact of programmes in order to expand the

knowledge base for effective prevention. Special attention should be paid to the robustness, long-term impact, cultural sensitivity and cost–effectiveness of the outcomes of available programmes and policies, and to ways in which they can be improved *(7)*. All sectors should be made accountable for the mental health impact of their policies and programmes, and recognize the benefits to themselves of promoting and protecting mental health. Mental health impact assessment must therefore be applied to any social or economic policy or programme, as well as to development projects likely to have an effect on mental health. Further use of quality assurance in implementation and audits of mental health promotion policy are essential.

Ensuring sustainability

The impact of evidence-based programmes on the mental health of communities depends on the duration of their implementation. The effectiveness of programmes is frequently limited by barriers to their sustainable implementation. The WHO report on prevention of mental disorders *(7)* stresses that interventions should:

> promote and build on indigenous resources in order to maximize their local impact over time. To generate mental and public health benefits over a longer period of time, it is crucial to develop communities' accountability to support sustainable strategies within health agencies. To enhance sustainable implementation, governmental authorities and providers should select programmes and policies that can build on existing infrastructures or resources. Mental health promotion and [mental disorder] prevention components could be structurally integrated into existing effective health promotion programmes and social policies in schools, workplaces or communities.

Some examples

Scotland: a comprehensive approach to mental health promotion

The aims of the National Programme for Improving Mental Health and Well-being in Scotland *(8)* are:

- to raise public awareness of mental health and mental illness and promote positive mental health and emotional well-being;
- to eliminate the stigma of mental ill health and the discrimination that people with mental health problems still encounter;
- to prevent suicide and help cope with the aftermath of suicide;
- to promote and support people's recovery from mental illness.

The Programme's work ranges across life stages and settings, including early years, children and young people, later life, employment and working life, community mental health and well-being, and public services. The Programme is a

national strategic approach to public mental health, part of an integrated mental health policy that contributes to improvements in health, economic wealth and prosperity, promoting well-being for all. It has introduced a research and evaluation strategy and each main component of work is subject to independent evaluation. The Programme aims to collect and disseminate the evidence base in mental health improvement and to support practice development. Its actions are supported by an implementation strategy, and agencies work in close collaboration, making the best use of the available infrastructure.

Finland: promoting children's mental health

In Finland, the European Early Promotion Project *(9)* has, since 1997, aimed to develop methods for promoting early parent–child interaction and effective prevention of psychosocial problems in families with infants and young children. The national Project trained more than 2000 primary health care nurses in half of the country's municipalities between 1997 and 2002. The training programme included a manual on the identification of risk factors and focused interventions to be used in primary care and with professionals, such as those working in day care and social services.

In addition, since 2001, the Effective Family Project *(10)* has provided support to children of mentally ill parents, the ultimate aim being to prevent future mental disorders in the children. The Project helps families to continue with life regardless of a parent's mental disorder and supports both the parents and their children's healthy development and ability to cope. Used by social and health care professionals, different cooperating partners and organizations, the Project promotes preventive approaches and builds cooperation between services for adults and those for children. It is based on a psycho-educational approach, through cooperation with the whole family, using the Beardslee preventive family intervention and the "Let's talk about children" intervention as its working methods.

The Netherlands: a specialized workforce on prevention of mental disorders

The Netherlands has an extended system for mental health promotion and mental disorder prevention within the health services, clinics and NGOs. Many of these services have specialized promotion and prevention teams targeting mental health, financed by municipalities or the national health insurance system. The Trimbos Institute, the national institute for mental health and addiction care *(11)*, acts as the coordinating centre for the field. It monitors and informs policy-makers about the organization, accessibility and quality of care and prevention facilities. Over several decades, the prevention teams of the 50 community mental health centres have developed a package of prevention programmes that respond to the needs of each district. By law, universal mental health promotion is set as a specific task for local services, for example, in schools. Nationally implemented programmes

include the "Coping with depression" course, which has been adapted for different groups (such as adolescents, adults, elderly populations), and preventive services for children of mentally ill parents. Two universities offer academic courses in prevention and promotion. Most of the 1000 prevention experts have had some specialized training and are members of the Dutch Association for Prevention and Health Education. The development, evaluation and implementation of evidence-based programmes in mental health are systematically enhanced by the national research programme of the Dutch Health Research and Development Council.

Europe: the Implementing Mental Health Promotion Action network

With the participation of 28 countries and co-sponsored by the European Commission, the Implementing Mental Health Promotion Action (IMHPA) network provides a European platform that combines support for policy priority setting and the dissemination of evidence-based knowledge on prevention and promotion in mental health. IMHPA has developed a European action plan for mental health promotion and mental disorder prevention, a policy framework identifying high-priority policy initiatives to improve mental health, based on their proven efficacy and the practicality of their implementation *(2)*. The action plan presents the case for action and the evidence for successful approaches and implementation strategies for each policy option, providing a framework on which to base the development of effective action plans at the national or regional levels. IMHPA is also compiling a web-based registry of evidence-based interventions for promotion and prevention in mental health across Europe, describing programmes, outcomes and essential features of implementation. To support dissemination and implementation and to stimulate partnership and action nationally, the network's national counterparts are building country coalitions that involve health workers at different professional levels. The purpose of such coalitions is to exchange information on mental health promotion and prevention of mental disorders, to build cooperation and to stimulate developments at national and regional levels.

Stakeholder involvement

Engaging partners for mental health

A wide range of partners must be involved if multisectoral policies and actions are to be developed and harnessed for mental health. Structures and processes should exist at all levels to facilitate harmonized collaboration between all actors and sectors. Many of these potential partners are not aware of the benefits they can gain from investing in mental health promotion. There is therefore a need to overcome the problems posed by single-sector approaches and specific

organizational objectives, budgets and activities; one of these problems is the lack of mechanisms to bring partners together in systematic cooperation. The health sector can provide leadership by engaging in active promotion and advocacy for mental health and by encouraging other sectors to join in multisectoral activities, sharing goals and resources.

Such partnerships are required at different levels (international, country, regional and local) and need to involve a wide range of actors: governmental and nongovernmental bodies, professionals within and outside the health sector, industry and the private sector, the media and civil society. The involvement of all sectors is fundamental to ensuring that programmes reflect priorities, have widespread support and are sustainable. All these initiatives focus on the development of participatory planning models, such as statutory committees and councils with long-term mandates, formal partnership groups, specialized working groups and more informal and ad hoc partnership arrangements.

NGOs, in particular, are essential partners in ensuring accountability in mental health; they are a vital component of a modern civil society, raising people's awareness of issues and their concerns, advocating change and creating a dialogue on policy. Of particular importance are the organizations concerned with civil, cultural, economic, political and social rights, including those that defend the rights of children, religious or ethnic minorities and people with physical and mental disabilities. Their role in mental health promotion and mental disorder prevention should be strengthened.

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8. Mental health and working life

"The mental health of a company's employees can have an important impact on business performance in the same way as does the industrial relations climate or inadequate training."
– Howard Davies, Director-General, Confederation of British Industry

Facing the challenges

The changing world of work

The workplace is one of the key environments that affect our physical and mental health. Working life is undergoing considerable and continuous change. Teleworking, increased use of information and communication technology, and the expansion of the service sector are some examples of changing work patterns. Other changes include the increase in self-regulated and team work, and changes in employment patterns: downsizing, outsourcing, subcontracting and globalization *(1)*. New management forms such as just-in-time delivery and lean organizations pose higher demands for worker flexibility in terms of number and functions of skills, shift work and unsocial hours *(2)*. Superimposed on these new patterns is the effect of ageing and the increased participation of women and immigrants in the European workforce *(1)*. All these changes in working life represent new challenges to mental health and well-being.

How does work affect mental health?

The effects of work on mental health are complex. On the one hand, work is a source of personal satisfaction and accomplishment, interpersonal contacts and financial security, and these are all prerequisites for good mental health. Lack of work or unemployment, on the other, can have negative effects on our mental well-being. Those who become unemployed are twice as likely to have increased depressive symptoms and be diagnosed with clinical depression as those who remain employed *(3)*. When work is poorly organized and when risks at the workplace have not been properly addressed, work can also have negative effects on our mental health and well-being.

Work-related stress is the response people may have when presented with work demands and pressures that are not matched to their knowledge and skills

and challenge their ability to cope. Stress-related hazards can be found in the job content, workload and pace of work, the organization of working time, the level of participation and control in decision-making. Most of the causes of stress concern the way work is designed and the way in which organizations are managed. Other sources of stress can be career development, status and pay, the role of the individual in the organization, interpersonal relationships, the organizational culture and the home–work interface *(4)*.

Stress affects different people in different ways. It can cause violence at work or addictive behaviours: smoking, alcohol and drug abuse, sexual promiscuity, gambling, addiction to modern technology. Stress can lead to psychological problems such as irritation, inability to concentrate, difficulty in making decisions or sleeping disorders. Long-term stress or traumatic events at work can cause mental illness (anxiety and depression) resulting in absence from work and preventing the worker from being able to work again. In the United Kingdom, psychiatric illness is the third most common cause of long spells of sick leave for women and the fourth for men. Depressed workers take 1.5–3.2 days more short-term sickness absence per year than other workers and lose about 20% of their productivity *(5)*. Work-related stress is also associated with physical diseases and health problems, such as myocardial infarction, high blood pressure, ulcers, headache, neck and back pain, skin rashes and low resistance to infections *(3)*.

Stress can affect organizations by causing high rates of absenteeism and staff turnover, disciplinary problems and unsafe working practices, as well as low commitment to work, poor performance, tension and conflicts between colleagues. In addition, stress damages the image of the organization, both among its workers and externally, and increases the liability to legal claims and actions by stressed workers *(4)*.

Another phenomenon present in many workplaces is psychological harassment. It is caused by deterioration of interpersonal relations and organizational dysfunction. One of the most widespread forms of workplace harassment is "mobbing" (or bullying). This is repeated, unreasonable behaviour directed towards an employee, or group of employees, that creates a risk to health and safety. Mobbing involves a misuse or abuse of power where the targets may have difficulty in defending themselves *(6)*. Some examples of mobbing are exclusion, gossiping, humiliation, instigation of colleagues against the victim, ridicule, sexual harassment, spreading false information, threats of violence and verbal abuse *(7)*.

How big is the problem?

A survey carried out in 2000 in the 15 Member States of the EU found that more than half of the 160 million workers report working at very high speeds (56%) or to tight deadlines (60%) for at least one quarter of their time. More than one third have no influence on task order; 40% report having monotonous work.

These work-related stressors are likely to contribute to the health problems reported by the workers: 15% of the working population in the EU in 2000 complained of headache, 23% of neck and shoulder pains, 23% of fatigue, 28% of stress and 33% of backache. Almost 1 in 10 workers reported being subjected to intimidation at the workplace *(8)*. A recent international survey among key stakeholders in the new EU Member States and the candidate countries revealed that almost 90% of the respondents stated that in their countries stress is considered a cause of disease, and that stress and mobbing result from poor work organization *(9)*.

Data from the individual Member States are disturbing. In Austria, 1.2 million workers reported suffering from work-related stress associated with time pressure. In Denmark, 8% of employees reported "often" being emotionally exhausted. In Germany, 98% of works councils claimed that stress and pressure of work had increased in recent years and 85% cited longer working hours. In Spain, 32% of workers described their work as stressful. In Sweden, 9 out of 10 white-collar workers reported working against the clock in their daily tasks, and 40% skipped lunch breaks *(10)*.

How much does it cost?

In the 15 Member States in the EU before May 2004, the cost of stress at work and the related mental health problems is estimated to be on average 3–4% of gross national product, amounting to €265 billion annually *(11)*. Studies estimate that work-related stress alone costs the businesses and governments of these countries about €20 billion in absenteeism and related health costs, in addition to the price of lower productivity, higher staff turnover and reduced ability to innovate *(12)*.

In the United Kingdom in 2000, one in five workers was "extremely" or "very" stressed as result of occupational factors. Stress-related diseases are responsible for the loss of 6.5 million working days each year in the United Kingdom, costing employers around €571 million and society as whole as much as €5.7 billion. In Sweden in 1999, 14% of the 15 000 workers on long-term sick leave said the reason was stress and mental strain. The total cost of sick leave to the state in 1999 was €2.7 billion. In the Netherlands in 1998, mental disorders were the main cause of incapacity (32%) and the cost of work-related psychological illness is estimated to be €2.26 million a year *(10)*.

Are all equally affected?

Not everybody is at the same risk of work-related stress. Certain groups of workers (younger and older workers, women, ethnic minorities, migrant workers and immigrants) are more vulnerable to stress than others. Workers in companies that have undergone major change, such as takeover, or have introduced new management are also at a higher risk of stress *(12)*.

Psychological harassment at the workplace is also related to social inequalities and discrimination based on individual traits and background. It is most frequent in public administration and defence (14%), followed by education and health, hotels and restaurants, and transport and communications (12%). Agriculture and fishing, and utilities supply are the sectors with the lowest frequency of workplace harassment (3%) *(8)*.

What are the challenges for health systems?

The above-mentioned figures suggest that work-related stress and psychosocial risks cause a serious burden of ill health and economic and social costs. Health policies, systems and services need to respond adequately to this challenge. Until now, most of the policies and services designed to prevent and eliminate health risks at the workplace were primarily directed at physical risks and largely ignored psychosocial risks and the effects of work on mental health.

As a result, in many Member States, the occupational health and safety legislation does not address work-related mental health problems. The existing occupational health services, which support employers and workers in assessing the risks at the workplace, do not have enough trained personnel and tools to develop efficient preventive measures to mitigate psychosocial risks at work. Besides that, very few European workers (less than 15%) have access to such services. People suffering from mental ill health face discrimination in the workplace and various barriers to finding a job or returning to work after being sick.

Building solutions

The WHO Mental Health Action Plan for Europe highlights the importance of interventions at the workplace to improve mental health. To improve work-related mental health, national governments, agencies and employers can take measures to minimize the effects of work-related stress and other psychosocial risks on the health of the working population, and to improve the access to work and the social inclusion of people with mental health problems.

Such measures will include incorporating mental health aspects into national policies, legislation, and programmes dealing with occupational health and safety, and into corporate management strategies. It is also important that all workers, particularly those at high risk, have access to occupational health services that can develop effective measures to protect mental health.

Capacities for protecting and promoting mental health at work should be developed through assessing the risks of and managing stress and psychosocial factors, training personnel and raising awareness. Work-related mental health should be monitored, which has been made possible through the development of appropriate indicators and instruments.

National, sectoral and enterprise policies need to be developed and implemented to eliminate discrimination in employment practices associated with

mental ill health and to stimulate measures for the reintegration, rehabilitation and vocational training of people suffering from mental ill health and for the adaptation of workplaces and working practices to their special needs.

Some examples

Good practice in the area of mental health at work includes measures taken at the national and enterprise levels.

Measures at the national level

Several Member States have already included mental health aspects in their national legislation on occupational health and safety. This provides a solid basis for protection and promotion of mental health at the workplace.

> *Work Environment Act, Sweden*
> "Working conditions shall be adapted to people's differing physical and mental capabilities. The employee shall be given the opportunity to participate in the design of his own work situation. … Technologies, work organization and job content shall be designed in such a way that the employee is not subjected to physical strain or mental stress that may lead to illness or accidents. … Closely controlled or restricted conditions of work shall be avoided or limited. Efforts shall be made to ensure that work provides opportunities for variety, social contact and cooperation, as well as coherence between different tasks."

No matter how good legislation is, it only works if properly implemented. For example, the Danish Working Environment Authority (Arbejdstilsynet) includes psychologists as inspectors in areas where workers have complained about symptoms of stress due to high workloads, time pressure and lack of prevention and emergency plans in institutions with violence and threats. Repetitive work and psychosocial problems are among the priorities of the 2002–2005 governmental programme on health and safety at work *(13)*.

Measures at the enterprise level

Whatever the original cause of mental health problems, employers and managers are faced with the following major issues as they attempt to address the mental health needs of their employees:

- recognition and acceptance of mental health as a legitimate concern of the organization;
- effective implementation of the country's anti-discrimination provisions;
- preventive, treatment and rehabilitation programmes that address employees' mental health needs.

Good practice in implementing interventions to improve mental health at the workplace should:

- include an early detection (early warning) system;
- involve the participants in the management of the whole project;
- be integrated into management philosophy;
- include different levels of interventions: that is, the individual, the social environment and working conditions *(5)*.

Anti-stress programme of the Mental Health Trust

The Mental Health Trust, which provides services to a large area in the United Kingdom, realized that the stress-related illnesses of its own employees account for 20% of sickness absenteeism. The Trust therefore introduced an anti-stress pilot programme to reduce anxiety and tension in its employees. The programme included: a stress management group, a listening group for representatives of employees, an organizational stress workshop and the establishment of action groups. As a result, the proportion of sickness absence due to stress was reduced by 3% *(3)*.

Measures by social partners

Trade unions are natural partners in interventions to reduce work-related stress and to promote mental health at the workplace. In Belgium, for example, a federation of trade unions carried out a large-scale cross-sectoral study to identify the basic causes of stress. The German metalworkers' union has been running a vigorous campaign with the telling title "The company: a place of crime – psychological loads – a terror for the soul". In some countries – notably Belgium, Denmark, Germany, Sweden and the United Kingdom – stress is included in collective agreements between the trade unions and employers *(10)*.

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9. Alcohol and mental health

"First the man takes a drink; then the drink takes a drink;
then the drink takes the man."
– Proverb

"Alcoholism isn't a spectator sport. Eventually the whole family gets to play."
– Joyce Rebeta-Burditt, author

Facing the challenges

The European Region of WHO is the one with the highest alcohol intake in the world. Alcohol is the third largest preventable risk factor in the Region and a major cause of mental disorders, accidents and injuries *(1)*. Alcohol consumption is an important mental health issue and a major factor in the global burden of disease.

Alcohol-use disorders are recognized and classified as mental disorders. Hazardous and harmful use of alcohol is associated with a wide range of mental and behavioural problems. It also has social consequences, affecting the lives and indeed the mental health of the people who live or work with an alcohol-dependent person.

Alcohol-use disorders are preventable and, although it is not realistic to expect to eradicate them completely, evidence shows that a whole array of measures can significantly reduce the harm done.

Alcohol can interact with mental health disorders in several ways:

- people with mental ill-health are at higher risk of experiencing alcohol-related problems;
- people with alcohol-use disorders are more likely to suffer from other mental health problems;
- alcohol use by a person with mental ill health can:
  - lead to a poorer treatment outcome;
  - make the symptoms worse;
  - increase the risk of alcohol dependence;
  - have harmful interactions with prescribed medicine;
  - contribute to a worse mood in the long run.

Management of alcohol-related problems should be incorporated into any public health response to mental health problems. Evidence-based preventive

measures are available at both the individual and population levels, with alcohol taxes, restrictions on alcohol availability and drink–driving countermeasures among the most effective policy options. Despite the scientific advances, alcohol problems continue to present a major challenge to medicine and public health.

The scale of the problem

Worldwide, alcohol use causes 1.8 million deaths and 4% of the total disease burden as measured by the WHO Global Burden of Disease study. Unintentional injuries alone account for about one third of the 1.8 million deaths, while neuropsychiatric conditions account for close to 40% of the overall disease burden *(2)*.

In the European Region, there are 86.8 million people (99 per 1000 population) who have harmful levels of alcohol consumption, causing 15.4 million DALYs each year. Of that figure, 5 million DALYs (32%) are lost owing to neuropsychiatric conditions.

Men have a far greater alcohol-related disease burden than women, the ratio being 5:1 (Fig. 9.1). The health damage and social harm caused by alcohol fall not only on the drinker but also on others. Women bear a disproportionate share of the burden of harm from others' drinking *(3)*.

Policies that affect the rates of alcohol-related harm thus not only improve the health and save the lives of those who drink but potentially have a broader impact on the health and well-being of families, communities and society at large.

Fig. 9.1. Proportion of alcohol-attributable disease burden according to subregion and gender in the WHO European Region, 2000
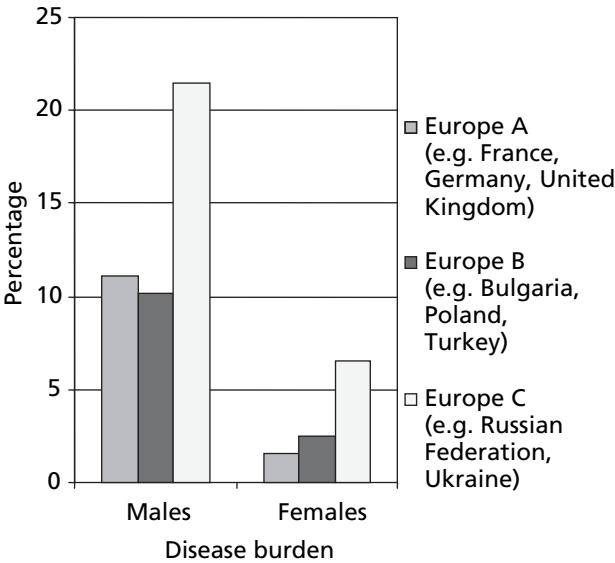
Source: Rehm *(4)*.

Alcohol and depression

The evidence indicates a close relationship between alcohol consumption and depression. Heavy drinking can lead to depression, and depression can lead to hazardous and harmful drinking and alcohol-use disorder. Studies of people in treatment have shown that one of the effects of long-term high alcohol consumption is an increase in depressive symptoms, which tend to disappear when alcohol consumption is reduced or stopped. Policies that reduce consumption, especially among heavier drinkers, might be expected to reduce the burden of disease related to depression.

Alcohol and suicide

The relationship between alcohol consumption and suicide or attempted suicide is well established among heavier drinkers. The risk of suicidal behaviour in this group increases with psychiatric comorbidity. Suicide rates are also found to rise with increased per capita consumption. The suicide rate for younger people seems to be more significantly related to per capita consumption than that for older people. In addition, research suggests that suicide rates tend to be more responsive to changes in per capita alcohol consumption in drinking cultures characterized by irregular heavy drinking occasions. Thus, cultural factors condition the association between alcohol consumption and suicide at the population level, and the strength of the overall relationship is greater in cultures where intoxication is a more prominent characteristic.

