The European Mental Health Action Plan

Mental disorders are one of the top public health challenges in the WHO European Region, as measured by prevalence, burden of disease and disability, affecting more than a third of the population every year. In all countries, most mental disorders are much more prevalent among those who are most deprived.

The WHO European Region therefore faces diverse challenges affecting both the (mental) well-being of the population and the provision of care for people with mental health problems. Systemic and coherent actions are needed to address these challenges. The European Mental Health Action Plan focuses on seven interlinked objectives and proposes effective and integrated actions to strengthen mental health and well-being in the European Region. Investing in mental health is essential for the sustainability of health and social policies in the European Region.

This document contains a draft European Mental Health Action Plan that corresponds to the four priority areas of the new European policy framework for health and well-being, Health 2020, and will contribute directly to its implementation.

The Action Plan has been developed in close consultation with Member States, guided by the Standing Committee of the WHO Regional Committee for Europe. The Regional Director for Europe and the Regional Office wish to thank all Member States and others who have contributed to developing this Action Plan.

A draft resolution is presented, for consideration by the Regional Committee.

Contents

Background

1.   The promotion of mental health and the prevention and treatment of mental disorders are fundamental to safeguarding and enhancing the quality of life, well-being and productivity of individuals, families, workers and communities, thus increasing the strength and resilience of society as a whole.

2.   These objectives were adopted by Member States in the WHO European Region, the European Commission and the Council of Europe in the European Declaration for Mental Health, signed in Helsinki in January 2005, and endorsed by the WHO Regional Committee for Europe in its Resolution EUR/RC55/R2. Building on this commitment and responding to the evolving mental health needs of the European Region, the WHO Regional Office for Europe has developed this Action Plan in close partnership with the leading actors in mental health in the Region.

3.   The Action Plan is fully aligned with the values and priorities of the new European policy framework for health and well-being, Health 2020, and contributes to achieving its vision (see matrix below). It also follows the agenda set by the WHO Global Mental Health Action Plan (WHA66.8). It adheres to the United Nations Convention on the Rights of Persons with Disabilities (2008) and has incorporated the conclusions of the European Pact for Mental Health and Well-being (2008).

4.   The Action Plan is closely interrelated with other WHO programmes, including equity and gender, social and health determinants, risk factors, child and adolescent health and healthy ageing, noncommunicable diseases (NCDs) and health systems, each producing plans and actions that require joint work to achieve all potential benefits for well-being (see Annex 1). In combination, the respective conventions, declarations, strategies and action plans offer a solid and inspiring basis for this Action Plan to address the challenges faced in the European Region today.

5.   This Action Plan covers mental health and mental disorders across the life-course. It does not include substance use disorders.

Table 1. Matrix: interface between Health 2020 and
European Mental Health Action Plan

	Obj. 1	Obj. 2	Obj. 3	Obj. 4	Obj. 5	Obj. 6	Obj. 7
Inequities and social determinants	x	x		x	x		x
Governance			x		x	x	x
Life-course	x		x				
Empowerment		x		x		x	
Health systems			x	x	x		x
Public health	x				x	x	x

Mental health in Europe: Status and challenges

6.   The European Region is facing diverse challenges affecting the (mental) well-being of the population and the provision of care for people with mental health problems (see Annex 2). Maintaining the well-being of the population at times of new economic realities, making a commitment to the rights and empowerment of service users and their families and guaranteeing access and quality of care while addressing the need for public service sector reforms are challenges common to Member States.

7.   The well-being of the population has become a central focus for governments. Policies across government can increase mental well-being and reduce exposure to risk factors. In a time of economic challenges and increased unemployment in many countries, as well as ageing populations, attention has to focus on efficient ways of preserving and maximizing well-being across the lifespan.

8.   Mental disorders are one of the greatest public health challenges in the European Region as measured by prevalence, burden of disease and disability. Mental health problems, including depression, anxiety and schizophrenia, are the main cause of disability and early retirement in many countries and a major burden to economies, demanding policy action.

9.   The commitment to deinstitutionalization and the development of community-based mental health services has continued, although progress is uneven across the Region. The consensus is that care and treatment should be provided in local settings, since large mental hospitals often lead to neglect and institutionalization. Thus, a focus on the expanding role of primary care, working in partnership with multidisciplinary mental health staff in community-based facilities, has become central.