Alcohol and schizophrenia

A person with alcohol dependence is more likely to have schizophrenia and a patient with schizophrenia is more likely to exhibit alcohol dependence, than is the general population. Most clinical studies, patient reports and anecdotal clinical observations suggest that excessive use of alcohol leads to a clear exacerbation of the symptoms of schizophrenia. Furthermore, about 30% of patients with comorbidity appear to show a harmful use of alcohol before the first signs of schizophrenia emerge.

Alcohol, aggression and violence

Alcohol is strongly associated with violent crime, and research suggests that it contributes to aggression. The strength of the relationship seems to be culturally dependent, and the pattern of drinking seems to play an important role in causing violence. Thus, both the environment and the characteristics of the drinker influence the effects of alcohol.

Building solutions

Drinking alcoholic beverages is an accepted social custom in most parts of the world. Nevertheless, as it is closely associated with mental disorders and is one

of the most important contributors to disease, injury, disability and premature death, greater attention to public health policies for alcohol control and harm prevention, brief interventions and treatment could prevent a considerable amount of human misery.

For example, the anti-alcohol campaign from 1985 to 1988 in the USSR produced a sharp decline in consumption. It was accompanied by a sudden sharp decline in mortality in the same period. For each litre reduction in pure alcohol consumption per capita in the latter half of the 1980s, the age-standardized mortality rate dropped by 2.7%. Alcohol consumption rose again in the early 1990s, also mirrored in a dramatic increase in mortality from 1990 to 1994. The situation improved in the period 1994–1998, but mortality started to rise again from 1999. The change in life expectancy in the Russian Federation in the past 20 years is a consequence of a complex pattern of trends in different causes of death. Evidence suggests that alcohol has played an important part in this fluctuation.

Even brief interventions can reduce alcohol use. A meta-analysis of 43 brief interventions in primary care and related settings for non-treatment-seeking populations showed that brief advice was effective in reducing drinking-related outcomes – including intoxication, alcohol dependence symptoms and problems in multiple life areas – by 12% more in the intervention group than the control group.

Nevertheless, in spite of the importance of alcohol in many mental health problems, there is little evidence that strategies to promote mental health have specifically targeted harmful and hazardous drinking.

Recent research has contributed substantially to the understanding of the relationship between alcohol consumption and the associated burden on society. There is thus a strong need for the health professions to step up their advocacy of policies that reduce the harm done by alcohol, including in the case of comorbid mental and behavioural disorders.

As a risk factor, alcohol consumption has two dimensions: average volume and patterns of drinking (Fig. 9.2). Research indicates a causal relationship between average volume of alcohol consumption and more than 60 types of disease and injury. Evidence is accumulating that patterns of drinking are an important factor in the link between alcohol and harm. In addition, 40% of the disease burden caused by alcohol arises from acute conditions and is thus almost immediately preventable.

Average consumption figures hide wide variations in individual levels of alcohol consumption and drinking habits. For instance, any population includes people who drink no alcohol. The majority of the drinking population is composed of moderate or light drinkers. Even if a minority, heavy drinkers account for quite a large part of the total alcohol intake.

However, the adverse effects of drinking are not confined to a minority of easily identified heavy or problem drinkers or people dependent on alcohol.

Fig. 9.2. Model of alcohol consumption, intermediate outcomes and long-term consequences
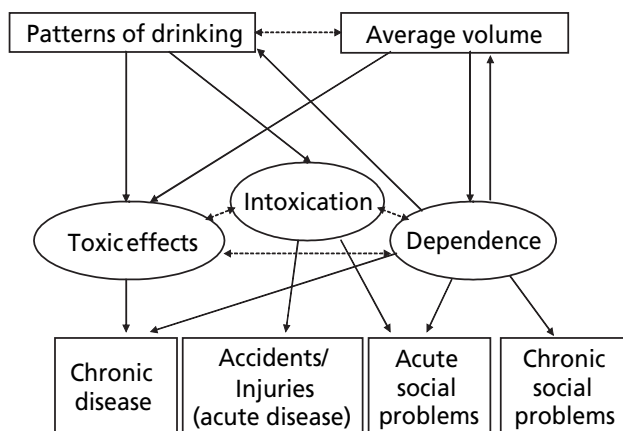
Source: Babor et al. (5).

Many moderate or occasional drinkers also suffer from alcohol-related problems, especially when they use alcoholic beverages as intoxicants. And no matter how drinking is measured, the risk of alcohol dependence begins at low levels of drinking and increases linearly with both the volume of consumption and a pattern of drinking larger amounts on occasion.

On the other hand, most alcohol consumers must see some benefits from drinking alcohol, since they are willing to buy it. Just as the patterns and culture of drinking vary greatly in different societies, so do the incidence and character of alcohol-related benefits and problems.

In the longer term, sustainable alcohol policies and programmes are needed:

- to reduce hazardous and harmful patterns of drinking;
- to separate drinking from certain activities and situations such as driving or operating machinery, working and being pregnant;
- to reduce the overall volume of drinking;
- to provide adequate help to people with alcohol problems, especially those with co-occurring mental and behavioural disorders.

Regional response

Alcohol problems arise in many different situations and affect a variety of people. Appropriate policies will therefore be a mix of different measures.

Three major instruments adopted by WHO have provided a framework for action in the European Region.

Since 1992, the European Alcohol Action Plan has provided a basis for the development and implementation of alcohol policies and programmes in the Member States. The Action Plan for the period 2000–2005 *(6)* aims to prevent and reduce the harm that can be done by alcohol consumption throughout the European Region.

The European Charter on Alcohol *(7)*, adopted by Member States in 1995, sets out the guiding principles and goals for promoting and protecting the health and well-being of all people in the Region. The Charter calls on all Member States to draw up comprehensive alcohol policies and implement programmes, as appropriate in their differing cultures and social, legal and economic environments.

The Declaration on Young People and Alcohol *(8)*, adopted by Member States in 2001, aims to protect children and young people from the pressures to drink and reduce the direct or indirect harm done to them by alcohol. The Declaration reaffirms the five principles of the Charter and underlines the need for public health policies concerning alcohol to be formulated on the basis of public health interests, without interference from commercial interests.

The Action Plan, Charter and Declaration have offered paths for the development and implementation of effective measures on alcohol and therefore contributed to general health policy in the Region.

European Alcohol Action Plan
The overall objectives of the Action Plan for 2000–2005 *(6)* are to:

- generate greater awareness of, provide education in, and build up support for public health policies that address the task of preventing the harm that can be done by alcohol;
- reduce the risk of alcohol-related problems that may occur in a variety of settings such as the home, workplace, community or drinking environment;
- reduce both the breadth and depth of alcohol-related harm such as fatalities, accidents, violence, child abuse and neglect, and family crises;
- provide accessible and effective treatment for people with hazardous and harmful alcohol consumption and those with alcohol dependence;
- provide greater protection from the pressures to drink for children, young people and those who choose not to drink alcohol.

European Charter on Alcohol
The Charter *(7)* was adopted at the European Conference on Health, Society and Alcohol, held in Paris on 12–14 December 1995. It establishes five ethical principles and goals for work to reduce the negative consequences of alcohol consumption in Europe.

- All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.

- All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
- All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
- All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
- All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

Declaration on Young People and Alcohol

Young people are more vulnerable to the effects of drinking, and alcohol is the most important avoidable risk for the burden of disease in adolescents and young adults. The WHO European Ministerial Conference on Young People and Alcohol, held in Stockholm on 19–21 February 2001, adopted a Declaration *(8)* recognizing:

- alcohol as an important issue in young people's health;
- the need to involve young people themselves in the policy-making process;
- the need to determine, at the national and local levels, targets to reduce the impact of alcohol on young people's health;
- the need for alcohol policies directed at young people to be part of a broader societal response, since drinking among young people to a large extent reflects the attitudes and practices of wider adult society.

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10. Suicide prevention

"I actually thought that Wendy was getting a little better and that all she had to do was stick it out. I now realize that it is at this very point that people are at their most vulnerable. They have a little energy and can see where they are and, of course, it is light years away from where they want to be. It all seems so hopeless to them, and it did to Wendy, as she said in her note."

– Widower, personal communication to Technical Officer,
Mental Health, WHO Regional Office for Europe

Facing the challenges

Suicide is not only a personal tragedy; it represents a serious public health problem, particularly in the WHO European Region. From 1950 to 1995, the global rate of suicide for men and women combined increased by 60% *(1)*. Among young and middle-aged people, especially men, suicide is currently a leading cause of death. In the European Region, suicide is the second most common cause of death after traffic accidents in the group aged 15–35 years.

According to the latest available data, an estimated 873 000 people around the world, and 163 000 in the European Region, die from suicide each year *(2)*. While suicide was reported to be the thirteenth leading cause of death globally, it was the seventh leading cause of death in the Region. The highest rates in the European Region are also the highest in the world.

A problem on the rise

Mental disorders and self-destructive behaviour have increased in both poor and rich countries *(3)*. All predictions point to a dramatic increase in suicidal behaviour in the coming decade unless effective preventive measures are put in place.

In the European Region, the average suicide rate is 17.5 per 100 000 population. The mortality supplement to the WHO European health for all database for the latest available year *(4)* shows that the rates vary considerably between countries: from 44.0 in Lithuania, 36.4 in the Russian Federation and 33.9 in Belarus, to 5.9 in Italy, 4.6 in Malta and 2.8 in Greece. The gap between the newly independent states of the former USSR (NIS) and EU countries is 15.8 per 100 000 population. There are also huge gender differences for all age groups. In Lithuania, for instance, 81.7 out of every 100 000 men commit suicide compared

with 11.5 women; corresponding figures in Kazakhstan are 58.8 and 9.1, and in Latvia 48.8 and 10.4, respectively.

Social impact and economic costs

The psychological, social and financial impact of suicide on the family and society is immeasurable. On average, a single suicide intimately affects at least six people. If a suicide occurs in a school or workplace, it has an impact on hundreds of people.

Besides the direct loss of life, there are the long-lasting psychological trauma of family and friends and the loss of economic productivity for society.

The burden of suicide can be estimated in DALYs. In 2002, self-inflicted injury was responsible for 1.4% of the total burden of disease worldwide *(2)* and for 2.3% of the burden in the European Region. Direct costs reflect treatment and hospitalization following suicide attempts, and indirect costs represent potential lifetime income lost due to suicide-related disability and premature death.

Risk factors

Suicidal behaviour has a large number of underlying causes. It is associated with a complex array of factors that interact with each other and place individuals at risk. These include:

- psychiatric factors such as major depression, schizophrenia, alcohol and other drug use, and anxiety disorders;
- biological factors or genetic traits, such as a family history of suicide;
- life events, such as the loss of a loved one or a job;
- psychological factors, such as interpersonal conflict, violence or a history of physical and sexual abuse in childhood, and feelings of hopelessness;
- social and environmental factors, including the availability of the means of suicide (firearms, toxic gases, medicines, herbicides and pesticides), social isolation and economic hardship.

Some risk factors vary with age, gender, sexual orientation and ethnic group. Marginalized groups such as minorities, refugees, the unemployed, people in or leaving prisons, and those already with mental health problems, are particularly at risk.

Protective factors

However, the presence of sufficiently strong protective factors may reduce the risk of suicide. Protective factors are related to emotional well-being; social integration through participation in sport, church associations, clubs, etc.; connectedness with family and friends; high self-esteem; physical and environmental aspects such as good sleep, a balanced diet, physical exercise and a drug-free environment; and various sources of rewarding pleasure.

Building solutions

In response to this serious public health problem, many countries have made substantial efforts to prevent suicide *(5)*. WHO has produced an updated inventory of national strategies for suicide prevention in WHO's European Member States *(6)*. Suicide rates can be reduced if depression and anxiety are treated. Studies have confirmed the beneficial effects of antidepressants and psychotherapy.

At a WHO meeting on suicide prevention strategies in Europe, held in 2004, health policy-makers and experts in mental health and suicide behaviour from 36 Member States in the European Region discussed current evidence on and practices in suicide prevention and formulated recommendations for suicide prevention strategies.

The conclusions of the meeting can be summarized as follows.

- Suicide and attempted suicide present serious public health problems. In some countries, more people commit suicide than are killed in traffic accidents.
- Age and gender are important aspects of suicide risk and trends, and need to be considered in the development of suicide prevention programmes.
- Media reporting that glamorizes suicide adversely influences public attitudes and may contribute to an increase in suicidal behaviour.

The main recommendations were the following.

- The prevention of suicide and attempted suicide requires a public health approach. The burden of suicide is so large that this should be a responsibility for the entire government, under the leadership of the ministry of health.
- Suicide prevention programmes are needed. They should consider specific interventions for different groups at risk (for example, age- and gender-related), including tasks allocated to different sectors (education, labour market, social affairs, etc.), and they should be evaluated.
- Health care professionals, especially in emergency services, should be trained to identify suicide risk and proactively collaborate with mental health services.
- Education of both health professionals and the general public should start as early as possible and focus on both risk and protective factors.
- Policy-oriented research on and evaluation of suicide prevention programmes are needed.
- The mass media should be involved and trained in suicide prevention and the WHO code of conduct on media behaviour in relation to suicidality should be promoted *(7)*.

The Mental Health Action Plan Europe proposes a number of specific measures, including:

- measuring base rates of stress indicators and identifying groups at risk;
- targeting marginalized groups with education, information and support programmes;

- establishing self-help groups, telephone help lines and web sites for people in crisis.

Strategies for suicide prevention

Suicide prevention strategies are concerned with:

- identifying and reducing availability of and access to the means of suicide;
- improving health care services and promoting supportive and rehabilitation functions for persons affected by suicidal behaviour;
- improving diagnostic procedures and subsequent treatment;
- increasing the awareness of health care staff of their own attitudes and taboos towards suicide prevention and mental illness;
- increasing knowledge through public education about mental illness and its recognition at an early stage;
- supporting media reporting on suicide and attempted suicide;
- promoting research on suicide prevention and encouraging the collection of data on the causes of suicide by avoiding duplication of statistical records.

Some examples of national suicide prevention programmes

The National Strategy for Suicide Prevention in Finland (1986–1996) *(8)* was implemented throughout the country, with arrangements for local, regional and national implementation. It was systematically evaluated, both internally and externally, and can be considered a success *(9)*. The Strategy included public education, improved access to mental health services, crisis intervention, reduction of access to means of suicide, training of health professionals, training in awareness of co-morbidity factors, monitoring of attempted suicide and recording of individuals at risk requiring preventive intervention. The programme incorporated action by professionals, the social services and statutory agencies, but not specifically by people bereaved by suicide.

Some other examples of continuing national programmes are given below.

Choose Life, the national strategy and action plan to prevent suicide in Scotland (2002), aims to reduce the rate of suicide by 20% by 2013. A national network has been formed with representatives of local councils, police, ambulance, accident and emergency services, prison services and key NGOs, and a national training and capacity-building programme was established. Implementation is concentrated on 32 local council areas, and the local plans focus on three key objectives:

- achieving coordinated action for suicide prevention across health care, social care, education, housing, police, welfare and employment services;
- developing multiprofessional training programmes to build capacity for supporting the prevention of suicide;

- providing financial support for local community and neighbourhood interventions *(10)*.

The Action Plan for Preventing Suicidal Behaviour in Estonia is structured on a detailed matrix setting out different strategies for specific target groups and detailing goals, programmes, timing, categories of people responsible, expected results, risks, etc. The Plan envisages setting up a national centre with an official mandate and funds for coordinating and developing suicide prevention work in the country. Monitoring of attempted suicide events and recording of individuals at risk who require preventive interventions are included as key elements in the Plan.

The German National Suicide Prevention Programme (Nationales Suizidpräventionsprogramm für Deutschand) (2003) *(11)* is remarkable in terms of the broad set of working groups, administrative agencies and federal institutions covered. The following interventions are indicated: public education, crisis intervention, suicide prevention in children and young people, suicide prevention in workplaces, reduction of access to the means of suicide, detection and treatment of depression and related conditions and dealing with specific psychiatric disorders, training of health professionals and awareness training on comorbidity factors.

Specific working groups are dedicated to substance abuse disorders and populations at risk, as well as to survivors and bereaved family members. Working with the media is also a key issue covered by the Programme.

To prevent suicide among adolescents, Denmark has developed an educational programme that has started pilot projects in schools and other educational institutions. Teachers, youth workers, clergy, doctors, nurses, social workers, etc. are involved. "Driving licence for a teenager" is a programme aimed at giving parents basic information about dialogue and frustration and teaching them how to bond with their children.[8]

Challenging the stigma

Suicide has long been a taboo subject and is still surrounded by feelings of shame, fear, guilt and uneasiness. Many people have difficulties discussing suicidal behaviour, which is not surprising since it is associated with extremely powerful religious and legal sanctions. Ideas about suicide being noble or detestable, brave or cowardly, rational or irrational, a cry for help or a turning away from support contribute not only to confusion but also to ambivalence towards suicide prevention. In many countries, it was not until as late as the twentieth century that religious sanctions were removed and suicidal acts ceased to be criminal. Suicide is often perceived as being predestined and even impossible to prevent.

Such taboos and emotions are important factors hindering the implementation of suicide prevention programmes. When working in suicide prevention,

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[8] For further information, contact: Centre for Suicide Research, Søndergade 17, 5000 Odense C, Denmark (tel. +45 66 13 88 11).

one must be aware that one must not only increase knowledge in a rational way but also work with unconscious ideas and attitudes about suicide prevention. This kind of work is of great importance in paving the way for the development of suicide prevention programmes in which scientific, clinical and practical knowledge concerning suicide prevention can be conveyed.

Stakeholder involvement

Examples of stakeholder involvement can be found throughout the European Region.

The International Association for Suicide Prevention *(12)* is an NGO in official relationship with WHO, bringing together professionals and volunteers from more than 50 different countries and dedicated to preventing suicidal behaviour, alleviating its effects and providing a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors.

Other organizations play a crucial role in proposing free services to help people who feel suicidal – by telephone, in face-to-face meetings, by letter and by e-mail – in a non-judgemental and confidential way. One of the oldest organizations in Europe, the Samaritans *(13)* has developed a network of international support services, run by volunteers trained in the art of listening and empathy to offer confidential emotional support to any person who is suicidal or despairing.

Various suicide prevention centres have been set up across Europe, providing early support and intervention: telephone crisis lines, training for front-line workers and general practitioners, support for survivors (friends and family who experience the death of someone by suicide), undertaking research and campaigning for raising public awareness to suicide.

"Further On" (Verder) *(14)* is a network that supports suicide survivors in Flanders (Belgium), made up of 15 support groups throughout the Flemish region that initiate and coordinate activities for suicide survivors to help them resolve their grief and pain. The network published a booklet *(15)* containing basic information on suicide bereavement and how to support survivors. This is freely distributed among GPs, hospitals, mental health centres, help lines, self-help groups, victim care centres and social services, and is announced in the media for the general public.

Other initiatives are a theatre play on survivorship that is presented across the country and a media award for journalists for responsible and respectful portrayal of suicide and suicide survivors. The network launched The Charter of the Rights of Suicide Survivors, which has been endorsed and translated by other organizations in Europe.

In Ukraine, a country with one of the highest male suicide rates (61.8 per 100 000) *(16)*, the NGO Human Ecological Health (Odessa) works particularly with prison services and the Ukrainian army, offering training on suicide prevention for officers and medical doctors working in penitentiaries.

The survivor has the right:
- to know the truth about the suicide;
- to live, wholly, with joy and sorrow, free of stigma or judgment;
- to find support from relatives, friends, professionals and to place his/her experience at the service of the others;
- to never be as before: there is a life before the suicide, and a life afterwards.

In Serbia and Montenegro, the "Heart" association (Srce) *(17)* has been working for more than ten years in the region of Novi Sad, offering emotional support by telephone for people in crisis and organizing outreach programmes aimed at high-school adolescents.

Mental Health Europe *(18)*, a European NGO, lobbies to heighten awareness of the burden of suicide and raise the profile of suicide prevention programmes at the policy-making level. It helps its member organizations, especially in central and eastern European countries, to take action and set up projects with national and local agencies, European academic and research groups, mental health service users and social organizations.

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11. Mental health of children and adolescents

"The international health community is concerned about the mental health status of our young. … It is a time bomb that is ticking and, without the right action now, millions of our children growing up will feel the effects."
– Dr Hans Troedsson, former WHO Director for Child and Adolescent Health

Facing the challenges

Some 2 million young people in the European Region of WHO suffer from mental disorders ranging from depression to schizophrenia, and many of them receive no care or treatment. Yet child and adolescent mental health is essential for the building and maintenance of stable societies. Europe has a long tradition of leadership in the development of programmes to support the mental health of children and adolescents, but new challenges require enhanced efforts to meet the needs of the twenty-first century. Immigration, migration, changes in family structure, alterations in future opportunities for employment and the continuing stresses of conflict all impact on child and adolescent mental health and, ultimately, on the health of nations and the Region.

It is now recognized that many mental disorders seen in adulthood have their beginnings in childhood. The prevalence of many psychiatric problems such as depression and suicidal behaviour increases markedly in adolescence *(1,2)*.

Worldwide, up to 20% of children and adolescents suffer from disabling mental health problems *(3)*. Data suggest that the overall rate of children's psychiatric problems has not increased over recent decades *(4)*. However, self-reporting of depression has increased and new diagnoses have become prominent. Many of the disorders are recurrent or chronic.

Four per cent of 12–17-year-olds and nine per cent of 18-year-olds suffer from depression, making it one of the most prevalent disorders with wide-ranging consequences *(5)*. Young girls are now diagnosed more frequently than in the past with mental disorders and particularly with depressive symptoms. Depression is associated with youth suicide, which is a major problem in many countries and the third leading cause of death in young people *(3)*. Geller *(6)* reports that pre-pubertal major depressive disorder is associated with the diagnosis of bipolar disorder, major depressive disorder, substance use disorder

and suicide in adulthood. The use of alcohol and drugs among adolescents has many consequences, but prominent among these is an association with suicide, other life-threatening behaviours such as violence, and road deaths. Rates for comorbidity – that is, the diagnosis of alcohol or drug use and a psychiatric disorder – appear to be increasing. The premorbid or prodromal phase of schizophrenia often starts in adolescence, and early detection and treatment may lead to a better prognosis *(7)*.

Some disorders

Two of the more common and widely discussed diagnoses are post-traumatic stress disorder (PTSD) and hyperkinetic disorder or attention-deficit hyper-activity disorder (ADHD). In some areas of Europe, notably the Balkans, the diagnosis of PTSD is now common. The elements associated with making this diagnosis illustrate the complexity of understanding childhood disorders and their consequences. It is likely that the context of conflict and stress fosters the manifestation of the disorder, but family factors, the ability of communities to respond and past psychiatric illness all have an impact. Likewise, the diagnosis of hyperkinetic disorder or ADHD is now prominent in many clinical settings, but it remains a controversial diagnosis surrounded with concerns about context. The use of standardized diagnostic criteria lapses in the absence of adequately trained personnel, and the diagnosis can be symptomatic of family dysfunction, rather than individual psychopathology, and may reflect inadequacies in the educational system. Leibson *(8)* shows that the nine-year median medical costs for children with a diagnosis of ADHD were US$ 4306, compared with US$ 1944 for those without this disorder, owing to higher rates of emergency health care and visits for outpatient care to primary care clinicians. These costs did not include those for psychiatric or other mental health professional care.

Conduct disorder has been studied in a number of settings. It is one of the most common diagnoses of mental disorder made in young people. In the United Kingdom, the prevalence of conduct disorders is reported to be 7.4% in boys and 3.2% in girls. The rates are higher in poorer areas, in single-parent families and in unemployed households *(9)*. The prevalence of the disorder has increased fivefold over the past 70 years in western countries *(10)*. The importance of this diagnosis, which can be made at an early age, is in its implications for the development of later psychopathology and, in particular, delinquency. The diagnosis is associated with adult criminality, marital problems, poor employee relations, unemployment and poor physical health *(11)*. Conduct disorder can predict educational underachievement, substance use and dependence, anxiety, depression and suicide. Between 25% and 40% of children diagnosed go on to develop dissocial personality disorder in adulthood.

Eating disorders have also gained prominence in recent years. They have been diagnosed in 1% of the population in the United Kingdom. Anorexia nervosa

and bulimia nervosa are commonly thought to be related to western attitudes towards body shape, weight and dieting behaviour. In fact, studies support this assumption but also note that, when exposed to western attitudes, individuals from other backgrounds develop eating disorders at rates comparable to their western contemporaries *(12,13)*. Eating disorders must be seen as disorders with lifelong consequences. A study of college students found that 21.6% of females with eating disorders still met the clinical criteria 10 years later *(14)*.

Obtaining essential services is a fundamental right highlighted in the European Social Charter *(15)*, yet recent surveys on services for children and adolescents report considerable qualitative and quantitative differences in the existence and level of services across the European Region. A survey of 31 European countries concluded that the provision of services and the number of child psychiatrists varied widely across the Region *(16)*, the latter ranging from 1 per 5300 people under the age of 20 to 1 per 51 800 for the same population group. The presence of clinical personnel to provide child psychiatric services varies in relation to income level *(16,17)*. The WHO Atlas project *(17)* has documented that 23% of countries have no programmes for children. Only 10–15% of young people with mental health problems receive help from the existing child mental health services. The provision of specialist help varies widely: for example, Finland and France have 1 specialist in child psychiatry for every 10 000 people under the age of 20, while the United Kingdom has 1 for every 30 000 and Serbia and Montenegro, 1 for every 50 000 or more.

Social impact

The presence in society of children and adolescents who are "at risk" or manifest mental disorders leads to destabilizing conditions in society as a whole. The diagnosis of conduct disorder and the presence of mental disorders, coupled with the use and abuse of alcohol and illicit drugs, are associated with violence, criminality, other antisocial behaviours and the inability of the individuals concerned to develop into productive citizens of countries and communities.

Funding

Funding for mental health services, and for child and adolescent mental health services in particular, has varied throughout Europe. In the past, with strong economies in the Nordic region and western Europe, access to high-quality services in those countries was relatively easy, with few restrictions. In the communist era, eastern European countries had services that were relatively easy to access, although their quality could not always be verified. Now, with moves towards privatization and a downturn in some economies, access to services has become much more of a problem. The introduction of "managed care" and various insurance schemes, often based on experiences from western Europe, has distorted previously functioning, albeit more costly, services.

The WHO Atlas survey has shown that "self pay" is too often the only way for families to get the care needed for their children or adolescents with mental disorders. This obviously limits access. Countries have quite variable schemes for the provision of needed services, with some moving away from state-supported universal care. Access to medication, particularly newer medications with potentially more benefit, is limited when they must be paid for by those who often can least afford to do so.

Building solutions

Some far-reaching recommendations were made at a meeting on the mental health of children and adolescents, held in Luxembourg in September 2004. The meeting was organized jointly by the European Commission, the Ministry of Health of Luxembourg and the WHO Regional Office for Europe, and the conclusions stressed the importance of giving greater priority and allocating appropriate funding to the mental health of infants, children and adolescents, including it in national plans as part of national public health policy *(18)*. They also stressed the use of community-based initiatives, training and user involvement. The meeting's recommendations are reflected in the Mental Health Action Plan for Europe.

Europe must move away from the vestiges of outdated modes of care, wherever they exist. Where possible, children and adolescents should be treated in the least restrictive and least stigmatizing environments. Mental health systems need to be tailored to the conditions of the particular country. The goal must be to develop a continuum of care that includes adequate inpatient services and accessible, appropriate outpatient programmes.

Addressing mental disorders and promoting mental health for children and adolescents in Europe has to be seen within the framework of respect for the human rights of those affected, as reflected in the European Social Charter.

Furthermore, to prevent the development of disorders, educational initiatives should be undertaken to inform parents, educators, health care providers and others about child and adolescent mental health issues.

With newer diagnostic techniques, more standardization in the processes of diagnosis, and a better appreciation of environmental, biological and family factors, relevant diagnoses can be made that lead to appropriate treatment options. To bring child and adolescent mental health services to a level where they can meet the documented need for diagnosis and treatment, capacity must be enhanced. The development of training programmes and support for educational initiatives will be fostered by drawing up appropriate policies for child mental health in the European Region. To this end, WHO has recently published *Child and adolescent mental health policies and plans (19)*, a manual that provides guidance on needs assessment, the provision of rational services and the development of accountable and sustainable governance. Child and adolescent mental health should be explicitly included in national action plans for mental health, and the relevant

sections drawn up in collaboration with the ministries responsible for education, insurance and social affairs to ensure an adequate multisectoral response.

Prevention is a key element of child and adolescent mental health services. The prevention of disorders is evidently both cost saving and in the best interests of the child, the family and the community. Much has been achieved in developing preventive programming, but the resultant programmes are not yet widely disseminated and supported. Prevention and promotion in relation to child mental health are essential. They form part of a more holistic approach to the care of children that needs to incorporate mental health concerns.

While child and adolescent mental health issues receive a great deal of media attention and are often the focus of discussion in relation to education and the criminal justice system, financial and legislative support for child and adolescent mental health services and training has lagged significantly behind in the European Region. Current efforts in economic and health care reform threaten relatively well-developed services and training functions in high-income countries. In low-income countries, the safety net of services for those in need has been eroded in the course of economic and political reforms. A way must be found to support adequate services; if this is not done, societies will be hit by the adult consequences of unrecognized and untreated child and adolescent mental disorders.

Europe has initiated and needs to continue or expand collaborative efforts in training. The guidelines for professional training produced by the European Union of Medical Specialists clearly encourage high-quality responsive care. These guidelines need to be universally supported to ensure common standards and approaches to clinical care. The European Commission's Tempus programme provides a model for collaborative training efforts between more developed programmes and programmes being established.

Some examples

In Marburg, Germany, a mobile child mental health service was used to provide follow-up for patients who had been previously hospitalized, new child psychiatric consultations on site and supervision of institutions for children. The mobile team consisted of three professionals: a child psychiatrist, a psychologist and a social worker. The team was able to reach people unable or unwilling to come to a major referral centre. The mobile team made it possible to deliver quality care in an effective and efficient manner where it would not otherwise have been available *(20)*.

The Effective Family Project *(21)* in Finland is a preventive intervention that provides health and social services to support families in order to prevent children's disorders. It seeks to build bridges between child and adult psychiatry and social work. Methods used include an intervention to support the development of resilience in children by helping them to understand parental disorder. "Let's talk about children" adopts a psychoeducational approach that involves parents

in a discussion of relevant clinical issues. The programme trains professionals to master the methods and to become trainers.

Telefono Azzurro is a national telephone helpline for the prevention of child abuse in Italy. It gives children and adolescents the possibility of speaking anonymously when they have been exposed to violence. The caller receives immediate telephone support and referral to an appropriate resource for further care. If a child is deemed to be in immediate danger, the case is reported, with consent, to the appropriate authority. The programme is now being replicated in many countries.

A group therapy programme at Timisoara Clinic in Romania has for many years used myth as a catalyst for therapeutic interventions with adolescents. Myth incorporates themes about the meaning of life, which is a core issue for many young people showing signs of depression and suicidal ideation. The groups bring individuals together to foster therapeutic interaction but also serve as a forum for confrontation regarding the symbolism of myth. A psychotherapist monitors the group interaction, but the main leader is an adolescent trained to serve as an "opening catalyser". Groups are held throughout the school year with a mix of teenagers identified as symptomatic. The core activity involves the use of psychodrama and analysis of the young people's own "scripts" *(22)*.

The Psychological Education Service Centre in Norway serves children diagnosed with autism spectrum disorders (ASD). This counselling service examines the needs of the child and advises kindergartens and schools. In Norway, every child with a disability or learning disorder is entitled to a special education programme. The programme is designed in cooperation with parents, teachers and experts from the Centre. Children with ASD receive early intervention and special education in kindergartens and nursery schools. Older children receive individualized interventions based on the desire to promote inclusion. People with ASD often have several other medical and psychiatric problems. The National Autism Network of Norway has established centres to provide services to people with ASD and severe psychiatric problems.

Stakeholder involvement

There is a high level of stakeholder involvement in issues related to child and adolescent mental health. The trend has been towards involvement focused on specific conditions or diagnoses. While this approach helps to disseminate information on specific disorders and to enhance advocacy efforts, it may detract from efforts to support the more general need for services and training in the field of child and adolescent mental health.

Autism Europe *(23)* is an NGO that is a prime example of a disorder-specific group composed primarily of parent organizations. Its individual members include many professionals and it collaborates with professional organizations. Autism Europe has become an authoritative source of information. It is also a

very effective advocacy group, using both legal challenges and media publicity to highlight the needs of young autistic people and their families.

Partnership for Children *(24)* was established in 2001 to promote the mental and emotional health of children and young people. The Partnership took over the Zippy's Friends programme, pioneered in Denmark and Lithuania by Befrienders International. It teaches 6- and 7-year-olds how to cope with difficulties and is built around a set of stories associated with activities that lead to the enhancement of coping skills. The aim is to reinforce the mental and emotional health of all children.

The European Society for Child and Adolescent Psychiatry *(25)* brings together professionals throughout Europe to promote professional development, information dissemination and advocacy. Its congresses provide a forum for professionals from the different mental health disciplines to exchange new knowledge. The Society also sponsors professional training.

FOCUS *(26)* is a project that promotes effective practice in child and adolescent mental health. Its main emphasis is on the dissemination of information to support an evidence-based approach to practice for all professional groups and in all service settings.

The International Association for Child and Adolescent Psychiatry and Allied Professions *(27)* is an umbrella organization for national child psychiatry and allied professional organizations. This NGO, which is in official relations with WHO, has promoted the development of child mental health services in eastern Europe, fostered child mental health as a human right, and established programmes to promote the development of child mental health research through a variety of training initiatives.

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12. Access to good primary care in mental health

"I'd had a miscarriage which caused me to have a breakdown. I didn't know it was a breakdown but I went to my doctor and explained how I felt. He said there was nothing he could do for me, he had all these patients to see and perhaps the nurse could get me a cup of tea …"
– Pauline Lee, interviewed in *Open up (1)*

Facing the challenges

Primary health care (PHC) is an important setting in which to introduce treatment and care for people with mental disorders. This:

- helps to reduce the stigma associated with seeking help from stand-alone mental health services;
- facilitates the early identification and treatment of such disorders and thus reduces disability;
- increases the possibility of providing care in the community and the opportunities for community involvement in care;
- importantly, improves access to mental health care among underserved populations.

The capacity of primary health care to provide effective services to people with mental disorders must be strengthened.

Mental disorders are prevalent in PHC

There is a high prevalence of mental disorders among people who attend PHC facilities. In a WHO study of 15 facilities across the world, the prevalence of mental disorders (as defined in the tenth revision of the International Classification of Diseases) among consecutive primary care attenders was 24% *(2)*. In addition, people with mental disorders usually present to primary care physicians with physical symptoms. In this study, 69% of patients with mental disorders presented in this way.

Services in PHC are poorly developed

Treatment and care for people with mental disorders at PHC level is highly variable across the WHO European Region, with some people receiving excellent services,

but others receiving no care at all. In addition, only 14% of low-income countries report having treatment facilities for severe mental disorders in PHC *(3)*. Almost a fifth of people with schizophrenia, half of people with depression and over 90% of those abusing alcohol are not receiving treatment, despite evidence of cost-effective interventions to reduce the suffering of individuals, families and society *(3)*. The presence of treatable disorders that receive inadequate care represents not only a huge personal and social burden for individuals but also a significant economic burden for countries in the European Region.

Primary care needs to develop the capacity and competence to detect and treat people with common (and some severe) mental health problems, while referring complex cases to specialist mental health services in community and hospital settings.

It is therefore essential that PHC workers (whether doctors or nurses) have the skills to detect mental disorders, treat them appropriately and refer to specialist services where necessary. Currently there are wide variations across the Region in the number of personnel receiving training and in the extent of the training they receive. The provision of mental health training for PHC personnel does not correlate with national income levels: some 71% of upper-middle-income countries make this provision, whereas only 62% of high-income countries do so *(3)*. Financial resources are thus not the only obstacle to mental health training for PHC personnel.

Building solutions

For countries with limited mental health service resources, delivering such services through PHC is one of the most effective and viable ways of improving access to mental health care *(4)*. Mental health services therefore need to be provided through PHC to achieve the following aims in service provision and skill development.

Service provision

Identify mental disorders

PHC personnel can help identify mental disorders, especially common ones. There is a significant association between mental and physical disorders, so PHC personnel have the opportunity to do this when people seek help for physical health problems.

Provide basic medication and psychotherapeutic interventions

PHC personnel can provide psychotropic medication and simple psychotherapeutic interventions for common (and some severe) mental disorders. In particular, people with chronic stable mental disorders who reside in the community and need continuing psychotropic medication and psychotherapeutic interventions can be helped by primary care services without requiring repeated visits to specialist services. This has a dual advantage: it is easier for patients, as primary

care services tend to be geographically more accessible and less expensive, and it reduces the burden on specialist mental health services, which are better used to provide specialist treatment and carry out supervision and training activities.

Prevent mental disorders and promote mental health
A wide range of strategies is available to promote mental health and prevent disorders. PHC facilities offer an excellent opportunity for preventive and promotive activities, particularly targeting factors that determine or maintain ill health. For example, the psychosocial and cognitive development of infants depends on their interaction with their parents. Interventions that enhance the quality of these relations, during perinatal and early childhood contact with primary care services, can substantially improve the emotional, social, cognitive and physical development of children *(5)*.

Refer complex cases to specialist mental health services
PHC facilities can function as an entry point as well as a referral point for mental health care. They can make appropriate referrals to specialist mental health services, after preliminary identification and treatment of presenting problems. This has many advantages: people can avoid unnecessary visits to specialist services, which are usually less accessible and tend to have higher direct and indirect treatment costs; and, when they are referred to a specialist service, these referrals are better directed, thus saving effort and costs in finding the appropriate service for their specific problem. Health services benefit too, because appropriate referrals reduce wastage of scarce financial and human resources.

The referral system should be operated in consultation with the district and regional health services. Regular meetings of service providers should be held in order to review and improve the referral system and to evaluate how the needs of people with mental disorders are being met. Even where specialist mental health services are well developed it is important to improve coordination between them and primary care facilities.

Provide family and community education
There is evidence that people are more likely to adhere to treatment plans if they understand their illness and its treatment. Knowledge about the symptoms and natural history of a disorder and the effective treatments has been shown to improve outcome *(6)*. PHC personnel are well placed to deliver simple family psychoeducation in the course of routine clinical work, as well as specific interventions for certain disorders.

Provide crisis intervention
Primary care services are best placed to provide crisis intervention, because they are usually the first point of contact with health care services. Crisis intervention

can prevent the development of full-blown episodes of illness, as well as the deterioration of pre-existing disorders. Primary care services can provide clinic-based as well as outpatient crisis intervention. They are also well placed to involve secondary-level mental health services, if required. Importantly, in the context of natural disasters or acts of violence, PHC personnel and aid workers can provide information, education, guidance and treatment for trauma victims.

Collaborate with other sectors

People with mental disorders have multiple needs related to health, welfare, employment, housing, criminal justice and education. In addition to strong referral links within the health sector, collaboration with other sectors is required to meet these needs.

Development of skills

The integration of mental health into PHC is a complex process that requires training, supervision and workforce development.

Training

First and foremost, integration requires the training of PHC personnel in primary mental health care. Primary care workers have to assume increasing responsibilities for the promotion of mental health and the provision of mental health services. Health workers in training institutions and those already in the field have to be oriented towards the provision of services in the primary care setting. They must have the necessary competencies to provide such services. Some of the key competencies required are in the areas of:

- diagnosis and treatment of mental disorders
- counselling, support and psychoeducation
- advocacy
- crisis intervention.

Supervision

PHC personnel must be adequately supervised if integration is to succeed. Mental health professionals should be regularly available to primary care staff, to give advice on the management and treatment of people with mental disorders. Lack of supervision can lead to a high rate of inappropriate referrals to specialist services for minor problems. A member of the mental health team in the secondary care service should regularly visit the primary care team, to discuss difficulties in management and to provide advice on interventions to be carried out by primary care personnel.

Workforce development

The process of integrating mental health into primary care requires close collaboration with existing primary care personnel. They may resist taking on these

new functions: for example, questioning their role in managing mental disorders. Such concerns need to be carefully addressed and expectations clarified during training and negotiations. The time factor has to be taken into consideration if primary care staff are to devote themselves adequately to mental health work. In many countries, they are overburdened and expected to deliver multiple health care programmes, albeit mainly concerned with physical disorders. In such situations, numbers of primary care staff must be increased so they can take on additional mental health work.

An example

Training GPs in mental health skills has been shown to have clear benefits. In Sweden, successful training led to fewer hospitalizations and a reduction in the suicide rate among the population served by the trained GPs *(7)*. The reduction in the suicide rate was not maintained at three-year follow-up, however, possibly indicating the need for ongoing training, supervision or support *(8)*.

Stakeholder involvement

Other key groups have several opportunities to become involved in the integration of mental health into PHC.

Consumer groups, family groups and advocacy organizations can:

- influence policy and service planning to provide more accessible mental health services through PHC;
- sensitize the general public about the need for high-quality services in PHC;
- provide education and support to people with mental disorders who attend PHC facilities.

Foundations can:

- support the development of mental health services in PHC, for example, in pilot sites;
- support research to develop effective mental health interventions at primary care facilities.

Academic institutions can:

- provide appropriate evidence-based mental health training for primary care personnel;
- develop research into care at the primary level and effective mental health interventions at primary care facilities;
- provide specialist supervision for both the planning and delivery of mental health services through primary care.

Professional societies can:

- set quality standards and provide accreditation for professionals working in primary mental health care;
- supporting the change of roles among PHC staff from working predominantly with physical disorders to a more holistic approach to health care that incorporates both physical and mental health.

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13. Mental health care in community-based services

"Community mental health services are needed to provide care to people with mental disorders in the communities where they live and work. These services should replace outdated psychiatric asylums, which remove sufferers from society, increase stigma and do not provide cost-effective care."

– Dr Matthijs Muijen, Regional Adviser for Mental Health,
WHO Regional Office for Europe

Facing the challenges

For many years, people with mental disorders have been removed from their communities and kept in psychiatric hospitals or institutions. A great deal of evidence from around the world *(1)* indicates that these institutions lead to further stigmatization of patients, are often associated with human rights abuses and can lead to further deterioration in mental health.

In response to pressures to develop new patient-oriented models of care, some countries in Europe have begun to develop community-based mental health services. Good evidence shows that these community mental health services are both more clinically effective *(2,3)* and more cost-effective *(4,5)*. They provide an ethical basis for care that respects the rights of people with mental disorders. They also allow for the delivery of care near to the places where people live and work and therefore improve the accessibility of services. Furthermore, people who receive such services indicate their preference for community over hospital-based care *(6,7)*.

WHO and other mental health and human rights experts have stated that many countries have not gone far enough and need to develop more community services, with better infrastructure and support systems *(1)*. Mental health services are still too often provided in institutions, with little choice for patients and carers. Many people suffering from severe mental health problems, particularly vulnerable and marginalized people, experience difficulties gaining access to and remaining in contact with services. Service structures and processes should offer evidence-based care that as far as possible keeps the patient in the community.