10.   There is strong evidence of effective treatments and care for many mental disorders and their co-morbidities. Well-being could be improved, productivity increased and many suicides prevented. However, a large proportion of people with mental disorders either do not receive treatment at all owing to poor accessibility, the so-called treatment gap, or experience long delays.

11.   Many people with mental health problems choose not to engage or maintain contact with mental health services, due to stigma and discrimination. Negative treatment and care experiences are another factor contributing to failure to engage. Reforms need to achieve higher confidence in the safety and effectiveness of care. Mental health policies need to combine structural reform of services with a focus on quality, ensuring the delivery of safe, effective and acceptable treatments by a competent workforce.

12.   The life expectancy of people with mental disabilities is many years shorter than that of the age- and sex-adjusted general population, owing to co-morbidities and interactions between mental and physical (ill) health that are ignored. Lack of awareness and stigma play an important part.

13.   Multisector working and partnerships are essential. All sectors of society have a responsibility for mental health. Every governmental and independent agency has a role and needs to contribute. It is not the case that no one cares about mental health and mental disorders. Indeed, it is difficult to find people who do not show concern and commitment. Nevertheless, it can still be difficult to identify who is in charge of coordinating action.

14.   The importance of choice and partnership emphasizes the need for transparent information and accountability to inform all stakeholders about quality of care and

interventions, and to demonstrate the need for improvement and the potential for innovation and change.

15.   Systemic and coherent actions are needed to address these challenges. The European Mental Health Action Plan proposes effective and integrated action to strengthen mental health and well-being in the European Region. The vision underpinning this Action Plan is expressed in Annex 3.

European values and vision for mental health

16.   Informed by the needs and aspirations of the people living in the European Region and guided by the fundamental human rights and experiences of service users and carers, there are three complementary values and accompanying visions inspiring this Action Plan.

(a)   Fairness: everyone is enabled to reach the highest possible level of mental well-being and is offered support proportional to their needs. Any form of discrimination, prejudice or neglect that hinders the attainment of the full rights of people with mental health problems and equitable access to care is tackled.

(b)   Empowerment: all people with mental health problems have the right, throughout their lives, to be autonomous, having the opportunity to take responsibility for and to share in all decisions affecting their lives, mental health and well-being.

(c)   Safety and effectiveness: people can trust that all activities and interventions are safe and effective, able to show benefits to population mental health or the well-being of people with mental health problems.

European Mental Health Action Plan: Scope

17.   In order to deliver the values and visions and in response to the challenges, the scope of the Action Plan proposes a three-pronged, interdependent, indivisible and mutually-enforcing approach.

(a)   Improve the mental well-being of the population and reduce the burden of mental disorders, with a special focus on vulnerable groups, exposure to determinants and risk behaviours.

(b)   Respect the rights of people with mental health problems and offer equitable opportunities to attain the highest quality of life, addressing stigma and discrimination.

(c)   Establish accessible, safe and effective services that meet people's mental, physical and social needs and the expectations of people with mental health problems and their families.

European Mental Health Action Plan: Objectives

18.   Seven objectives, four core and three cross cutting, have been developed, which together cover the full scope of this Action Plan. For each of the objectives, actions are proposed for Member States and WHO that would achieve measurable outcomes in policy and/or implementation. Actions should be prioritized according to needs and resources at national, regional and local levels.

19.   The four core objectives are:

(a)   everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk;

(b)   people with mental health problems are citizens whose human rights are fully valued, protected and promoted;

(c)   mental health services are accessible and affordable, available in the community according to need; and

(d)   people are entitled to respectful, safe and effective treatment.

20.   The three cross-cutting objectives are:

(e)   health systems provide good physical and mental health care for all;

(f)   mental health systems work in well-coordinated partnerships with other sectors; and

(g)   mental health governance and delivery are driven by good information and knowledge.

Objective 1: Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk

21.   Governments and citizens value well-being and wish to see it taken into account in policy. Mental well-being provides a foundation for resilience, strengthening hope for the future, and builds the capacity to adapt to change and cope with adversity. At times of high social and economic stress, action to strengthen well-being and prevent mental health problems is essential, particularly for vulnerable groups.