Every country in Europe can improve its provision of community mental health services. Currently 28% of countries in Europe do not have any community-based mental health services *(8)*. There is wide variability according to levels of economic

development. Only 33% of low-income European countries have community-based mental health services, while 91% of high-income countries have such services. Among the countries that report having community services, the actual extent of service coverage also varies widely.

As some countries move towards deinstitutionalization, there is concern that bed reductions have proceeded in advance of the development of community-based services, leaving both hospital and community services underresourced. In London, a review of mental health services concluded that the balance between hospital and community services was inappropriate. There were now too few beds to admit patients to, and too few community residential places to which inpatients could be discharged *(9)*. In Austria, Germany, Luxemburg and Switzerland, while psychiatric bed numbers have been reduced, there have been political and financial constraints on these reductions and on the development of appropriate care in general hospital and community settings *(10)*.

Building solutions

To address the multiple needs of people with mental disorders, a range of community mental health services needs to be planned and coordinated. In countries where large psychiatric institutions still prevail, these should be downscaled, in parallel with the development of community services.

Community mental health services can include a wide array of settings and different levels of care provided by mental health professionals and para-professionals, usually working in multidisciplinary teams. Such services need:

- to provide community-based rehabilitation and treatment programmes;
- to develop specialist mental health services to treat and care for people with severe mental health problems in the community;
- to offer residential services;
- to provide crisis intervention services;
- to provide education and training;
- to collaborate with other community- and hospital-based service providers;
- to conduct research;
- to link with other sectors.

The aim of **community-based programmes** is to assist people with mental disorders to live a full community life. There are many models of community-based service provision, such as case management, hospital diversion programmes, intensive home support and outreach services. All these models have their strengths and weaknesses, and the choice of a particular model in a country depends on various factors including the sociocultural context, how health services are organized and the availability of financial and human resources.

Specialist teams need to be organized. Examples are specialist community services to care for people with severe problems such as schizophrenia, bipolar

affective disorder, dementia and severe depression. These services need to be accessible 24 hours a day, 7 days a week, and should be delivered by multidisciplinary staff.

Community mental health services need to include therapeutic and supervised **residential services**, on their own or in collaboration with other services such as social services and housing departments. These arrangements vary from country to country, depending on the particular context of social and health care provision.

Crisis intervention services need to be provided in association with primary care providers, who are usually the first "port of call" in a crisis. This requires good referral and linkage systems with primary care services, as well as with mental health services in general hospitals. In some countries, community mental health teams also provide home-based intensive crisis intervention services through mobile and outreach crisis teams. Hospital diversion programmes in other countries try to divert people in crisis from a hospital admission to other community-based facilities such as crisis shelters.

Community mental health services are usually involved in the **education and training** of staff for their own services, as well as of primary health care staff and mental health professionals working in general hospitals.

Community mental health services need to develop good **intersectoral collaboration**, because people with mental disorders have complex needs that cut across service sectors. Links need to be established with primary health care services and with services provided through general hospital settings.

Community mental health services need to participate in **research**, especially in the area of service delivery: for example, by investigating the effectiveness of different models of service delivery. Community mental health services have first-hand knowledge of delivering community-based services, and this can usefully feed into the framing of research priorities and questions.

People with mental disorders have multiple needs related to health, welfare, employment, housing, criminal justice and education. For these reasons, community mental health services need **to work collaboratively with other sectors** and establish clear referral pathways, mutual supervision and training.

Some examples

As an example of deinstitutionalization, the psychiatric hospital population in Austria declined from 12 000 in 1974 to 5000 in 2000. In community-based services such as day hospitals, crisis intervention services and hostels for people with mental disorders, multidisciplinary teamwork prevails. In some parts of the country there are procedures for the systematic supervision of such teams *(11)*.

In Emilia-Romagna, Italy, the substantial reduction in bed numbers following the introduction of psychiatric service reforms in 1978 was accompanied by considerable growth in community services. By 1994, in a population of 4 million people, community services included 145 community mental health centres,

48 day treatment or rehabilitation centres, 12 general hospital psychiatric wards, 3 university psychiatric clinics, 24 staffed hostels, and 123 supervised apartments, not to mention 7 private psychiatric clinics *(12)*.

In the Norwegian mental health programme, deinstitutionalization has been promoted and greater emphasis placed on community-based psychiatry, where treatment is given closer to the patient's normal living environment and primary health care services. Around the country, district psychiatric centres are being established as community-based outpatient clinics. This community mental health model represents a form of all-round psychiatric practice and consists of a network of services that offer continuing treatment, accommodation, and occupational and social support, which together enable people with mental disorders to maintain or achieve an acceptable social role *(11)*.

Stakeholder involvement

Other key groups have several opportunities to become involved in the development of community mental health care.

Consumer groups, family groups and advocacy organizations can:

- influence policies and legislation to improve community services for people with mental disorders;
- sensitize the general public about the need to integrate people with mental disorders into normal community life;
- provide education and support to people with mental disorders living in the community;
- organize informal community mental health services such as counselling, self-help services, drop-in centres, assistance with activities of daily living, community reintegration, case management, outreach programmes and crisis services;
- provide disease prevention and health promotion services, such as school-based mental health promotion programmes;
- identify and campaign against outdated and inhuman forms of treatment, poor service delivery, inaccessible care and involuntary treatment.

Foundations can:

- support the development of community mental health care projects;
- support research into cost-effective community-based interventions.

Academic institutions can:

- provide appropriate evidence-based training for mental health workers in community mental health care;
- conduct research to evaluate the effectiveness of a variety of community-based interventions;

- provide specialist supervision for both the delivery and planning of community mental health services.

Professional societies can:

- set quality standards and provide accreditation for professionals working in community mental health care;
- support the change of roles among mental health staff from working in predominantly institutional settings to predominantly community-based settings.

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14. Human resources and training for mental health

The shift from an institution-based service to a community-oriented model is more than merely a change in the place of care. It involves different values, a new style of practice, the adoption of unfamiliar roles and responsibilities and the acquisition of new skills.

Facing the challenges

An available and skilled workforce is essential if a country is to respond adequately to the substantial burden of mental disorders. There can be no mental health care without the necessary human resources. Worryingly, most European countries face significant workforce shortages and need to develop skilled workforces to ensure the delivery of effective and efficient mental health services.

Inadequate supply of mental health workers

Most countries in Europe have a shortage of skilled mental health workers. While the average number of psychiatrists (9.0 per 100 000 population) and psychiatric nurses (27.5 per 100 000 population) reported by European countries is higher than in other regions of the world, the distribution within Europe is irregular, with the available workforce largely concentrated in a few high-income countries *(1)*. The availability of other mental health specialists such as psychologists and social workers is also very variable.

> *European workforce*
> In the WHO European Region, the number of psychiatrists per 100 000 population ranges from 1.8 to 25, the number of psychiatric nurses, from 3 to 104 and the number of psychologists working in mental health, from 0.1 to 96 *(2)*.

The size and quality of the available workforce is influenced by factors such as low investment in mental health services, poor working conditions, limited resources for training and education and the migration of mental health workers from low- and middle-income countries to high-income countries. In addition, mental health workers often experience stigma and discrimination from colleagues in other sectors and the general public.

Mental health workers often underskilled

Many mental health workers are underskilled, and there is an urgent need to improve workers' competencies to meet the future needs of the mental health system. For example, many nursing education programmes have limited mental health content, and much of what is provided focuses on institutional models of care. Many countries have no specialist education at all for nurses in mental health and limited continuing education programmes *(3)*.

Training in mental health is also urgently needed for family doctors and other primary care workers. Providing mental health services in PHC enables the largest number of people to get fast and easy access to services (see Chapter 12). Unfortunately, many primary care workers lack the confidence and skills to recognize and treat mental disorders. Training is also likely to improve the treatment in PHC of people who have more severe mental disorders, a necessity if countries are to implement community-based mental health treatment and care.

> *Primary care training in Belarus*
> Between 1999 and 2001, Belarus trained about 720 primary care professionals in mental health. Psychiatric care is being shifted from inpatient to outpatient and integrated into the care provided by family doctors *(1)*.

Uneven distribution in countries

Mental health workers are often unevenly distributed in countries, concentrated in urban settings and close to large inpatient facilities. This contributes to inequity, effectively preventing large segments of the population from accessing mental health care. Problems also arise when a disproportionate number of mental health workers are only available in the private sector.

Inefficient roles

Traditional roles of mental health workers are often inefficient, focusing on high-cost treatments for small numbers of patients. In most countries, the majority of mental health workers are employed in psychiatric hospitals that provide institutional care for a small number of people with mental health problems. Training and support to reorient the roles of mental health workers is an essential component of the redevelopment of mental health services.

Changing models of care

Ethical and scientific considerations have given impetus to the transfer of mental health care from mental hospitals to PHC, general hospitals and a range of community services. The aim is to enhance the accessibility and acceptability of services, achieve better outcomes and ensure the rational use of resources *(4)*. These changes to the delivery of mental health services have significant human

resource implications. Staff currently working in mental hospitals need training to adopt more recovery-focused treatments so that they can prepare people for discharge from hospital; community mental health workers need to be trained; and primary care workers require education and support so that they can identify and treat people with mental disorders.

Recruitment and retention

The inadequate supply of mental health workers underscores the importance not only of encouraging the recruitment of new workers but also of retaining existing staff. The inclusion of mental health within general health training programmes is essential to ensure that primary care workers have the necessary confidence and skills. Exposure to mental health settings during training also provides an important opportunity to identify and support health workers with an interest in mental health.

Retaining staff not only ensures the availability of an adequate workforce, it is also cost-effective, as it reduces the costs associated with high staff turnover. A wide variety of retention strategies that focus on the personal, professional and organizational needs of the employee should be considered. For example, improving salary and conditions, developing career pathways for mental health workers and providing opportunities for professional development are all effective strategies for improving the retention of staff.

Stigma and discrimination

The stigma and discrimination associated with mental disorders have been widely documented. Human resource and training policies must recognize the impact of stigma and discrimination on people and their families, so that mental health workers can be equipped with strategies to redress the situation. This issue should be addressed in training programmes that also include service user and family perspectives. In addition, it is important to recognize that the stigma and discrimination experienced by mental health workers themselves affect the size and quality of the workforce. This problem can be tackled by ensuring that employment conditions in mental health services are equivalent to those in general health care and by introducing education on mental health in general health training programmes.

Involving users and carers

Involving service users and their families is an important part of the mental health reform process. The mental health system exists for people with mental disorders and their families, and they can and should make important contributions to defining what works and how the mental health system can be improved. The evidence also demonstrates that the active involvement of people with mental disorders and their families improves the quality of services and care provided.

They should also be actively involved in the development and delivery of education, to give mental health workers a better understanding of their needs.

In addition, families assume a great part of the responsibility for caring for people with mental disorders, and this is likely to increase with the movement towards deinstitutionalization and community care. Access to training for families will enhance their understanding, knowledge and skills, and greatly influence the quality of care and support they give to people with mental disorders.

Multidisciplinary approaches

An effective mental health workforce needs to include both professional and non-professional workers from a range of different backgrounds. People with mental disorders have multiple needs, and it is effective for workers with different skills to work together in teams to respond to those needs. Training in mental health should be available to a wide variety of professional and nonprofessional groups and include education on effective teamwork.

Psychosis teams in Finland
Finland has established multidisciplinary psychosis teams in every catchment area to provide active intervention and family support to people newly diagnosed with psychosis *(1)*.

Labour practices

Labour practices should conform to existing legislation and protocols on labour in the country and should ensure the rights of mental health workers. Specific issues that require attention include staff selection, potential affirmative action, induction, deployment, unionization, conflict management and licensing *(5)*.

Building solutions

To build up a sufficient and competent mental health workforce by 2008, countries need to undertake the following actions:

- develop a national human resource strategy for mental health that:
  - identifies the human resource needs for the provision of mental health services to the population;
  - identifies existing staff in the generic and specialist workforce and the need to reorient their roles and responsibilities;
  - identifies the need for new staff roles and responsibilities across the specialist and generic workforce employed in the health sector and other relevant areas, such as the education and justice sectors;
  - identifies strategies to encourage the recruitment of new mental health workers and enhance the retention of existing workers, and ensures an equitable distribution of mental health workers;

- plan and fund, in partnership with colleges and universities, programmes addressing the training needs of existing and newly recruited staff, with plans considering the issue of lack of expertise in new technologies of present trainers and including a "train the trainers" programme;
- include mental health in the curricula of all health professionals and design continuing professional education and training programmes for the workforce;
- include service user and family input into human resource planning, education and training.

Some examples

United Kingdom

The National Institute for Mental Health in England has recently released a National Mental Health Workforce Strategy. Its purpose is to ensure that there is a sufficient number of mental health workers with the appropriate capabilities, sufficiently motivated and well led to meet the needs of people who use mental health services and their families. The document sets out key workforce targets and describes the responsibilities of different authorities in meeting them *(6)*.

Slovenia

The Slovenian Association for Mental Health (ŠENT) has initiated a training programme for service users, their families and mental health workers that includes basic education about mental health and mental disorders; care management, self-help, human rights and rights of users of mental health services, legal procedures, team and multidisciplinary work, social skills training and vocational rehabilitation. The programme has increased public awareness about mental health and improved communication between users, families and service providers *(7)*.

European Forum of National Nursing and Midwifery Associations

Founded in 1996, the Forum represents 26 nurses' associations and 4.5 million nurses in Europe and fosters dialogue between nurses and WHO to promote health and health care in Europe. The Eighth Annual Meeting in 2004 focused on mental health and developed a consensus statement on mental health nursing and midwifery *(8)*. The statement calls on governments, nurses and midwives to work together to enhance the skills of all health workers to respond to the mental health needs of individuals, families and communities.

Stability Pact for South Eastern Europe: mental health project

Strengthening social cohesion through community mental health services was one of the health topics of highest priority agreed in the Dubrovnik Pledge. The

initiative focuses on developing new and reinforcing existing community mental health services in south-eastern Europe, by establishing mental health policy and institutional links between stakeholders, including social organizations and NGOs, and education, research and community services. The project's immediate objectives include developing a region-wide standardized training forum and collaboration network on community mental health and related multisectoral issues, and establishing a region-wide training curriculum for professionals in mental health, primary health care and social work.

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15. Mental health legislation

"It is time to frame the concerns of persons with mental disability not simply as a social problem, but as a human rights imperative."
– Lawrence O. Gostin *(1)*

Facing the challenges

Widespread human rights violations against people with mental disorders

People with mental disorders are exposed to a wide range of human rights violations both within and outside the health care context. Violations often occur in psychiatric institutions through inadequate, degrading and harmful care and treatment, as well as unhygienic and inhuman living conditions. Issues related to consent to admission and treatment are often ignored; people are assumed to be incapable of making decisions on their admission and treatment because independent assessments of capacity are not undertaken. This means that people can be locked away for extensive periods of time, experience a lack of autonomy and restrictions in their freedom of movement and are excluded from society. This in turn reinforces the stigma surrounding mental illness.

The myths and misconceptions associated with mental disorders also negatively affect the day-to-day lives of people with mental disorders, leading to discrimination and the denial of even the most basic rights. Because of this stigma, people with mental disorders experience limitations in employment, education and housing. This in turn affects their ability to gain access to appropriate care, integrate into society and recover from their illness.

Need for progressive legislation

The vast majority (92%) of countries in the European Region have some mental health legislation. The mere existence of a mental health law, however, is not in and of itself a guarantee against human rights violations. Indeed, legislation in many countries is outdated and serves to take away rights rather than protect them. Recent cases presented before the European Court of Human Rights *(2,3)* – as well as a number of recent reports by NGOs *(4–6)* concerning human rights violations, particularly inhuman and degrading treatment and conditions, in psychiatric institutions – clearly indicate that many countries in Europe still have a long way

to go in promoting and protecting the rights of people with mental disorders in accordance with international and regional human rights standards.

Progressive legislation on mental health provides a legal framework to ensure that critical issues affecting the lives of people with mental disorders are addressed. Legislation can, among other things, prevent human rights violations and discrimination, promote human rights, encourage autonomy and liberty of people with mental disorders and promote access to mental health care and community integration. It also needs to balance the rights of the individual with the protection of the community in those rare instances of people's posing a risk to others as a consequence of their mental health problems.

Building solutions

Countries need to develop mental health laws that respect the rights and meet the obligations set out in international and European human rights instruments. The majority of European countries have ratified the International Bill of Human Rights (the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights and its two optional protocols) and/or the Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms. These instruments create legally binding obligations on governments to respect, protect and fulfil the rights within them. In addition, both the European and United Nations human rights systems have a number of internationally agreed standards related to the rights of people with mental disorders. The United Nations *Principles for the protection of persons with mental illness and the improvement of mental health care* (1991) and the Council of Europe Recommendation 1235 (1994) on psychiatry and human rights are two such documents.

Some key issues to be considered when reforming a national mental health law are set out below.

Improving access to quality mental health care in accordance with the principle of the least restrictive alternative

Appropriate mental health services should be accessible, acceptable and of adequate quality. Legislation can make a difference in ensuring parity with other health care services and ensuring that what is provided is appropriate to people's needs. In accordance with the principle of the least restrictive alternative, countries should take legislative and other necessary measures to increase opportunities for people with mental disorders to live fulfilling lives in the community by preventing inappropriate institutionalization and providing appropriate facilities, services, programmes, personnel and protection, as well as opportunities for people with mental disorders to thrive in the community.

Respecting the rights of users of mental health services

Some key rights of people with mental disorders include:

- the right to confidentiality
- the right to access to information
- rights and conditions in mental health facilities
- notice of rights.

Legislation should ensure that patients' **rights to confidentiality** are respected, and should lay down penalties and sanctions for wilful breaches of confidentiality by professionals or mental health authorities. Legislation may outline the exceptional circumstances when confidentiality may be legally breached and ensure that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to release information.

Legislation should ensure that people with mental disorders have the **right to free and full access to their clinical records** and should also lay down the exceptional circumstances when access to this information may be restricted. Legislation may ensure that patients and their personal representatives have the right to ask for judicial review of, or appeal against, decisions to withhold information.

Legislation should guarantee patients who are living in mental health facilities **protection from cruel, inhuman and degrading treatment**. It should guarantee the provision of a safe and hygienic environment that includes facilities for leisure, recreation, education and religion, and that adequate provision is made for vocational rehabilitation in mental health facilities, to help patients prepare for community living once they leave. The environment should be structured so that patients' privacy is protected as far as possible. Patients must not be forced to undertake work they do not wish to do and, when they do take up work, this should be appropriately remunerated.

Legislation should include provision for informing patients of their rights when interacting with mental health services. **Notification of rights** should take place as soon as possible. The information should be conveyed in such a way that patients are able to understand it.

Promoting voluntary admission and treatment

Free and informed consent should form the basis of treatment and rehabilitation for most people with mental disorders. Involuntary admission and treatment should be the exception and should happen only in very specific circumstances. Legislation should outline these exceptional circumstances and lay down procedures to be followed for involuntary admission and treatment. Each case of involuntary admission and treatment should be regularly reviewed by an independent review body, and patients should also have the right to appeal to this review body against their involuntary treatment or detention.

Discouraging the use of seclusion and restraints

Legislation should discourage the use of restraints and seclusion procedures in mental health facilities. To facilitate this, countries will need to develop their mental health infrastructure, as it is often a lack of resources that encourages staff to use these interventions. To protect against abuses, legislation may outline the exceptional circumstances when these procedures are permitted. Restraints and seclusion may be allowed when they are the only means available to prevent immediate or imminent harm to the patient or others, and should be used for the shortest period of time necessary.

Establishing review mechanisms to monitor and protect rights

Independent review bodies should be set up to protect the human rights of people with mental disorders. The functions of such bodies may include conducting regular inspections of mental health facilities. They should also review cases of involuntary admission and treatment, and receive appeals from patients.

Including mental health and human rights provisions in other laws

For people with mental disorders to lead productive lives within their communities, a range of laws that protect and promote their rights is needed. These include:

- antidiscrimination legislation: laws against discrimination that also promote affirmative action to protect vulnerable populations should include provisions concerning people with mental disorders;
- general health care legislation: people with mental disorders may need legislative protection in their interaction with the general health care system, covering access to treatment, quality of treatment offered, confidentiality, consent to treatment and access to information;
- housing legislation: legislation can incorporate provisions for giving people with mental disorders priority in state housing schemes and for setting up subsidized housing schemes, as well as for establishing a range of specialized housing facilities such as halfway homes and long-stay supported homes;
- employment legislation: legislation can include provisions for the protection of people with mental disorders from discrimination and exploitation in employment and promote equal employment opportunities, can promote return to the workplace for people who have experienced mental disorders and can ensure protection from dismissal from work solely on account of mental disorder;
- social security legislation: the payment of disability grants can represent a huge benefit for people with mental disabilities and should be encouraged through legislation;

- civil issues: people with mental disorders have the right to exercise all civil, political, economic, social and cultural rights, which include the right to vote, marry, sign cheques and engage in other financial transactions, have children and maintain parental rights, and own property, as well as the right to religious freedom and practice, work and employment, education, freedom of movement and choice of residence, health, a fair trial and due process of law.

Implementing mental health legislation

Implementation issues are particularly challenging and need to be addressed at an early stage. Adequate funding must be provided to put the provisions of the law into effect. Engaging key stakeholders through consultation during the drafting and adoption stages will enhance the chances of effective implementation. In addition, awareness-raising, education and training activities are required to sensitize the public and the professionals in health, mental health and other areas who are affected by mental health law.

An example

Italian Law 180 on voluntary and compulsory health treatment, enacted in 1978, is an example of a shift from custody and incarceration to integration and rehabilitation of persons with mental disorders. This act emphasizes voluntary treatment of persons with mental disorders in the community and integrated health institutions, as opposed to segregated mental asylums. Patients are thus more able to integrate into community life.

Stakeholder involvement

For legislation to be effective, it is important that various stakeholders participate in its development and implementation. Some of these stakeholders and their roles include:

- consumer groups, family groups and advocacy organizations:
    - advocating better protection of the rights of people with mental disorders and their families, and the development of a progressive mental health law;
    - participating in the formulation and implementation of the mental health law;
    - conducting awareness-raising campaigns to sensitize the general public to mental health and human rights issues and to the provisions of the mental health law;
- foundations:
    - supporting the implementation of mental health legislation through, for example, mental health and human rights awareness-raising activities;
    - supporting the creation and activities of consumer, family and advocacy organizations;

- academic institutions:
  - incorporating training on mental health and human rights issues into undergraduate and postgraduate curricula for health and mental health professionals, including those in primary care;
  - conducting research activities to monitor and evaluate the effectiveness of mental health legislation;
- professional societies:
  - contributing to the elaboration of mental health legislation;
  - raising awareness of their constituency to mental health and human rights issues.

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16. Empowerment and mental health advocacy

*"Advocacy is one of the most important pieces in the jigsaw
of getting control of our own mental (ill) health, yet most people don't really
know what it means. In truth, I didn't even know the word existed.
I only found out by chance, a few years after I was first admitted to hospital,
when I got some information about my diagnosis.
I had no idea of the real use an advocate could be to me in my dealings with the
mental health service until I was 'well' enough to find out for myself."*
– Rachel Studley, a mental health service user/survivor

Facing the challenges

Advocacy

Advocacy is about empowerment, but it can also have a hugely beneficial effect on the improvement of mental health *(1)*. Advocacy *(2)*:

> seeks to ensure that people are able to speak out to express their views and defend their rights. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

Service users, their families, NGOs, mental health workers, policy-makers and lately the media are all involved in mental health advocacy. The core group is the users of the services and their relatives, who are closest to the issue, the first to organize themselves and make their voices heard. This may be through dissemination of information, raising awareness, campaigning, education, training, mutual help, counselling and lobbying.

Empowerment and advocacy have been shown to reduce the duration of inpatient treatment and the number of visits to the health service; build self-esteem and feelings of well-being; enhance coping skills; strengthen social support networks; improve family relationships; further the development and implementation of programmes on mental health promotion, treatment and rehabilitation; contribute to improving and implementing mental health legislation; and improve public awareness of mental health issues *(1)*.

The silent majority

The number of organizations of mental health service users, their carers and other advocates in civil society in Europe is impossible to estimate, but it has certainly grown. This has happened despite the existence of a silent majority of users who are not active in any sort of civil movement related to mental health. They are the quiet civilians, the teachers, doctors, bus drivers, salespeople, etc., who become ill and use services and medication without the disease interrupting their daily lives to the extent that they have to be hospitalized. At any given time, the silent majority, together with those who are labelled as mentally ill, may represent up to one in every four Europeans, or around 218 million people *(3)*.

> "I suffered myself in the mental health system and I feel as though I would be able to help others to defend their rights. … As somebody who was labelled 'crazy', I was afraid to express my feelings and thought that I had nothing to offer. Now I realise that I can offer so much."
>
> – Alkent Birko, Alternativa Association, Albania

The presence of NGOs in the European Region is approximately 90% – they are active in at least 46 of the 52 countries in the Region *(4)*. However, this does not mean that local NGOs are active throughout the population or that users and carers are directly represented. Often in countries where civil society is still in its infancy, international NGOs help local user and carer NGOs to gain a voice for their empowerment and their own advocacy. NGOs in Europe are dynamic, broad and diverse, working for improved mental health and increased user and carer participation, empowerment, human rights and choice.

Human rights, effective services

The advocacy movement of mental health users and carers has grown up in response to the historic marginalization of people with mental disorders in Europe, which sometimes even now includes inhuman and degrading treatment such as exclusion, imprisonment, ridicule and inappropriate involuntary treatment. The movement has defended citizens' rights against medical and governmental authorities and will continue to do so where human rights violations occur.

> "It is like a cage in a zoo. Like a small prison. I felt confused and trapped and was not allowed out to eat or use the toilet. I had to pee through the cage once because I could not hold it in. My mouth was so dry I even attempted to drink my own urine."
>
> – Michel Celetka, patient in a cage bed in a psychiatric hospital in Europe, 2004

Some of the key issues that users and carers find important to advocate are:

• the right to autonomy and self-determination;
• the right to be free from torture and other inhuman or degrading treatment;

- the right to acceptable and accessible services;
- the inclusion of user-led research, evaluation of services and training in the mental health field;
- the right for everyone to be recognized as a person before the law with no discrimination and no loopholes for discrimination in legislation and policy-making;
- the destigmatization of mental disorders;
- more inclusive, respectful and listening services with a chance for user involvement.

Building solutions

WHO has encouraged ministries of health in Member States to work in an egalitarian way with other stakeholders in the field towards a common goal of inclusion and improved mental health.

In a conclusion from a joint WHO and European Commission meeting on balancing mental health promotion and mental health care, held in Brussels in 1999, one of the common goals was to develop innovative and comprehensive, explicit mental health policies in consultation with all stakeholders, including users and carers, and respecting NGO and citizen contributions.

One of the ten overall recommendations in *The world health report 2001. Mental health: new understanding, new hope (3)* is that:

> communities, families and consumers should be included in the development and decision-making of policies, programmes and services. This should lead to services being better tailored to people's needs and better used. In addition, interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families.

The Athens Declaration *(5)* was signed at a WHO meeting for the countries of southern and south-eastern Europe in June 2001. It calls for cooperation between all sectors, including users and carers, in the field of mental health, man-made disasters, stigma and community care.

WHO set up the Global Council for Mental Health in 2002 as the first all-inclusive global partnership of constituencies of stakeholders in the area of mental health. Two of those constituencies are users and carers. The objectives of the Council are:

- to bring together different constituencies with a real interest in promoting mental health, preventing and treating mental disorders, to reach a common vision of the problem starting from diverse perspectives;
- to stimulate and support action aimed at raising awareness of the burden of mental disorders, the interventions available to reduce it and the pervasive effects of stigma and discrimination;

- to promote the implementation of the 10 recommendations of *The world health report 2001 (3)* in all regions, and the adoption of the strategies put forward by the mental health Global Action Programme.

The road map of information and good intentions seems to be in place, but in need of implementation.

What difference will the Action Plan make?

The WHO Mental Health Action Plan for Europe acknowledges that a lack of empowerment of users and carers and poor advocacy hinder the delivery of care. It strongly commits countries to including mental health service users and carers in planning and implementing mental health services. On that basis, it encourages action to stimulate the creation and development of user- and carer-run organizations; the setting of standards of representation of users and carers on committees responsible for planning, delivery, review and inspection; and the introduction of a legal right to independent advocacy for people subject to involuntary care.

Strategies for empowerment and advocacy

Empowerment and advocacy strategies in the Action Plan are intended:

- to increase public awareness and advocacy to eradicate stigma and improve access;
- to empower the general population, especially vulnerable and marginalized groups, by producing targeted information that will allow them choice and involvement in their care, particularly addressing stress, depression, alcohol and substance misuse, and suicide;
- to organize and run agencies that empower and advocate on behalf of vulnerable people;
- to set up schemes to improve parenting, education and tolerance, and to tackle alcohol and drug misuse, violence and crime;
- to develop local services that target the needs of minority groups;
- to run help lines and Internet counselling for people in crisis, suffering from violence or at risk of suicide;
- to create employment opportunities for disabled people;
- to work with local media.

Some examples

Multisectoral partnership on mental health promotion – A horizontal approach in Iceland

Geðrækt (which means mental health promotion) was a project in Iceland, designed as a partnership between the three sectors of society: state, private and civil society *(6,7)*. The cooperative project was run by the Icelandic Directorate of Health, the Icelandic Mental Health Alliance (an NGO), the Mental Health

Cluster of the University Hospital and the Icelandic health care services. The structure of the project was based on the need to keep it independent, to follow its strategy of attracting most of its funding from the private sector. Private companies gave 75% of the total funding, with the remaining 25% coming from government ministries.

The approach that Geðrækt used can be described as a merging of the top-down and bottom-up approaches, with the policy aims of the top-down approach and an action-oriented bottom-up perspective. This has proved to be a promising method for state authorities to work through civil society in order to implement policy decisions and achieve set objectives.

An outcome-based survey of the project and people's knowledge of it was carried out by IMG Gallup two years after the project started. It showed that almost 50% of the nation had heard about Geðrækt and that more than 60% of those knew what it stood for.

The personal ombudsman system for psychiatric patients in Sweden

The personal ombudsman (PO) system came out of the reform of the Swedish psychiatric system in 1995. The PO is a professional, highly skilled person who works on behalf of the psychiatric patient only. The PO has no alliance with psychiatry, social services or any other authority, or with the patient's relatives or other contacts. The PO does only what the client wants. It can take a long time before the client knows and has the courage to say what kind of help he or she wants. The PO builds up a long-term relationship with the client, in contrast to most traditional services where the psychiatric patient is sent from one person to another, often with little support.

The PO is especially focused on supporting those patients who are most hard to reach. POs are employed either by communities or by NGOs, with preference for the latter in order to avoid any suspicion about the PO's loyalties.

In the province of Skåne in southern Sweden, with a population of 1.1 million, approximately 25 POs are employed by an independent user and family organization that supports about 400 seriously mentally ill people, of whom 75 are homeless *(8)*.

The POs have guidelines for their work, including the following:

- the PO has a forty-hour working week but is prepared to work at any time, according to the client's needs;
- the PO does not have an office because "office is power";
- the PO works by building up a relationship. As many clients are suspicious and hard to reach, the PO has to go out and find them where they are, reaching them by making contact, developing communication, establishing relations, starting a dialogue and getting commissions;

- there is no bureaucratic or formal procedure required to get a PO;
- POs should be of various ethnic backgrounds to ensure that needs of psychiatric patients of ethnic minorities are met;
- a client should have the right to be anonymous to the authorities; the PO must respect this.

Pathways to Policy

The Hamlet Trust is an international NGO, based in the United Kingdom, that has run the Pathways to Policy programme in Armenia, Bosnia and Herzegovina, Estonia, Kyrgyzstan, Romania and Slovenia for more than three years *(9)*. The programme aims to enable local NGOs to work with other local mental health stakeholders in order to exert a greater influence on local mental health policies, practices and procedures. The other stakeholders include professionals such as psychiatrists, social workers and nurses; families and carers; politicians; bureaucrats and administrators; the media; and local businesses. Local policy forums enable these groups to meet and work together on a regular basis to develop strategies to influence policy.

It is estimated that, in the first year of the programme alone, there were already around 400 direct beneficiaries from 17 events in 6 countries. Now, the local policy forums are developing national policy forums for their countries based on the principles of grassroots networking, bottom-up policy development and active service-user participation. While the desired long-term outcome of the programme is for users and NGOs to influence mental health policy at a local level, the immediate outcomes (at the end of 2004) were more specific:

- that users and NGOs form new, deeper and sustainable relationships with other stakeholders, especially bureaucrats, local politicians, administrators and the media;
- that local action is initiated by the forums to increase their voice in mental health policy through, for example, campaigns, lobbying, public relations;
- that the profile of users as active participants in the policy process is raised, for example in the media.

    After December 2004, it was expected that:

- the programme would be independently evaluated and the lessons learned collated;
- a policy toolkit would be published to share new knowledge and case studies from the programme;
- if local people felt that the forums should continue, Hamlet would support groups to seek sustainable funding to enable them to do so.

The Pandora Foundation in the Netherlands

The Pandora Foundation was set up in 1964 to fight prejudice against former psychiatric patients. Now, 40 years later, over 100 volunteers and staff members

work to improve the social position of everyone who has or has had mental health problems *(10)*. To improve the social position of people with mental problems and to contribute to a higher quality of care and assistance, the Pandora Foundation is active in a number of different areas, such as mental health care, the job market, social security and insurance. Pandora always thinks and acts from a client-centred perspective. It provides independent information and is in no way sponsored by the pharmaceutical industry.

Activities

The "Ever met a normal person?" workshops tackle important issues such as fighting stigma and improving the way in which people who have had mental health problems are treated, and make mental problems a topic of open discussion. These goals are achieved by "experts by experience": people with first-hand experience of psychological or psychiatric problems provide the education. They bring to light the experiences, motivation and dilemmas of people with psychological and psychiatric problems. The educators provide general education to, among others: schools, (health care) educational facilities, buddy projects, client groups, women's groups, police and caregivers.

Being overworked or suffering from burnout or depression is a problem not only for the employee, but also for management and human resources personnel. "Sick leave due to mental problems" workshops for employers are held to clarify the position and the experiences of people with mental problems, and to stimulate dialogue between employees and management.

Thirty people – all of whom have had mental health problems themselves – provide support, information and advice by telephone to clients, their families and the general public.

> "The constructive involvement of all actors, including persons with mental disabilities themselves, their families, politicians, the legal and medical professions and NGOs is vital. These actors are partners, not antagonists, and they all have a contribution to make."
>
> – Conclusion 13 from a seminar organized by the Commissioner for Human Rights of the Council of Europe, hosted by the WHO Regional Office for Europe in February 2003

Stakeholder involvement

A horizontal approach to mental health involves intergovernmental agencies, governments, policy-makers, the market and civil society, working towards a mutual goal in partnership and cooperation. Spreading the task of improving mental health through advocacy is easier than leaving it to a single sector of society, such as government.

Allowing service users and carers to be included as active partners in planning their own and their relatives' mental health services and delivery would be a big

step forward towards more equal and fair communication between those who treat and those who receive treatment. Measures in this direction are already being implemented in Europe, fulfilling the user movement's longstanding plea for more involvement in decision-making about matters concerning them.

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17. The economics of mental health in Europe

"Behind all the barriers to improving mental health lies the scarcity of resources. It is helpful to bring an economic perspective to the attempt to overcome these barriers."
– Professor Martin Knapp, at the Mental Health Economics and Policy in a Global Context Conference, London, May 2003

Facing the challenges

Society cannot afford not to invest in mental health. The economic costs to society of mental health problems are enormous, with one cautious estimate from the International Labour Organization putting them at 3–4% of gross national product in the Member States of the EU *(1)*.

A growing number of national cost estimates is available, although making direct comparisons remains difficult since the methods used vary. Official estimates of the health care costs for all mental and behavioural disorders in Germany in 2002 totalled €22.44 billion, of which 62% were incurred by women. They included costs for depression of €4.025 billion, for schizophrenia and associated disorders of €2.756 billion, and for neurotic disorders, including stress, of €2.825 billion. The average cost per head of population was €270. Another recent study from England, which included the costs of lost productivity, estimated the total costs of adult depression in 2002 to be €15.46 billion or €309.2 per head of population; treatment accounted for only €636 million, the major part of costs resulting from lost employment because of absenteeism and premature mortality. Millions of working days are lost each year; for example, 31.9 million working days were lost in France in 2000 because of depression. A review of studies looking at the costs of schizophrenia, a condition affecting a much smaller absolute number of people than depression, confirms that these costs also remain substantial *(2)*. Studies in Hungary and England both report that health and social care costs account for around one third of all costs, with the other two thirds due to lost employment. The economic impact of schizophrenia has been estimated by several studies in Belgium and the Netherlands to be equivalent to around 2% of all health care costs, but these estimates do not include lost productivity costs or other adverse economic consequences *(3)*.

Other major costs are less well reported. The costs of reduced performance at work by people with untreated mental health problems such as depression may be five times as great as those for absenteeism *(4)*. There are also long-term fiscal effects, as mental health problems are a leading cause of early retirement or receipt of a disability pension. Substantial costs for family carers may be overlooked: for schizophrenia alone, families may provide 6–9 hours per day of support, while for dementia and related disorders, the contributions of caregivers can make up more than 70% of total costs, with some carers providing support 24 hours a day. Some adverse impacts are difficult to value in monetary terms but add still further to the costs of mental health problems; for instance, the rate of marriage or cohabitation for people with psychoses is much lower than for the general population. The stigma associated with mental health disorders also increases discrimination in the labour market.

Thus, the economic costs of mental health problems are substantial. In contrast to the situation for other health issues, most of these economic costs are incurred outside the health care system. This can be well illustrated by the results of a study of childhood conduct disorder in England (Fig. 17.1), which shows that the health care system only accounts for 16% of costs, while other factors – such as the lost employment opportunities of parents, the need for special education, social care and household repairs – also contribute to costs. Typically, lost employment, absenteeism and sick leave, reduced performance at work, lost leisure opportunities and premature mortality account for 60–80% of all costs of major mental health problems.

Fig. 17.1. Comprehensive costs of childhood conduct disorder in England
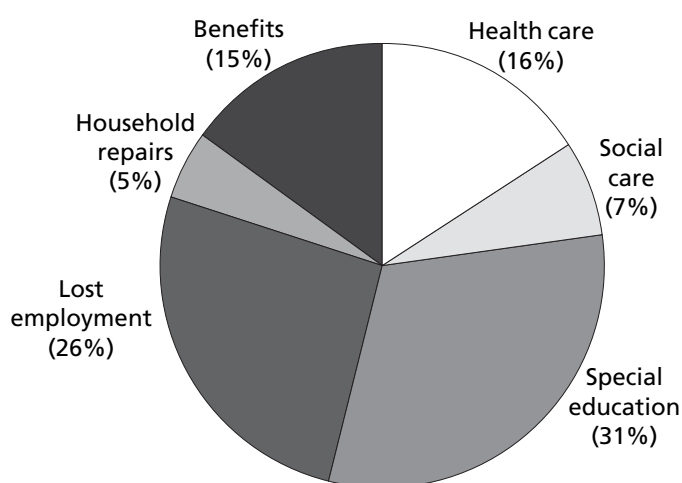
Source: Knapp et al. *(5)*.

Contribution of economics

It is not, of course, enough to know that there are substantial costs associated with poor mental health or even that effective interventions are available to help promote and regain positive mental health and well-being. Since scarcity is a permanent and pervasive feature of all societies, the level of resources available for all health problems will never be enough to meet all needs. In the face of such scarcity, choices have to be made. By combining information on both the costs and the effectiveness of different policies and interventions, economic techniques such as cost–effectiveness or cost–benefit analyses can provide decision-makers with data that can inform and assist their decisions on how to make the best use of available resources to maximize benefits. This can be a powerful tool for strengthening the case for investment in mental health.

While the evidence base on the cost–effectiveness of interventions for mental health is growing, most studies have taken place in North America, western Europe or Australasia, and their results may not be relevant for other settings. A continuing challenge is to further improve the understanding of cost–effectiveness in other national contexts, especially in central and eastern Europe, taking account of local circumstances, available resources and system structures. Most cost–effectiveness studies have looked at pharmaceutical treatments, and much more can be done to evaluate other interventions, including those for the promotion of mental well-being. More cost-effective interventions may actually require more resources than existing services, and there may be issues of "silo budgeting" to overcome. This can occur where mental health services are funded by a number of different sectors, and when there are tensions and difficulties in agreeing a coordinated approach to funding proven cost-effective interventions. For instance, a highly cost-effective intervention may increase costs substantially in one sector (such as health) but may generate benefits and a reduction in costs in another sector (such as social care).

Addressing equity concerns

Decisions on how resources are allocated should never be made on the basis of cost–effectiveness alone. Tackling fundamental abuses of human rights is a vital part of the decision-making process, as is the importance of providing equal opportunity to access services on the basis of need. Even where services are available without financial barriers such as out-of-pocket payments, as many as two thirds of those who could benefit may not actually use them. This is partly due to the fear of stigmatization and discrimination that people experience when they are labelled as having mental health problems. Inequalities in health outcomes across populations may be another consideration, so it may be considered appropriate to target groups at high risk of developing mental health problems, even if this is less cost-effective than using interventions aimed at the whole population. Such groups might include those living in poverty or in social isolation, refugees and ethnic minority populations.

Funding for mental health in Europe

Another challenge is to ensure that mental health receives a fair share of available health funding. The historically low level of funding for mental health in many European systems is inefficient, because of the substantial benefits that interventions would bring, and inequitable, given that mental health problems account for nearly 20% of all health problems in Europe.

The atlas of mental health resources *(6)* published by WHO in 2001 was the first attempt to systematically collect information on expenditure on mental health across the countries in the WHO European Region. Overall, only 23 of the 52 countries provided information, a primary reason for this being the fragmented structure of funding systems, especially where social insurance systems operate. Another complication is that many services are often provided outside the health care sector, and are subject to different funding structures. Combining data from the atlas with more recent work by the European Mental Health Economics Network *(7)*, it has been possible to produce data on mental health expenditure in 28 countries. The figures range between just over 13% and less than 2% of total health expenditure, with only 4 countries allocating more than 10% of their health budgets to mental health, 16 spending 5–10%, and the remainder less than 5%. The lowest reported budgets, of less than 2%, are all found in the NIS, where mental health services have historically been a low priority.

Although the level of resources available for mental health through the publicly financed health budget varies considerably, methods of funding mental health care are broadly equitable, differing little from those for health care in general. They rely largely on taxation and social insurance, respecting the principles of solidarity and universality. Private insurance provides minimal coverage for services related to mental health, owing to the chronic nature and high cost of mental health treatments and interventions. Where treatments are covered, premiums are likely to be higher. However, the importance of private insurance is growing in many parts of the European Region, and a future challenge may be to ensure that, where countries shift towards more reliance on private insurance, mental health disorders are fully covered in the same way as other conditions.

Funding services for mental health outside the health sector

Many mental health services are funded and provided outside the health sector. Few countries provide a fully comprehensive range of services within the health care system. Increasingly, community-based services are being shifted out of health and into the social care sector, with potentially significant implications for both entitlement and access to services. In contrast to the universality and solidarity found in health care systems, access to services in social care systems may be restricted, subject perhaps to means testing, significant co-payments and/or other criteria such as assessment of disability. Here the challenge is to ensure that any

continuing shift of funding out of the health sector does not increase inequities in access to or provision of services.