22.   Standard of living has a major impact on population well-being. However, mental well-being is also influenced by control over life, autonomy and social connectivity.

23.   The large proportion of people off work for extended periods due to mental health problems or disabilities poses a growing challenge for many countries. The rate of return to employment of this group is worryingly low. An integrated package of promotion, prevention and interventions in the workplace, linked to good management practices, has been shown to be effective.

24.   There is robust evidence that adequate levels of social support and social integration, including the provision of universal welfare, offer protection against mortality. Moreover, poor outcomes, such as income deprivation, lack of educational achievement, unemployment, drug and alcohol misuse, crime, emergency hospital admissions, low life expectancy, mental disorders and suicide often occur in clusters in individuals and in families. Integrated, comprehensive approaches are increasingly shown to be more effective and cost effective than single interventions. Such approaches are targeted, take full account of psycho-social and cultural factors, and build on assets, as well tackling deficits.

25.   Some countries in the European Region experience man-made or natural disasters, resulting in intense stress and suffering for large numbers of people. Adequate prevention and/or early intervention measures can strengthen resilience and limit the prevalence of post-traumatic stress disorders (PTSD), depression, anxiety, substance use disorders, violence and suicide.

26. Governments have a central role in creating conditions to empower individuals and communities, promote and protect well-being and strengthen resilience. To reduce inequalities in mental health and well-being, actions must be universal, integrated and coordinated, but with a scale and intensity proportionate to the needs of vulnerable and disadvantaged groups. Some actions to promote mental health and prevent mental health problems have been shown to be both effective and cost-effective.

Outcomes

27. Objective 1 aims to achieve the following outcomes:

   (a)   raised awareness of mental well-being and factors that support it – in lifestyles, in the family, at work, in schools and kindergartens, in the community and in wider society;

   (b)   increased support for mental health needs in antenatal and postnatal care, including screening for domestic violence and alcohol abuse;

   (c)   capacity in primary care to enhance mental health promotion, the prevention and early recognition of mental disorders and low-threshold psychological support;

   (d)   increased return to work of people with mental health conditions;

   (e)   reduced suicide rates among the population as a whole and in subgroups related to age, sex, ethnicity and other vulnerable groups; and

   (f)   means of measuring well-being and the determinants of well-being (in addition to measures of mental disorder) throughout the life-course agreed and implemented.

Proposed actions

28. The following actions are proposed for Member States:

Across the lifespan

   (a)   develop and implement suicide prevention strategies that incorporate best evidence, combining a universal approach with activities protecting vulnerable groups;

Best start

   (b)   provide support for family life, ante-/postnatal care and parenting skills;

   (c)   provide opportunities for pre-school education and encourage parents to value the home as a learning environment, such as play, reading to children and family meals;

   (d)   reduce adverse childhood experiences (such as abuse, neglect, violence and exposure to drug and alcohol misuse) by raising awareness, increasing recognition, and ensuring early intervention;

Education and skills

   (e)   offer universal and targeted mental health promotion programmes in schools, including early identification of emotional problems in children and action on bullying;

   (f)   apply whole-of-community approaches to education in areas of multiple deprivation to break the cycle linking poverty, deprivation and poor educational outcomes;

(g)   promote lifelong learning: improving literacy, numeracy and basic skills in those who are most deprived and excluded;

Employment (productive and valued activities)

(h)   create incentives for employers to reduce psychosocial and job-related stress, enhance stress management and introduce simple programmes to promote well-being in the workplace;

(i)   encourage optimal organization of work and working hours to achieve work-life balance;

Healthy places, healthy communities

(j)   promote healthy nutrition and physical activity for all age groups, through sport and other activities, and provide safe play space for children;

(k)   promote the establishment and protection of healthy places outdoors and contact with nature;

Dignity in old age

(l)   provide living spaces and neighbourhoods that are safe, convenient and accessible, as defined by older people themselves; and that facilitate their participation, mobility and autonomy; and

(m)   provide opportunities for e-learning for older people to facilitate access to social networks and early intervention programmes.