Access to housing and long-term care services in particular are subject to means assessment. Thus, before qualifying for assistance, an individual's (or, in some cases, family members') ability to pay must first be assessed, and the person may be expected to contribute most of his or her own income, as well as run through any capital, savings and other assets, before finally becoming eligible for assistance. Out-of-pocket payments for non-health-sector services can form a very high proportion of total costs, affecting the ability to access services. Of the 15 Member States of the EU before May 2004, only Sweden currently appears to fund all social care services fully from taxation and assess only need, rather than income.

Financial barriers to deinstitutionalization

An issue of particular concern in some Member States in the WHO European Region, particularly the NIS, is the challenge of moving away from continued heavy reliance on institutional care, either in psychiatric hospitals or social care homes. Financial systems in many of these countries link funding directly to bed occupancy, allowing no flexibility for local planners to develop community-based alternative services. Even where deinstitutionalization is taking place, there remains a danger that funds will not be transferred to the provision of community-based services. Moreover, the economic climate in some countries has meant that there are perverse incentives for institutions to discharge their most costly individuals first, without transferring funds to community-based care, while retaining low-cost (and therefore the least appropriate) individuals to increase the level of resources available.

Building solutions

It is important to further strengthen the information base to record how mental health services are funded, better identify their costs and map their availability across Europe, in order to help decision-makers allocate resources and identify gaps in access to essential services. This should focus not only on health care systems, but also on other sectors such as social care. The increasing amount of information available on the cost–effectiveness of different interventions can be adapted and used in different national contexts, taking account of organizational structures, levels of income and costs of health care interventions.

The European Mental Health Economics Network (7) is collecting data on both the financing and the availability of services across different sectors, analysing the links between employment and mental health, and the cost–effectiveness of mental health promotion and employment interventions across 31 countries. The aim is to build local expertise to tackle the many challenges facing mental health systems and to examine how economic incentives may be used to encourage the

shift away from institutions and towards appropriately resourced community-based services. This may help facilitate greater use of mental health economics in the decision-making process.

Elsewhere, the WHO-CHOICE (CHOosing Interventions that are Cost Effective) programme *(8)* has put together a database on the cost–effectiveness of many interventions for mental health in the European Region. While not available for individual countries, the information is provided for three subregions in a transparent manner so that data can potentially be adapted to take account of local costs and the availability of resources. The database already provides evidence that cost-effective treatments are available for all of the European Region, even where resources for health are very limited *(9)*. This is so even without taking account of the additional benefits of reducing productivity losses and limiting other adverse consequences of mental health problems.

Financial incentives and other mechanisms are also available to improve the allocation of resources to mental health within systems. The closure of long-stay institutions and social care homes can be encouraged by changing financing incentives in systems so that funding follows an individual, regardless of where he or she receives services. Such a change requires political will. It is also necessary in any transitional period to provide funding both for new community-based services and for existing institutions until they are phased out.

Where information is available on the level of psychiatric need within countries – for instance through regular surveys of psychiatric morbidity – it can be used in allocating resources from central to local level. This is the case in England, where local purchasers receive a share of the national health budget, based not only on the age and gender composition of the local population but also on an additional measure of mental health need. This takes account of psychiatric morbidity, as well as the state of housing and level of poverty in a locality. Although these funds are not strictly protected, local service planners have to make available services that meet the needs of the National Service Framework for Mental Health, which ensures that resources are targeted to mental health.

One way of facilitating the equitable use of funds to meet needs, particularly within the community, is by providing so-called direct payments to those with mental health problems, empowering them to purchase the services that best meet their needs. This system has been introduced as an option in some countries such as the Netherlands and the United Kingdom and, while it has not yet been fully evaluated, it is likely to avoid the problems of coordinating funding of services across different sectors, since payments can be used to purchase services in any sector.

Most fundamentally, however, mental health economists need to work with other stakeholders to convey to decision-makers the message that economics can be used as a powerful tool to objectively strengthen the case for investing in mental health and, furthermore, that economic analysis can also contribute much

to discussions on the way financial incentives can be used to promote reform. Equally, there is a need for economists and others to be more responsive to the needs of policy-makers and undertake research that can answer fundamental policy questions.

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18. Mental health information and research

"Good information is a prerequisite to good decisions."
– Mental health Global Action Programme (1)

Facing the challenges

Information systems

Mental health is poorly covered by existing health monitoring systems. Many international and national health information systems collect data related primarily to disease. A complete picture of a population's mental health also requires data on the social, cultural, demographic and economic determinants of mental health, as well as on the infrastructure and activities for promotion and prevention. These data are hardly ever available. Furthermore, data on resources for mental health, both within and outside the health sector, are generally not available.

Internationally agreed measures of the mental health of populations (mental health indicators) are often inadequate or unavailable, and lack relevance to policy. One of the major challenges is the fact that the necessary data on mental health indicators are often missing or are not comparable between or even within countries. Major coordination efforts are needed to harmonize existing national and international mental health indicators.

Insufficient and poorly coordinated mental health information limits the effective evidence-based development, delivery and monitoring of mental health strategies and interventions. The information currently available does not assist in the adequate planning of policies and services for the promotion of mental health and prevention, treatment and rehabilitation for mental ill health. The lack of data compromises needs-assessed distribution of resources and generates gaps in services.

Research

European mental health research lacks an international strategy. A common research policy on mental health is needed for the effective management of resources and to support informed evidence-based policy decisions across the European Region. However, research has to be closely linked to the information needs of

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policy-makers and practice. The consequence of the lack of relevant research is a lack of effective policy.

Most existing evidence is in the field of treatment of mental disorders. An international register based in Europe has identified 19 000 controlled prospective trials on mental health treatment interventions *(2)*. However, the existing knowledge base is not always translated into practice. Use of ineffective or even harmful interventions continues, while policy-makers and mental health services may not adopt new evidence-based effective treatments.

Long-term follow-up studies of effectiveness are generally lacking. Many of the existing studies are exploratory trials performed in controlled conditions and thus cannot be generalized to the "real world".

Many plausible policy interventions may be expected to affect mental health directly or indirectly, but apparently lack strong evidence of effectiveness. Research is needed into links between a population's mental health and public social and economic policies. Policy analyses and mental health impact assessments of public policies are largely lacking *(3)*.

There is good evidence for some policy-level interventions and service programmes, such as deinstitutionalization, but not for others. The evidence base for some mental health strategies, programmes and policy actions is limited due to a lack of evaluative research. Primary economic data on the relative costs and benefits of mental health promotion interventions, as on many other areas of promotion, are sparse *(4)*.

In spite of rapid development, the evidence base on preventive activities is still small and needs to be expanded. However, the evidence is sufficient to support preventive actions at different levels and for different target groups in areas such as substance misuse and suicide. Virtually no European studies exist on the cost–effectiveness of preventive measures *(5)*.

Building solutions

The Mental Health Declaration and Action Plan for Europe highlight the commitment of WHO's European Member States to identifying and developing information and research that will help in the planning of policies and interventions.

The European research community needs to collaborate to lay the foundations of evidence-based mental health work. Major research tasks include analysing mental health policy and the mental health impact of other policies, evaluating promotion activities, strengthening the evidence base for preventive programmes and stimulating research on mental health economics. Collaboration and partnerships between research, policy and practice need to be facilitated to bridge the knowledge gap between research and practice. Sustainable partnerships should be established to implement and evaluate new or existing interventions.

Evaluative research on mental health promotion needs to be initiated to fill the current gap in the evidence base. The limited amount of evidence in this field is due to the methodological difficulties associated with this type of research. Efforts should be made to apply evaluative research to shifts in any policy that may affect mental health, such as housing or employment policy initiatives. Longitudinal observational studies can play a valuable role in informing mental health policy by providing mental health monitoring data. Research-based opportunities for estimating the health effects of non-health sector policies need to be promoted, as non-health policies clearly have the potential to promote mental health *(3)*.

Mental health research in the field of prevention needs to be strengthened *(5)* and European research collaboration needs to be expanded in this area. This should include networking between European WHO collaborating centres and other centres with research activities in the field of prevention.

Priorities for prevention research include expansion of the knowledge base on effective prevention across countries and cultures. Special attention should be paid to expanding knowledge about the robustness and cultural sensitivity of the outcomes of programmes and policies, by performing multisite and replication studies. Longitudinal studies are needed to test the long-term impact of early preventive interventions. Research is needed that facilitates the development of preventive programmes that reach populations at risk. Research is also needed on the implications for effective preventive programmes and policies of the interrelatedness of many mental, physical and social health problems. Studies should strive to identify predictors of effect *(5)*.

To build a strong case for making investments in mental health, data on relative cost–benefit and cost–effectiveness are needed. Some data exist on the cost–effectiveness of service models and treatments, but the economic evidence base for actions in the fields of promotion and prevention is more limited. Important areas for future economic research should include evaluation of the cost–effectiveness of mental health promotion strategies in a variety of settings, including the workplace and the school. This research should include the broad economic impact of maintaining good mental health through increases in productivity in the labour force, long-term benefits through better educational performance, and assessment of the resource implications of such policies for health and other sectors such as social care.

Some issues are unique to individual countries or population groups. New research must therefore sometimes be commissioned on specific national or local questions and service evaluations.

Information systems

Information systems need to be tailored to provide relevant and important data on mental health. The information required for national and local objectives

should be identified and matched with data already collected. New mental health indicators need to be developed for information not yet available on the determinants and epidemiology of mental health and for the design and delivery of services. Developing indicators to measure positive mental health and determinants of mental health will be a priority. Research should be commissioned to construct and validate missing indicators *(6)*.

Two types of data are needed for monitoring mental health: routine statistics and health survey data. Efforts should be made to include mental health indicators in all health surveys.

Data collection needs to be standardized within the European Region to enhance the comparability of mental health information. Common views need to be developed among stakeholders and international organizations on standards that are sensitive to cultural and economic contexts but relevant across the Region. Building a Region-wide system of comparable data collection and analysis will allow international benchmarking. A comprehensive review of relevant mental health indicators *(7)* has identified a minimum European data set. Data should be collected on a repeated basis to allow the monitoring of trends and developments.

Existing European databases on good practices and the effectiveness of mental health interventions need to be maintained and effectively disseminated. Examples include the work of the WHO Health Evidence Network *(8)*, the IMHPA database on promotion and prevention in mental health *(9)* and the PsiTri database on treatment effectiveness trials *(10)*, maintained by the Finnish National Research and Development Centre for Welfare and Health (STAKES). The European Mental Health Economics Network *(11)* exchanges information and shares evidence on the cost–effectiveness of strategies and interventions. Optimum use can be made of scarce resources by finding and using international knowledge where appropriate.

Rational and effective use of resources should be supported by international evidence-based guidelines to improve the implementation and effectiveness of prevention programmes and policies, and treatment practice. Care should be taken not to duplicate existing efforts to pool and disseminate evidence, such as the Cochrane Collaboration.

Comprehensive metadata on mental health infrastructures at regional, national and European level, along with definitions of mental health indicators, need to be collected and made easily available.

An example

The IMHPA project, supported by the European Commission, is a good example of a combination of policy-relevant priority setting and dissemination of evidence-based knowledge (see also p. 55). This multinational project, coordinated by the University of Nijmegen in the Netherlands, is creating a European policy

action plan for prevention and promotion in mental health *(12)* and compiling a web-based register of evidence-based interventions within mental health promotion and prevention. The project's national counterparts are building country coalitions to support the dissemination and implementation of IMHPA measures at the national level.

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19. The way forward

The challenges have been accepted, the solutions endorsed. The task of the mental health programme at the WHO Regional Office for Europe now is to assist countries to implement the Declaration and the Action Plan, as mandated at the Ministerial Conference in Helsinki.

The priorities for the programme's work between 2005 and 2010 are stated in the Declaration. All its activities in the European Region will respect and promote the values of equality, fairness and solidarity, in line with the WHO Constitution and its policy for health for all. On the basis of these values, countries will strive:

- to offer all citizens equal opportunities for well-being, information and choice of services, access to good-quality care and integration into society;
- to give special attention to those with greatest needs, including groups at risk and people with severe mental health problems, and to offer resources proportionate to needs; and
- to encourage individuals, groups and countries to support each other and share knowledge, expertise and resources.

The mental health programme will base all its work on the following principles; all its activities will be:

- driven by the needs and experiences of people, communities and society;
- based on the best evidence, including both scientific evaluation and local experience; and
- sensitive to local cultures and resources, and respectful of diversity.

European mental health programme

Within this context, the mental health programme will implement a programme with four core objectives and related indicators (Table 19.1), incorporating the responsibilities adopted by the Member States and the Regional Office.

Partnerships

The scope of these four core objectives is broad and the level of expertise required is high. To make the most efficient use of the resources available and to achieve the greatest impact, partnerships will be stimulated across the European Region

Table 19.1. Four core objectives and indicators

Objective	Indicators
Reducing stigma, promoting mental well-being and preventing mental health problems	Coordination, implementation and dissemination of effective activities against stigma and discrimination across the European Region
	Design of programmes to promote mental well-being in schools and workplaces and dissemination and implementation of model programmes
	Scrutiny of the mental health impact of public policy in countries in the European Region
	Publication of evidence on effective strategies to prevent mental health problems and suicide that will be incorporated in national policies
Implementing policy and services delivered by a competent workforce	Design of policies that will deliver community-based services
	Development of specialist services for the problems facing young and older people, and gender-specific issues
	Creation of service networks and pathways involving primary care and social services
	Design of services that improve the recovery of people in marginalized and vulnerable groups
	Identification of disincentives that hinder joint work
	Support to policies that stimulate partnership
	Analysis of parity status of mental health in health systems and funding across the Region
	Building of a sufficient and competent mental health workforce across the Region
Generating and disseminating information and research	A set of indicators measuring the determinants and epidemiology of mental health and the status of implementation and delivery of services, developed by WHO in partnership with Member States and partner organizations
	An effective system for the dissemination of information
Advocating user empowerment and human rights	Ending of inhumane and degrading treatment and care, and enactment of legislation on human rights and mental health across the Region
	Increase in the level of education and employment opportunities of people with mental health problems
	Increase in active grass-roots NGOs
	Representation of service users and carers on groups responsible for the planning, delivery, monitoring and inspection of mental health activities.

among credible and respected organizations and individuals. The Regional Office has asked WHO collaborating centres to take responsibility for the coordination of some work areas. NGOs will be involved in their fields of experience and interest. The European Commission and the Council of Europe will be partners in activities of joint interest, and the technical expertise and networks of WHO headquarters will be utilized.

Local implementation in Member States

Impact at the country level will determine the effectiveness of the mental health programme. Member States need to be involved in and the owners of activities, from planning through implementation to evaluation.

The mental health programme proposes two approaches. First, each Member State will be asked to nominate a national counterpart, who will be asked to identify lead contacts representing expertise in the country. WHO will invite the counterparts to meetings to agree on priorities and to present findings and progress in their countries. According to the subject, some meetings will focus on a selection of Member States.

Second, the mental health programme will inform the WHO country offices in the Region of progress in the activities relevant to their countries. Liaison officers will be asked to communicate with their local networks about needs for information and the feasibility of implementation. The Declaration and Action Plan will shape the content of country programmes, and targets will be set to determine the progress of their delivery.

WHO headquarters

WHO headquarters has been a major source of comparative research on policies and services in Member States, developing modules of good practice in a range of important areas and supporting countries in the design of policies. It also provides expertise in health economics and health systems. The Regional Office is committed to intensifying its partnership with headquarters in these areas, including the funding of joint projects and sharing of staff. Headquarters will be closely involved in many work areas, leading some and contributing to others. Duplication of work and inefficiencies will be avoided.

European Commission and Council of Europe

The Ministerial Conference was organized in partnership with the European Commission and the Council of Europe, which committed themselves to the parts of the Declaration and the Action Plan within their competences. The organizations share many objectives with WHO. The European Commission is active in mental health promotion, the prevention of mental health problems including suicide, and the collections and dissemination of information on mental health. The Council of Europe plays a very active role in supporting

human rights, combating stigma and discrimination and promoting good mental health legislation. The Member States of all three organizations overlap, and have expressed a desire for them to work in partnership.

The Regional Office will explore opportunities to develop joint programmes with these organizations in their respective areas of expertise and responsibility.

Collaborating centres and NGOs

Action across the 12 areas of work specified in the Declaration and the Action Plan will achieve the 4 core objectives. In each area, WHO and countries will take action forward in partnership with collaborating centres, NGOs with a track record in the area or experts from across the Region.

The coordination and management of some areas of work will be the responsibility of a lead collaborating centre, accountable to the Regional Office. For each area of work, WHO and the centre will agree on a partnership work plan that is based on the actions specified in the Action Plan and covers objectives, budgets, targets and deliverables. The objectives of the areas of work will determine the actions to take, which will include meetings and publications.

Each lead collaborating centre is expected to contribute sufficient resources for the coordination of its programme. The Regional Office will call joint meetings with these centres twice yearly to coordinate activities and communicate key findings relevant across a range of areas of work. Table 19.2 lists the areas of work, the coordinating institutions and some agreed activities.

Empowering service users and carers is another important area for action. The mental health programme is establishing a partnership with users' and carers' NGOs across the Region, supported by the Regional Office and donors.

Conclusion

The WHO Regional Office for Europe has proposed an ambitious implementation programme that has the potential to effect change in all the priority areas covered by the Declaration. It will design a model of mental health activities – incorporating promotion, prevention, treatment, care and social inclusion – that will have at its heart the quality of life and functioning of the population, groups at risk and people with mental health problems.

The impact of this programme will be evaluated, and reported to Member States around 2010. Mental health in the WHO European Region is now everyone's business, and the success and impact of the Declaration and the Action Plan will be everyone's responsibility.

Table 19.2. Areas of work in the Declaration and Action Plan, coordinating institutions and activities

Areas of work	Coordinating institutions and activities
1. Promoting mental well-being for all	National Research and Development Centre for Welfare and Health (STAKES), Finland
2. Demonstrating the centrality of mental health	The mental health programme at the WHO Regional Office for Europe in partnership with national counterparts: monitoring
3. Tackling stigma and discrimination	Scottish Health Office, United Kingdom
4. Promoting activities sensitive to vulnerable life stages	WHO European mental health programme, with WHO headquarters: • developing modules for young and older people for dissemination to Member States • encouraging the development of specialist services
5. Preventing mental health problems including suicide	Karolinska Institute, Sweden
6. Ensuring access to good primary care	Trieste mental health service, supported by the regional government, Italy
7. Offering effective care in community-based services	WHO European mental health programme: directing activities in each area
8. Establishing partnerships across sectors	WHO Regional Office for Europe and WHO headquarters, with country offices: managing mental health policy, legislation and system design
9. Creating a sufficient and competent workforce	WHO Regional Office for Europe, in partnership with agencies across the Region, including NGOs such as the World Psychiatric Association and the European Union of Medical Specialists
10. Establishing good information	Trimbos Institute, the Netherlands, in partnership with the Regional Office and WHO headquarters (which is running several key projects such as the WHO Assessment instrument for Mental Health Systems (WHO-AIMS) and Project Atlas)
11. Providing fair and adequate funding	WHO Regional Office for Europe, with WHO headquarters: analysing funding allocation, equity and perverse incentives in systems across the Region
12. Evaluating effectiveness and generating new evidence	Trimbos Institute, the Netherlands, on behalf of WHO: convening expert seminars and groups and disseminating the results

Annex 1. Conference participants

Representatives of Member States

Albania
Dr Leonard Solis
    Minister of Health, Ministry of Health

Dr Sokol Dedja
    General Secretary, Ministry of Health

Dr Petro Mersini
    Director of Cabinet, Ministry of Health

Ms Saemira Pino
    Deputy Minister of Health, Ministry of Health

Andorra
Mme Mònica Codina Tort
    Ministre de la santé et du bien-être, Ministère de la santé et du bien-être

Mme Conxita Heras Colell
    Présidente, L'Association des Familles de malades mentaux

Dr Joan Obiols Llandrich
    Directeur des Services de Santé Mentale, Servei Andorrà d'Atencio Sanitària

Dr Angelina Santolaria Rossell
    Chef de service en toxicomanie, Servei Andorrà d'Atencio Sanitària

Armenia
Dr Alexander Ghukasyan
    Deputy Minister of Health, Ministry of Health of Armenia

Dr Gagik Karapetyan
    Director, Psychiatric Hospital of Sevan

Dr Samvel Torosyan
    Chief Psychiatrist, Ministry of Health of Armenia

Austria

Frau Maria Rauch-Kallat
    Bundesministerin, Bundesministerium für Gesundheit und Frauen

Ms Maria-Antonia Croy
    President, Association for Alzheimer Patients and Their Carers

Dr Verena Gregorich-Schega
    Direktorin, Internationale Angelegenheiten, Bundesministerium für Gesundheit und Frauen

Professor Heinz Katschnig
    Vorstand der Universitätsklinik für Psychiatriek, Medizinische Fakultät der Universität Wien

Mr Florian Pressl
    Kabinett von Frau Bundesministerin, Bundesministerium für Gesundheit und Frauen

Professor Werner Schöny
    Pro Mente Österreich

Belarus

Dr Liudmila Andreevna Postoyalko
    Minister of Health, Ministry of Health

Dr Alexander Konovalenko
    Chief Doctor, Grodno Medical Clinical Association "Psychiatry–Narcology"

Dr Svetlana A. Moroz
    Deputy Chief Doctor, Minsk City Psycho-Neurological Dispensary for Children and Adolescents

Professor Pavel Rynkov
    Chief Psychiatrist, Ministry of Health

Belgium

M. Rudy Demotte
    Ministre, Service public fédéral de la Santé publique

Mme Patricia Bernaert
    Cabinet du Ministre Rudy Demotte, Service public fédéral de la Santé publique

Mme Annick Dedobbeleer
    Cabinet du Ministre Rudy Demotte, Service public fédéral de la Santé publique

Dr Pol Gerits
Chef du Service des Soins Psychosociaux, Service public fédéral de la Santé publique

Ms Leen Meulenbergs
Coordination Relations Internationals, Service public fédéral de la Santé publique

Professor Isidore Pelc
Chef du service, Institut de Psychiatrie et Psychologie Medicale

Bosnia and Herzegovina

Dr Marin Kvaternik
Minister of Health and Social Care, Ministry of Health and Social Care, Republika Srpska

Mr Tomo Lucic
Minister of Health, Ministry of Health, Federation of Bosnia and Herzegovina

Mr Milos Candic
Ministry of Health and Social Care, Republika Srpska

Dr Goran Cerkez
Assistant Minister for International Relations, Ministry of Health, Federation of Bosnia and Herzegovina

Dr Milan Latinovic
Deputy Minister of Health and Social Welfare, Ministry of Health and Social Care, Republika Srpska

Dr Joka Blagovcanin-Simic
National Coordinator for Mental Health, Ministry of Health and Social Care, Republika Srpska

Ms Halida Vejzagic
Nongovernmental Organizations' Representative, Mental Health Issues

Bulgaria

Mr Slavcho Bogoev
Minister of Health, Ministry of Health

Dr Hristo Hinkov
Chief Expert, Centre for Hygiene, National Centre for Public Health

Professor Lubomir Ivanov
Director, National Centre for Public Health

Ms Valeria Ivanova
    Head of Minister's Cabinet, Ministry of Health

Ms Shereen Mestan
    Chairperson, State Agency for Child Protection

Dr Petko Salchev
    Deputy Minister of Health, Ministry of Health

Dr Galina Veshova
    Director, Regional Office of Geneva Initiative on Psychiatry

Croatia

Dr Velimir Bozikov
    State Secretary, Ministry of Health and Social Welfare

Dr Marin Andrijasevic
    Ambassador, Embassy of the Republic of Croatia in Finland

Mr Claude Grbesa
    Head, International Cooperation Department, Ministry of Health and Social Welfare

Dr Neven Henigsberg
    University Department of Psychiatry

Ms Vlasta Hrabak Zerjavic
    Medical Superintendant, Head, Chronic Diseases Service

Cyprus

Mr Andreas Christou
    Minister of Health, Ministry of Health

Dr Evangelos Anastasiou
    Athalassa Mental Hospital

Mrs Elli Kanari-Morpaki
    Administrative Officer, Ministry of Health

Mrs Florentina Petridou
    Scientific Consultant, Advocacy Group for the Mentally Ill

Czech Republic

Dr Milada Emmerova
    Minister of Health, Ministry of Health

Dr Miroslava Ourednikova
    Vice Minister, Ministry of Health

Ms Sabina Pope
  Interpreter, Ministry of Health

Mr Radovan Urban Kocak
  Deputy Director, Minister's Cabinet, Ministry of Health

Denmark

Dr Jens Kristian Gøtrik
  Director-General and Chief Medical Officer, National Board of Health
  (Sundhedsstyrelsen)

Mr Frede Budolfsen
  SIND – The Danish Federation for Mental Health

Mr Sven Erik Bukholt
  Ministry of the Interior and Health

Dr Marianne Jespersen
  Consultant, National Board of Health

Dr Dorte Sestoft
  President, Danish Psychiatric Association, Department of Psychiatry,
  Frederiksberg Hospital

Estonia

Mr Marko Pomerants
  Minister of Social Affairs, Ministry of Social Affairs

Dr Külvar Mand
  Deputy Minister of Social Affairs, Ministry of Social Affairs

Dr Katrin Saluvere
  Deputy Secretary-General for Health Policy, Ministry of Social Affairs

Ms Merike Vedru
  Board Member, Estonian Association for Supporters of People with Mental
  Disorders

Finland

Ms Liisa Hyssälä
  Minister of Health and Social Services, Ministry of Social Affairs and Health
  (*Chairperson*)

Dr Eero Lahtinen
  Senior Medical Officer, Health Department, Ministry of Social Affairs and
  Health

Mr Sakari Lankinen
  Ministerial Counsellor, Health/Medical Affairs, Ministry of Social Affairs and Health

Professor Jouko Lönnqvist
  Department of Mental Health and Alcohol Research, National Public Health Institute

Mr Tapani Melkas
  Director-General a.i., Ministry of Social Affairs and Health

Dr Markku Salo
  Senior Researcher, Finnish Central Association for Mental Health

Ms Terttu Savolainen
  State Secretary, Ministry of Health and Social Services

Professor Vappu Taipale
  Director-General, National Research and Development Centre for Welfare and Health (STAKES)

Professor Harri Vainio
  Director-General, Finnish Institute of Occupational Health (FIOH)

France

Dr Fabienne Debaux
  Chef du bureau de la santé mentale, Ministère de la Santé, de la famille et des personnes handicappées

Mme Evelyne Bonnafous
  Adjoint au chef du bureau des populations spécifiques à la direction de l'hospitalisation, Ministère des solidarités, de la santé et de la famille

Professor Viviane Kovess
  Directeur, Fondation MGEN pour la Santé publique

M. Pierre Larcher
  Chargé de mission, Ministère des solidarités, de la santé et de la famille

Dr Alain Lefebre
  Councillor, Social Affairs and Health, Embassy of France

Georgia

Dr Vladimir Chipashvili
  Minister of Labour, Health and Social Affairs, Ministry of Labour, Health and Social Affairs

Mr Koba Khabazi
Minister of Labour, Health and Social Affairs, Ministry of Labour, Health and Social Affairs

Dr Andro Kandelaki
National Coordinator on Mental Health, Ministry of Labour, Health and Social Affairs

Ms Manana Sharashidze
Executive Director, Georgian Association for Mental Health

Germany

Dr Klaus-Theo Schröder
Staatssekretär, Bundesministerium für Gesundheit und Soziale Sicherung

Dr Anna Brockmann
Reform der Psychiatrie, Bundesministerium für Gesundheit und Soziale Sicherung

Ms Beate Lisofsky
Pressebüro, Bundesverband der Angehörigen psychisch Kranker

Dr Peter Pompe
Leiter des Referates Protokoll, Internationaler Besucherdienst, Verbindung zu den Botschaften Bundesministerium für Gesundheit und Soziale Sicherung

Dr Thomas Stracke
Bundesministerium für Gesundheit und Soziale Sicherung

Frau Lilli Wilding
Dolmetscherin, Bundesministerium für Gesundheit und Soziale Sicherung

Greece

Mr G. Constantopoulos
Under-secretary of State, Ministry of Health and Social Solidarity

Dr Adamantios Avgoustidis
"Diakonia" Church of Greece

Professor George Christodoulou
Psychiatrist, Hellenic Psychiatric Association, University of Athens

Ms Filomila Raidou
Director, Ministry of Health and Social Solidarity

Mr Dimitrios Vartzopoulos
President, 2nd Regional Health and Welfare System (PESYD) of Central Macedonia

Hungary

Professor Dr Lázló Tringer
    Director, Psychiatric Department, Semmelweis Medical School

Iceland

Mr Jón Kristjánsson
    Minister of Health and Social Security, Ministry for Health and Social Security

Mrs Elín Ebba Ásmundsdóttir
    Lecturer, University Hospital

Mr Ingimar Einarsson
    Director of Planning and Development, Ministry for Health and Social Security

Mrs Gudrún Gudmundsdóttir
    Project Manager, Public Health Institute

Mr Sigurdur Gudmundsson
    Chief Medical Officer, Directorate of Health

Mr Sigursteinn Másson
    Chairman, Geðhjálp

Mr Thor Thorarinsson
    Director, Ministry for Health and Social Security

Ireland

Ms Bairbre Nic Aongusa
    Mental Health Services, Department of Health and Children

Mr Brian Howard
    Mental Health Association of Ireland

Dr John Owens
    Chairman, Mental Health Commission

Mr John Saunders
    Director, Schizophrenia Ireland

Israel

Ms Alla Gershenson
    Adviser to the Minister, Ministry of Health and Chief Specialist, Psychiatry, Ministry of Health

Dr Alexander Grinshpoon
Acting Director, Mental Health Services, Ministry of Health

Professor Avi Israeli
Director-General, Ministry of Health

Italy

Professor Antonio Guidi
Vice Secretary of State for Health, Ministry of Health

Dr Maria Stella Aloisi
Psychologist, Ministry of Health

Dr Renata Bastiani
Scientific Coordinator, Women Commission, Ministry of Health

Dr Teresa Di Fiandra
Scientific Coordinator, Mental Health Commission, Ministry of Health

Professor Fabrizio Starace
Scientific Coordinator, Mental Health Commission, Ministry of Health

Kazakhstan

Professor Aikan Akanov
First Deputy Minister of Health, Ministry of Health

Mr Nickolay Negay
Head of Department, Republican Research Centre for Psychotherapy and Narcology, Ministry of Health

Ms Saltanat A. Nurmagambetova
Head of Department, Department of Psychiatry, Narcology and Psychotherapy, Kazakh National Medical University

Kyrgyzstan

Professor Mitalip Mamytovich Mamytov
Minister of Health, Ministry of Health of Kyrgyzstan

Dr Toktogazy Kutukeev
Head of Department, Medical Service Organization and Licensing, Ministry of Health of Kyrgyzstan

Dr Suiutbek Nazarkulov
General Director, Republican Centre for Mental Health

Latvia

Mr Rinalds Mucins
    Deputy State Secretary, Ministry of Health of Latvia

Ms Ieva Leimane-Veldmeijere
    Programme Director, Mental Disability Advocacy Programme

Dr Daina Murmane-Umbrasko
    Deputy Director, Department of Public Health, Ministry of Health of
    Latvia

Dr Maris Taube
    Chief Specialist, Psychiatry Centre

Lithuania

Professor Zilvinas Padaiga
    Minister of Health, Ministry of Health

Dr Ona Davidoniene
    Director, State Mental Health Centre

Ms Danute Kasubiene
    Chairperson, Lithuanian Welfare Society for Persons with Mental Illnesses

Mr Viktoras Meizis
    Ministry of Heath

Ms Anzela Slusniene
    Chief Officer, Personal Health Division, Ministry of Health

Luxembourg

M. Mars di Bartolomeo
    Ministre de la santé, Ministère de la santé

Dr Yolande Wagener
    Médecin-chef de service, Division de la médecine preventive, Direction de la
    santé

Malta

Dr Louis Deguara
    Minister of Health, Ministry of Health, the Elderly and Community Care

Mr Louis Bonnici
    Chairman of Board of Directors, Mount Carmel Hospital

Mr Saviour Gambin
  Personal Assistant to the Minister, Ministry of Health, the Elderly and Community Care

Dr Ray Xerri
  Director, Policy and Planning, Ministry of Health, the Elderly and Community Care

Monaco
M. Peter Furstenborg
  Consul Général de Monaco, Gouvernement de Son Altesse Sérénissime, le Prince de Monaco

Netherlands
Ms Annemiek van Bolhuis
  Director, International Affairs, Ministry of Health, Welfare and Sport

Mr Frans Clabbers
  Senior Policy Adviser, International Affairs, Ministry of Health, Welfare and Sport

Mr Paul Groenewegen
  Senior Policy Advisor, International Affairs, Ministry of Health, Welfare and Sport

Mr Clemens Huitink
  Policy Office, International Affairs, Dutch Mental Health Association

Professor Ad. J.M.F. Kerkhof
  Department of Clinical Psychology, Free University of Amsterdam

Dr Milou Leunissen
  Prevention Research Centre on Mental Health Promotion and Mental Disorder Prevention, Department of Clinical Psychology, Radboud University Nijmegen

Dr Franz Trautmann
  Head, Unit of International Affairs, Trimbos Institute

Professor J. A. Walburg
  Chief Executive Officer, Trimbos Institute

Norway
Mr Jan Otto Risebrobakken
  State Secretary, Ministry of Health and Care Services

Dr John Glad
    Senior Medical Adviser, Social and Health Directorate

Mr Erling Jahn
    Head, Mental Health Norway

Ms Bjørg Njaa
    Head, Norwegian National Association for the Families of the Mentally Ill

Mr Thor Rogan
    Deputy Director General, Health Services Department, Ministry of Health
    and Care Services

Dr Torleif Ruud
    Research Director, SINTEF Health Research

Poland

Mr Pawel Sztwiertnia
    Undersecretary of State, Ministry of Health

Dr Jan Czeslaw Czabala
    Deputy Director for Research, Institute of Psychiatry and Neurology, WHO
    Collaborating Centre for Research and Training in Mental Health

Dr Wojciech Klosinski
    Head, Section of Psychiatry and Neurology, Department of Public Health,
    Ministry of Health

Professor Irena Namyslowska
    Head, Department of Child and Adolescent Psychiatry, Institute of Psychiatry
    and Neurology

Portugal

Dr Maria João Heitor dos Santos
    Directorate of Psychiatric and Mental Health Service, Directorate-General
    of Health

Professor José Pereira-Miguel
    Director-General and High Commissioner of Health, Ministry of Health

Dr António Mocho
    Adviser to the Minister, Ministry of Health

Dr Fernando G.P. Soares
    Minister's Head Officer, Ministry of Health

Republic of Moldova

Dr Andrei Gherman
   Minister of Health, Ministry of Health and Social Protection

Dr Iuliana Samburschi
   Senior Adviser, Foreign Relations Department, Ministry of Health and Social
   Protection

Romania

Professor Dr Mircea Cinteza
   Minister of Health, Ministry of Health of Romania

Professor Petre Boisteanu
   President of the Committee for Mental Health and Psychiatric Assistance,
   Ministry of Health of Romania

Dr Ioan Buraga
   General Director, General Direction of Medical Assistance, Ministry of Health
   of Romania

Dr Dana Farcasanu
   Counsellor of the Minister of Health, Ministry of Health of Romania

Mr Liviu Jicman
   Cabinet Secretary, Cabinet of the Minister

Professor Dr Tudor Udristoiu
   President, Romanian Association of Psychiatry

Russian Federation

Professor Boris A. Kazakovtsev
   Chief Psychiatrist, Ministry of Health and Social Development of the Russian
   Federation

Professor Valery N. Krasnov
   Director, Moscow Research Institute of Psychiatry

Dr N.B. Levina
   Chairman of the Board, All-Russian NGO of Mental Health Users and their
   families "New Opportunities"

San Marino

Dr Sebastiano Bastianelli
   Neuropsychiatric Services, The State Hospital

Serbia and Montenegro

Professor Tomica Milosavljevic
 Minister of Health of Serbia, Ministry of Health of Serbia

Professor Miodrag Pavlicic
 Minister of Health of Montenegro, Ministry of Health of Montenegro

Professor Dusica Lecic Tosevski
 Director, Institute of Mental Health

Dr Mirko Pekovic
 Head, Mental Health Clinic, Clinical Centre of Montenegro

Slovakia

Dr Ján Gajdos
 State Secretary, Ministry of Health

Dr Marcela Barova
 Open the Doors – Open Your Hearts

Dr Peter Breier
 Head, Department of Psychiatry, Ruzinov General Hospital

Ms Klara Frecerova
 Director, Foreign Relations Department, Ministry of Health

Slovenia

Mr Andrej Brucan
 Minister of Health, Ministry of Health of the Republic of Slovenia

Dr Lidija Kristancic
 Adviser, Ministry of Health of the Republic of Slovenia

Dr Andrej Marusic
 Director, Institute of Public Health of the Republic of Slovenia

Dr Vesna-Kerstin Petric
 Undersecretary, Ministry of Health of the Republic of Slovenia

Spain

Dr Fernando Lamata Cotanda
 Secretary General of Health, Ministry of Health and Consumer Affairs

Mr José Perez Lazaro
 Deputy Director General, International Relations, Ministry of Health and Consumer Affairs

Professor Manuel Gómez Beneyto
Adviser to the Minister, Ministry of Health and Consumer Affairs

Dr Paloma Soria
Technical Adviser, Ministry of Health and Consumer Affairs

Sweden

Mr Morgan Johansson
Minister for Public Health and Social Services, Ministry of Health and Social Affairs

Mr Carl Älfvag
Deputy Head of Delegation, Director, Chairman, Committee of Senior Representatives of the Northern Dimension Partnership in Public Health and Social Wellbeing, Ministry of Health and Social Affairs

Mr Jan-Olof Forsén
Chairman, Swedish National Association for Social and Mental Health

Mr Bengt Linder
Senior Adviser, Federation of Swedish County Councils

Mr Anders Milton
National Psychiatric Services Coordination

Mr Bengt Rönngren
Desk Officer, Public Health Division, Ministry of Health and Social Affairs

Mr Stefan Sjöquist
Political Adviser, Ministry of Health and Social Affairs

Mr Daniel Zetterberg
Desk Officer, Ministry of Health and Social Affairs

Switzerland

Frau Landamman Alice Scherrer-Baumann
Delegierte für Internationales der Schweiz, Gesundheitsdirektorinnen – Konferenz (GDK), Gesundheitsdirektion Kanton Appenzell

Ms Stephanie Zobrist
Deputy Head of Section, Division of International Affairs, Swiss Federal Office of Public Health

Dr Regula Ricka-Heidelberger
National Health Policy Section, Bundesamt für Gesundheit

Dr Herbert Heise
  Deputy Director, Universitäre Psychiatrische Dienste (UPD)

Mr Juerg Gassmann
  Zentralsekretar, Pro Mente Sana

Tajikistan

Dr Khurshed Kunguratov
  Chief Physician, Republican Psychiatric Hospital N1, Ministry of Health of
  Tajikistan

The former Yugoslav Republic of Macedonia

Professor Dr Vladimir Dimov
  Minister of Health, Ministry of Health

Ms Snezana Cicevalieva
  Head, Sector for European Integration and International Cooperation, Ministry of Health

Ms Gordana Majnova
  Head, Cabinet of the Minister, Ministry of Health

Dr Vladimir Ortakov
  Country Project Coordinator for the Stability Pact, Mental Health Project
  for South East Europe

Turkey

Professor Necdet Unüvar
  Undersecretary, Ministry of Health

Ms Sevim Tezel Aydin
  Deputy Head, Department of External Relations, Ministry of Health

Dr Oguz Karamustafalioglu
  Head of Clinic, Istanbul Sisi Etfal Hospital Clinic of Mental Health and
  Diseases

Professor Rüstem Askin
  Department of Psychiatry, Selcuk University

Professor Dr Can Cimilli
  Secretary of Foreign Affairs, Central Administrative Board of the Psychiatric
  Association of Turkey, Department of Psychiatry, Eylül University

Professor Bülent Coskun
  Director, Community Mental Health Research and Training Centre, faculty
  member, Psychiatry Department, Kocaeli University Medical School

Turkmenistan

Dr Byashim Sopyev
Deputy Minister of Health, Ministry of Health and Medical Industry of Turkmenistan

Dr Jumageldy Meredov
Chief Physician, Ashgabat City Centre of Prophylaxis of Drug Addiction, Alcohol and Mental Diseases

Ukraine

Professor Andriy Pidayev
Minister of Health, Ministry of Health of Ukraine

Dr Valentyna Dombrovska
Chief Specialist, Mental Health Care, Ministry of Health of Ukraine

Dr Raisa Kravchenko
Executive Director, All-Ukrainian Public Organization Coalition for the Protection of the Rights of the Disabled and Persons with Mental Deficiency

Dr Borys Mykhaylov
Head, Psychotherapy, Ministry of Health of Ukraine

Professor Alexandr Napriyenko
Chief Psychiatrist, Ministry of Health of Ukraine

Professor Stanislav Tabachnikov
Director, Ukrainian Research Institute of Social and Forensic Psychiatry and Narcology

Ms Zhanna Tsenilova
Head, External Relations Department, Ministry of Health of Ukraine

United Kingdom of Great Britain and Northern Ireland

Ms Rosie Winterton
Minister of State for Health, Department of Health

Mr Craig Alexander
Personal Secretary to Ms Brankin, Scottish Executive

Ms Rhona Brankin
Deputy Minister for Health and Community Care, Scottish Executive

Ms Anne Clarke
Director, National Children and Young People's Mental Health Project, Glasgow Centre of Population Health

Ms Caroline Farquhar
  Head of Implementation, Choose Life

Mr Gregor Henderson
  Director, Mental Health Division, National Programme for Improving Mental Health and Wellbeing

Dr Nicola Hilton
  Private Secretary to Ms Winterton, Department of Health

Mr Anthony Kingham
  Head, International Division, Global Health Team, Department of Health

Ms Anne Richardson
  Head, Mental Health Programme

Uzbekistan

Professor A.M. Khadzhibaev
  Deputy Minister, Ministry of Health

Dr Farukhtdin B. Abdulkasimov
  Republican Clinical Psychiatric Hospital of the Ministry of Health

Dr Vasila S. Alimova
  Specialist, Curative and Preventive Department, Ministry of Health

Dr Nargiza Khodjaeva
  Chief specialist, Psychiatry, Ministry of Health

Representatives of intergovernmental organizations

Council of Europe

Mr Alexander Vladychenko
  Director General a.i., Social Affairs and Health, Directorate General of Social Cohesion

Mrs Vera Boltho
  Head, Department of Health and of the Partial Agreement in the Social and Public Health Field, Directorate General of Social Cohesion

Mr Piotr Mierzewski
  Administrator, Directorate General of Social Cohesion

Parliamentary Assembly of the Council of Europe

Mr Paul Flynn
  Member of Parliament, United Kingdom

Mr Andrea Rigoni
    Senator, Italy

European Commission

Mr Markos Kyprianou
    European Commissioner for Health and Consumer Protection

Mr Jean-Bernard Blatrier
    Primo-Somadec (Belgium), Health and Consumer Protection Directorate-
    General, Unit C2 "Health Information"

Mr Erdem Erginel
    Member of Commissioner Kyprianou's Cabinet

Ms Marjatta Hautala
    Press Officer, The European Commission Representation in Finland

Mr Rejo Kemppinen
    Head of Representation, The European Commission Representation
    in Finland