29.   The following actions are proposed for the WHO Regional Office for Europe:

(a)   strengthen awareness of the impact of the social determinants of health on mental health, the importance of mental health as an intermediary determinant, and the contribution of population mental health to public health;

(b)   identify interventions and develop care pathways for prevention of and early intervention in harmful stress and its consequences at individual and population levels;

(c)   support the promotion and dissemination of sound educational programmes, covering suicide prevention, stigma and discrimination, alcohol and drug use and dementia; and

(d)   disseminate evidence of effective workplace interventions to Member States.

Objective 2: People with mental health problems are citizens whose human rights are fully valued, respected and promoted

30.   Around the European Region, the aim of mental health policies and legislation is being transformed towards creating opportunities that empower people with mental health problems to make use of their own assets, and to participate fully in community and family life in ways they would choose and to which they are entitled.

31.   It is now accepted that disability and handicaps are not only a consequence of illness, but also result from the interaction between people with mental health problems and external attitudinal and environmental barriers. The United Nations Convention on the Rights of Persons with Disabilities requires governments and institutions to provide the social, economic and legal support to allow persons with mental disabilities to exercise all their rights to citizenship.

32.   Mental health systems have an essential contribution to make in this regard, since good community services promote social inclusion and foster recovery. Services must be provided and activities undertaken that empower individuals as well as communities to realize their potential, while protecting and promoting their human rights.

33.   Such an approach represents a commitment to fundamental values of social justice and equity. It is also a powerful means by which health systems can enhance individual and population health, and address social and health inequalities.

34.   All steps should be taken to promote voluntary admission and treatment, and avoid coercion, while guaranteeing protection in accordance with international and national human rights instruments. Strong safeguards need to be in place if involuntary admission and treatment are deemed necessary, including independent reviews, inspection of the conditions under which people are detained and access to complaints procedures, independent legal advice and other relevant support.

35.   A rights-based approach demands an understanding and analysis of how inequality and discrimination affect people with mental health problems both inside and outside the health system. Such inequality, stigmatization and discrimination can make it hard or impossible for some groups, including those characterized by ethnicity, sex, age, religion, sexuality, refugee or immigrant status, socioeconomic status and physical and/or mental disability, to be able to access appropriate and wide-ranging mental health interventions.

Outcomes

36.   Objective 2 aims to achieve the following outcomes:

    (a)   all human rights are guaranteed and protection against discrimination is safeguarded for people with mental health problems;

    (b)   opportunities associated with full citizenship, including employment, housing and education for people with mental health problems are equal to those of other people, taking into account adjustments required to compensate for any disability; and

    (c)   people subjected to involuntary care and/or treatment have access to free information and legal advice.

Proposed actions

37.   The following actions are proposed for Member States:

    (a)   adopt or update policies and legislation according to ratified conventions and endorsed declarations, guaranteeing human rights and protection against discrimination associated with mental health problems in areas such as benefits, employment, education and housing;

    (b)   address inequalities and discrimination in access to and experience of mental health services;

    (c)   provide each patient and family member with appropriate information, in an accessible format, about rights, care standards and treatment options;

    (d)   create and/or identify mechanisms for people with mental health problems to participate in the design, delivery, monitoring and evaluation of mental health policies and services;

(e)   enable the capacity of patient and family advocacy groups, including financial support, strengthening representation of their interests;

(f)   ensure free access to legal advice for people detained involuntarily; and

(g)   conduct evidence-based anti-stigma activities in communities, targeting people who have the potential to impact the lives of those suffering from discrimination.

38.   The following actions are proposed for the Regional Office:

(a)   work with intergovernmental partners to guarantee human rights and social justice for people with mental health problems;

(b)   disseminate good practice examples of services and systems that support and promote recovery and social inclusion; and

(c)   offer technical support to Member States to draft and implement policies that promote recovery and social inclusion, and address inequalities and discrimination.

Objective 3: Mental health services are accessible, competent and affordable, available in the community according to need

39.   The vision at the heart of community care is of mental health services not only treating the symptoms of mental disorders, but also of building hope and creating opportunities for people with mental health problems, thus enhancing recovery. Psychological, biomedical socioeconomic and cultural matters are all equally central to living a full life.