Mr Robert Madelin
    Director-General for Health and Consumer Protection

Mr A. Saturno Mallia
    Health and Consumer Protection Directorate-General, Unit C2
    "Health Information"

Mr Kevin McCarthy
    Research Directorate-General, Health Policy Unit

Mr Juergen Scheftlein
    Health and Consumer Protection Directorate-General, Unit C2
    "Health Information"

Mr Philippe Todd
    Spokesman (for Commissioner Kyprianou)

Representatives of nongovernmental organizations in official relations with WHO

International Association for Child and Adolescent Psychiatry and Allied Professions

Professor Per-Anders Rydelius
    Secretary-General

World Association for Psychosocial Rehabilitation

Professor Edvard Hauff
  Vice President for Europe

World Federation for Mental Health

Ms Pirkko Lahti
  Director, Finnish Association for Mental Health, Finland

Ms Mary van Dievel
  Director, Mental Health Europe

World Federation of Occupational Therapists

Professor E. Sharon Brintnell
  Department of Occupational Therapy, Faculty of Rehabilitation Medicine,
  University of Alberta, Canada

Ms Julie Piergrossi

World Psychiatric Association

Professor John Cox
  Secretary-General

Representatives of other nongovernmental organizations

Amnesty International

Mr Ivan Fiser
  Research, Europe Regional Program, International Secretariat, Amnesty International

Association of European Psychiatrists

Professor Mario Maj
  President

Council of Occupational Therapists for European Countries

Ms Maria Skouroliakos
  President

Danish Nurses' Organization

Ms Merete Thorsén
  Chief Executive Officer

European Federation of Associations of Families of People with Mental Illness

Ms Begoñe Ariño Jackson

Ms Janet McCrae
   Vice-President

Ms Inger Nilsson
   President

European Federation of Psychiatric Trainees

Dr Defne Eraslan

European Federation of Psychologists Associations

Ms Vesa Nevalainen
   Chief, Professional Affairs, Finnish Psychological Association

European Forum of Nurses and Midwifery Associations and WHO

Ms Lis Wagner
   Manager and Short-term Professional, Nursing and Midwifery, WHO Regional Office for Europe

European Network of (ex-)Users and Survivors of Psychiatry

Ms Wilma Boevink
   Trimbos Institute, the Netherlands

Mr Olli Stalström

European Union of Medical Specialists

Dr R.J.A. ten Doesschate
   Treasurer, Section of Psychiatry

Dr Anne Lindhardt
   President

Hamlet Centre Trust

Ms Jane Shears

International Federation of Social Workers

Ms Maaria Numminen

Mental Disability Advocacy Centre

Ms Diana Hoover
  Executive Director

Mr Oliver Lewis

Mental Health Europe

Mr Claude Deutsch
  President

Dr Mojca Z. Dernovsek
  Assistant Professor, Ljubljana University Psychiatric Hospital, Slovenia

Ms Mary van Dievel
  Director

The Mental Health Foundation

Mr Andrew McCulloch
  Chief Executive

Open Society Mental Health Initiative

Ms Judith Klein
  Director

Ms Camilla Parker
  Legal and Policy Consultant, Open Society Institute

The Sainsbury Centre for Mental Health

Ms Angela Greatley
  Acting Chief Executive

World Association for Infant Mental Health

Professor Tuula Tamminen
  President

Temporary advisers

Professor Alan Apter
  Chairman, Department of Psychiatry, Schneiders Children's Medical Centre of Israel

Dr Diana Brahims Muço
  Director, Psychiatric Hospital of Valona, Albania

Professor Athanassios Constantopoulos
  Director, Mental Health Centre, Regional General Hospital of Athens, Greece

Professor Thomas Cox
   Director, Occupational Health, Institute of Work, Health and Organisations,
   University of Nottingham, United Kingdom

Dr Michael von Cranach
   Medical Director, Bezirkskrankenhaus Kaufbeuren, Germany

Mr Nicolas Daumerie
   Centre Médico-Psychologique, Centre Collaborateur de l'OMS pour la Re-
   cherche et Formation en Santé mentale, Faches-Thumesnil, France

Dr Giuseppe Dell'Acqua
   Director, Department of Mental Health, Italy

Ms Linda Dunion
   Campaign Director, See Me Scotland, United Kingdom

Ms Helja Eomois
   Chief Specialist, Public Health, Ministry of Health, Estonia

Mr Bjorn Erikson
   Industrial Hygienist, Norwegian Confederation of Trade Unions, Norway

Professor Berthold P.R. Gersons
   Psychiatric Centre, Netherlands

Mr Gabor Gombos
   Advocacy Coordinator, European Network of (ex-)Users and Survivors of
   Psychiatry, Hungary

Professor Ulrich Hegerl
   Klinik und Poliklinik für Psychiatrie und Psychotherapie, Klinikum der
   Universität München, Germany

Dr Riitta-Liisa Heikkinen
   Senior Research Specialist, Docent, Finnish Centre for Interdisciplinary
   Gerontology, University of Jyväskylä, Finland

Dr John H. Henderson
   Senior Policy Adviser, Mental Health Europe, United Kingdom

Professor Marija Holmila
   National Research and Development Centre for Welfare and Health
   (STAKES), Finland

Professor David Hunter
   Health Policy and Management, Wolfson Research Institute, University of
   Durham, United Kingdom (*Rapporteur*)

Dr Ainagul Isakova
Head, Family Group Practitioners Association, Kyrgyzstan

Dr Eva Jané-Llopis
Head of Science and Policy, Prevention Research Centre, University of Nijmegen, Netherlands

Mr John Brian Jenkins
Consultant in Mental Health, National Institute for Mental Health, United Kingdom

Professor Matti Joukamaa
Professor of Social Psychiatry, Institute of Medicine, Finland

Dr Marianne C. Kastrup
Chief Physician, Rigshospitalet, Denmark

Dr Reinhold Killian
Abteilung Psychiatrie II, Am Bezirkskrankenhaus Gunzburg, Germany

Professor Martin Knapp
Director, LSE Health and Social Care, London School of Economics and Political Science, United Kingdom

Dr Juha Lavikainen
Project Manager, Health and Social Services, National Research and Development Centre for Welfare and Health (STAKES), Finland

Dr Stavroula Leka
Lecturer in Occupational Health, Institute of Work, Health and Organisations, University of Nottingham, United Kingdom

Mr Gagik Makaryan
Executive Director, UMBA and HAI CONSULT Consulting Fund, Armenia

Mr David McDaid
Research Fellow, LSE Health and Social Care, London School of Economics and Political Science, United Kingdom

Dr Roberto Mezzina
Head of Sector, Centre for Mental Health, Italy

Dr Aleksandra Milicevic Kalasic
City Institute for Gerontology and Home Care, Serbia and Montenegro

Professor Maurice B. Mittelmark
Professor of Health Promotion, Research Centre for Health Promotion, University of Bergen, WHO Collaborating Centre for Research on Health Promotion and Health Education, Norway

Ms Melita Murko
  Assistant, Regional Project Manager, Regional Project Office, Mental Health Project for South Eastern Europe, Bosnia and Herzegovina

Dr Petr Nawka
  Chair, Association for Mental Health, and Pilot Programme Leader, Community Mental Health Care Service, Psychiatric Hospital Michalovce, Slovakia

Dr Alexander V. Nemtsov
  Head, Department of Informatics and System Research, Moscow Research Institute of Psychiatry of the Russian Ministry of Health, Russian Federation

Ms Mary Nettle
  European Network of (ex-)Users and Survivors of Psychiatry, United Kingdom

Ms Margareta Nilson
  European Monitoring Centre for Drugs and Drug Addiction, Portugal

Mr Tim Pfeiffer-Gerschel
  Klinik und Poliklinik für Psychiatrie und Psychotherapie, Klinikum der Universität München, Germany

Professor Dainius Puras
  Head and Associate Professor, Centre of Child Psychiatry and Social Pediatrics, Vilnius University, Lithuania

Ms Vesna Puratic
  Regional Project Manager, Mental Health Project for South Eastern Europe, Bosnia and Herzegovina

Professor Jorma H. Rantanen
  President, Finnish Institute of Occupational Health (FIOH), Finland

Dr Mario Reali
  Director of Health District, Italy

Professor Henk Rigter
  Netherlands

Dr Jean-Luc Roelandt
  Centre Médico-Psychologique, Centre Collaborateur de l'OMS pour la Recherche et Formation en Santé mentale, France

Dr Robin G.W. Room
  Centre for Social Research in Alcohol and Drugs, Stockholm University, Sweden

Professor Sir Michael L. Rutter
  Department of Child and Adolescent Psychiatry, Institute of Psychiatry, United Kingdom

Professor Wolfgang Rutz
  Head of Unit, Department of Psychiatry, Academic University Hospital, Sweden

Professor Armin Schmidtke
  Department for Clinical Psychology, Clinic for Psychiatry and Psychotherapy, Germany

Professor Paul Schnabel
  Director, Social and Cultural Planning Office of the Netherlands

Dr Tytti Solantaus
  National Research and Development Centre for Welfare and Health (STAKES), Finland

Professor Tores Theorell
  Director, Institute for Psychosocial Medicine, Sweden

Professor Graham Thornicroft
  Director, Health Services Research Department, Section of Community Psychiatry, Institute of Psychiatry, United Kingdom

Dr Toma Tomov
  Head, Department of Psychiatry, Alexandrovska Hospital, Sofia Medical Academy, Bulgaria

Professor Richard Velleman
  Director, Mental Health Research and Development Unit, University of Bath, United Kingdom

Mr Robert van Voren
  General Secretary, Geneva Initiative on Psychiatry, Netherlands

Professor Airi Värnik
  Estonian-Swedish Institute of Suicidology, Estonia

Dr Mladenka Vrcic-Keglevic
  Director, Andrija Stampar School of Public Health, University of Zagreb, WHO Collaborating Centre for Primary Health Care, Croatia

Professor Danuta Wasserman
  National Centre for Suicide Research and Prevention of Mental Ill Health, Sweden

Professor Katherine Weare
    School of Education, University of Southampton, United Kingdom

Professor Lilia E. Zikanshina
    Head, Department of Clinical Pharmacology and Pharmacotherapy, Russian
    Federation

Observers

Ms Vuokko Ahti
    Executive Manager, Mental Health User Association (HELMI), Finland

Ms Kristina Aminoff
    Executive Manager, National Family Association, Promoting Mental Health
    in Finland

Mr Chris Bale
    Director, Partnership for Children, United Kingdom

Professor Franz Baro
    Centre Interuniversitaire Belge de Recherche et d'Action, "Santé et Facteurs
    psychosociaux et psychobiologiques", WHO Collaborating Centre for Re-
    search and Training in Psychosocial and Psychobiological Factors, Belgium

Ms Cajsa Björkman
    Project Secretary, Finland's Swedish-speaking National Psychosocial Central
    Association

Mr Per Bøge
    Project Manager, Omsorg, and Educational Adviser, Danish Cancer Society,
    Denmark

Ms Maria Grazia Cogliati
    Italy

Mr Bob Cools
    Adviser, Cabinet of Flanders, Belgium

Ms Claire Curran
    Research Officer, LSE Health and Social Care, London School of Economics,
    United Kingdom

Mr Jan van Dessel
    Embassy of Belgium, Finland

Mr Jes Dige
    Danish Cancer Society, Denmark

Mr Jonathan Gordon
  Scottish Executive, United Kingdom

Ms Anne-Marie Grouev
  Project Manager, National Research and Development Centre for Welfare
  and Health (STAKES), Finland

Ms Martine van Hecke
  Ministry of Flanders – Department of Health, Belgium

Ms Emma Hogg
  Public Health Adviser (Mental Health Improvement), NHS Health Scotland,
  United Kingdom

Mr Jeff Huggins
  Head of Mental Health Division, Directorate of Service Policy and Planning,
  Scottish Executive, United Kingdom

Ms Seija Järvinen
  Chairman of the Board, Counsellor of Social Affairs (HON), Finland

Dr Jorma O. Järvisalo
  Research Professor and Deputy Director, Health Policy and International
  Development, Social Insurance Institution of Finland

Ms Pirkko Karjalainen
  Executive Director, Central Union for the Welfare of the Aged, Finland

Ms Hilkka Kärkkäinen
  Vice President, GAMIAN-Europe, Finland

Ms Outi Karvonen
  Project Manager, National Research and Development Centre for Welfare
  and Health (STAKES), Finland

Ms Tuula Kauppinen
  Director of Nursing, Finland

Ms Taru Koivisto
  Senior Officer, Ministry of Social Affairs and Health, Finland

Ms Anne Koskela
  Senior Officer, Legal Affairs, Ministry of Social Affairs and Health, Finland

Ms Katrin Lange
  UNOPS/PASARP-Vlore, Albania

Professor Ville Lehtinen
  Finland

Dr Kari Lindström
  Director, Institute of Occupational Health, Finland

Mrs Tessa Lush
  Bristol-Myers Squibb Corporate Affairs, United Kingdom

Mr Martti Mäki
  Executive Director, Finland

Dr Simo Mannila
  Senior Adviser, National Research and Development Centre for Welfare and
  Health (STAKES), Finland

Ms Taina Mäntyranta
  Director, ROHTO Centre for Pharmacotherapy Development, Finland

Dr Ernesto Muggia
  President, National Association for Mental Health, Italy

Ms Liisa Ollila
  Ministerial Adviser, International Affairs, Ministry of Social Affairs and
  Health, Finland

Ms Marja-Liisa Partanen
  Deputy Director-General, Health Department, Ministry of Social Affairs and
  Health, Finland

Ms Helena Partinen
  Executive Director, Nyytiry, Finland

Ms Elena Georgina Pascu
  Programme Manager, Advocate for Dignity, Centre for Legal Resources,
  Romania

Dr Marjaana Pelkonen
  Senior Officer, Ministry of Social Affairs and Health, Finland

Mr Teuvo Peltoniemi
  Head of Information, A-Clinic Foundation, Helsinki, Finland

Ms Tarja Reponen
  Director, Ministry of Foreign Affairs, Finland

Ms Susanna Rix
  Acting Regional Director/Programme Director, National Institute for Mental
  Health in England (NIMHE Eastern), United Kingdom

Dr Pietro Roselli
  Director, Italian Institute of Culture, Finland

Mr Pilar Saiz
  University of Oveido, Spain

Dr Mike Shooter
  President, Royal College of Psychiatrists, United Kingdom

Mr Giorgio Tabori
  Embassy of Italy, Finland

Ms Hannele Tanhua
  Senior Officer, Ministry of Social Affairs and Health, Finland

Mr Skerdilajd Truja
  UNOPS/PASARP-Vlore, Albania

Ms Ritva Varamäki
  Development Manager, Centre for Health Promotion, Finland

Ms Liliana Verdha
  Honorary Consul for Albania, Finland

Dr Kristian Wahlbeck
  Research Professor, Mental Health, National Research and Development
  Centre for Welfare and Health (STAKES), Finland

Ms Kirsten Zenzinger
  Centre Interuniversitaire Belge de Recherche et d'Action, "Santé et Facteurs
  psychosociaux and psychobiologiques", WHO Collaborating Centre for Re-
  search and Training in Psychosocial and Psychobiological Factors, Belgium

Professor Lilia Eugenevna Ziganshina
  Clinical Pharmacology, Kazan State Medical Academy, Russian Federation

World Health Organization
Regional Office for Europe
Mr Dmitriy Konstantinovich Botcheliouk
  Translator/Reviser (R), Languages

Dr Yves Charpak
  Adviser (Health Policy), EURO Representation to the EU

Mr Oluf Christoffersen
  Supervisor, Printing and Conference Services

Dr Marc Danzon
  WHO Regional Director for Europe

Mr Sasa Delic
Assistant, Printing and Conference Services

Dr Anca Dumitrescu
Director, Division of Information, Evidence and Communication

Dr Leena Eklund
Technical Officer, Health Evidence Network

Dr Jill Farrington
Coordinator, Noncommunicable Diseases

Mr Frank George
Regional Adviser, External Cooperation and Partnerships

Dr Maria Haralanova
Project Manager, Strategic Country Support

Ms Birgit Heesemann-Nielsen
Documentation Assistant (G), Languages

Ms Svenja Herrmann
Associate Professional Officer, External Cooperation and Partnerships

Dr Ivan Dimov Ivanov
Technical Officer, Occupational Health

Dr Kees de Joncheere
Regional Adviser, Health Technologies and Pharmaceuticals

Mr Bent Jørgensen
Office Equipment Operator, Printing and Conference Services

Ms Johanna Kehler
Programme Assistant, Mental Health

Ms Tina Kiaer
Conference Communications Officer, Mental Health

Dr Simo Kokko
Coordinator of the European Ministerial Conference on Mental Health, Mental Health Programme

Mr Bruce Leech
Administrative Services, Supply and Conference Officer, Administration, Supplies and Conference

Dr Gudjón Magnússon
Director, Division of Technical Support, Reducing Disease Burden

Dr Nata Menabde
  Director, Division of Country Support

Ms Kay Miller
  Documentation Assistant (E), Languages

Dr Matthijs Muijen
  Acting Regional Adviser for Mental Health (*Secretary*)

Ms Anna Müller
  Programme Assistant, Mental Health

Ms Liuba Negru
  Press and Media Relations Officer, Press and Media Relations

Mr Jens Nielsen
  Acting Network Administrator, Operations (Production and Support), Informatics Support

Ms Debbie Offen
  Secretary, Mental Health

Ms Ionela Petrea
  Technical Officer, Conference Coordination, Mental Health

Ms Kristel M. Bronwen Player
  Documentation Assistant (F), Languages

Mr Dag Rekve
  Programme Manager Alcohol and Drugs, Alcohol and Drugs

Mr Charles Robson
  Head, Translation and Editorial, Languages

Dr Gerald Rockenschaub
  Regional Adviser, Disaster Preparedness and Response

Ms Anna Roepstorff
  Programme Assistant, Communication and Advocacy

Ms Christine Rosenberg
  Secretarial Assistant, Director's Office, Division of Technical Support, Reducing Disease Burden

Mr Michal Rustanowicz
  Regional Adviser, Informatics and Telematics Services, Informatics Support

Ms Liz Shrapnel
  Personal Assistant and Secretary, Office of the Regional Director

Ms Larisa Stepanova
  Documentation Assistant (R), Languages

Ms Natalia Sterlikova-Løhr
  Secretary, Mental Health

Ms Vivienne Taylor Gee
  Communication Officer, Information Outreach

Mr Eric Tordeur
  Translator/Reviser (F), Languages

Dr Héðinn Unnsteinsson
  Technical Officer, Mental Health

Dr Liliana Urbina
  Desk Officer for Mental Health Activities, Mental Health

Mr Rainer Verhoeven
  Translator/Reviser (G), Languages

Headquarters

Dr José M. Bertolote
  Coordinator, Noncommunicable Diseases and Mental Health, Mental Health
  and Substance Abuse, Management of Mental and Brain Disorders

Dr Daniel Chisholm
  Health Economist, Department of Health System Financing, Expenditure
  and Resource Allocation, Evidence and Information for Health Policy

Dr Michelle Funk
  Coordinator, Noncommunicable Diseases and Mental Health, Mental Health
  and Substance Abuse, Mental Health Policy and Service Development

Dr Benedetto Saraceno
  Director, Noncommunicable Diseases and Mental Health, Mental Health
  and Substance Abuse

Dr Shekhar Saxena
  Coordinator, Noncommunicable Diseases and Mental Health, Mental Health
  and Substance Abuse

WHO offices in countries

WHO Country Office, Albania

Dr Santino Severoni
  Head of Office

Ms Dévora Kestel
  Short-term Professional, Mental Health Care Officer

Dr Ledia Lazeri
  National Professional Officer, Mental Health, Disaster Preparedness and Response Programme

WHO Country Office, Estonia
Dr Jarno Habicht
  WHO Liaison Officer

WHO Country Office, The former Yugoslav Republic of Macedonia
Dr Stojan Bajraktarov
  Project Manager, Mental Health

Ms Dimitrinka Jordanova-Pesevska
  National Professional Officer, Mental Health

Dr Jukka Pukkila
  Head of Office

WHO Office, Pristina
Dr Skender Syla
  National Health Policy and Systems Officer

Assisting staff from Finland

Ministry of Social Affairs and Health
Ms Marjatta Anttila
  Secretary

Ms Anna Ehrnrooth
  Secretary

Ms Marjatta Fyhr
  Secretary

Ms Noora Heinonen
  Senior Officer

Mr Jarmo Hämäläinen
  Security Officer

Ms Monika Kankaanrinta
  Department Secretary

Mr Petri Kauppi
  Information Technology Officer

Ms Tiina Neal

Ms Tuija Perälä
  Secretary, International Affairs Unit

Ms Nina Palin
  Secretary, Information and Communication

Mr Pirjo Pietilä

Ms Satu Renko

Ms Tarja Tamminen
  Deputy Communication Manager

Mr Lassi Tammi

Ms Ilari Wickström

National Research and Development Centre for Welfare and Health (STAKES)

Ms Paivi Erbrech
  Secretary

Ms Virpi Honkanen
  Project Secretary

Ms Ulla Katila-Nurkka
  Project Secretary

Ms Elina Lembinen
  Office Clerk

Mr Niko Metso
  Office Manager

Ms Mari Miekkala
  Research Assistant

Ms Merja Paimensaari
  Local Conference Coordinator

Ms Tanja Potepenko
  Conference Assistant

Mr Pekka Salakka
   Transportation Officer

Mr Aimo Silvenius
   Chief Office Manager

Ms Marianne Sipilä
   Project Coordinator

Ms Britta Sohlman
   Special Planner

Ms Päivi Tapiovaara
   Project Secretary

Ms Laila Turkia
   Office Secretary

Social Insurance of Finland

Ms Tanja Blomqvist
   Coordinator, International Affairs

Tampere School of Public Health

Ms Pia Solin
   Research Fellow

University of Turku

Ms Reeta Kangas