40.   All countries in the European Region have adopted strategies and/or action plans aiming to deliver the shift from institutional psychiatry to such community based mental health care. Large asylums that cover wide geographical areas and are commonly associated with neglect and abuse have been closed in some countries, while closure plans are in place in others. The number of psychiatric beds has been reduced significantly in most countries. Major challenges do, however, remain and progress is uneven.

41.   For the large majority of people with mental health problems, primary care remains the first point of access. The stigma of accessing primary care is low, settings are accessible and brief interventions can be delivered efficiently, particularly for common mental health problems such as anxiety and depression. Primary care staff require adequate training to identify, diagnose, treat and prescribe appropriately, and when required, to refer people with mental health problems to specialist care. Psychiatrists and other mental health specialists need to be available to offer expertise and support.

42.   Many countries now aim to establish mental health services that are local and community-based, organized around the needs of a population catchment area. Such mental health services need to provide and integrate: information and means to help oneself or support family members; primary care linked services for treatment of common mental health problems; community mental health services for prevention, treatment and psychosocial rehabilitation of people with severe and/or complex mental health problems; beds available as a last resort in settings such as health centres or district general hospitals for people requiring intensive care; support in residential homes for people with long term mental health problems and some regional or national services for special conditions including forensic services. Community services often rely on the commitment of families. The coping capacity and skills of families should be assessed regularly, and measures taken to ensure that families benefit from the necessary support, education and the provision of resources.

43.   Many patients present with multiple problems, and services need to offer expert interventions and establish partnerships. Substance misuse disorders are so frequent that some community mental health services would benefit from integrated expertise and specialist treatment for people with combined mental health and substance misuse problems.

44.   Some groups, such as children, young people and older people, can present with age-related developmental or neuropsychiatric disorders that require specialist interventions and care. Mental health services for children and older people are specialist services that must work closely with families and the social care and welfare sectors.

45.   Good mental health service delivery requires sufficient competent staff. Changes in service structure and ways of working require changes in workforce numbers and skill mix in all parts of the mental health services.

46.   Mental health care in Europe is usually, but not always, free of user charges at the point of entry. Payment or co-payment may be required for specialized services in some countries. Funding arrangements should ensure that appropriate care is available for the whole population, without barriers for the most vulnerable.

Outcomes

47.   Objective 3 aims to achieve the following outcomes:

   (a)   mental health services are organized in order to facilitate a (normal) life in society and comprise a spectrum of care, integrating specialist mental health and generic services;

   (b)   primary care can ensure correct early diagnosis, treatment and referral for people with mental disorders;

   (c)   community-based mental health services are accessible to all groups in the population;

   (d)   large institutions, associated with neglect and abuse, are closed;

   (e)   hospital care is therapeutic, offering a range of treatment, care and support tailored to individual needs, rather than simply confining patients;

   (f)   mental health services are provided in decent settings;

   (g)   mental health services offer appropriate care for different age groups;

   (h)   family capacity and needs are assessed periodically, and training and support provided;

   (i)   a multidisciplinary workforce is available in sufficient numbers; and

   (j)   mental health services can be accessed without unfair financial barriers.

Proposed actions

48.   The following actions are proposed for Member States:

   (a)   develop a national mental health strategy specifying the priorities and responsibilities of national and local specialist and generic agencies;

   (b)   establish primary care as the first point of access for people with mental health problems, and provide the capacity to deliver treatment for common mental disorders;

      (c)   base community mental health services in accessible settings, close to the most vulnerable groups and provide essential support services;

      (d)   offer special outreach programmes in areas with a high prevalence of risk populations such as poor minority groups or homeless people;

      (e)   create community services that are age-appropriate and competent to offer early intervention and continuing support to young people with a first episode of a severe mental health problem;

      (f)   develop psychiatric units that are therapeutic, with single sex facilities with adequate privacy, particularly bedrooms, toilets and bathrooms, and with staff that offer individualized and effective care in a respectful manner;

      (g)   provide homes in the community, offering dignified and person-centred living arrangements and care;

      (h)   ensure that forensic services for people with mental disorders are managed by mental health services, with special training and facilities;

      (i)   identify and provide resources to support families that look after loved ones requiring long-term care, including education, relief services and adequate benefits;

      (j)   analyse and if required rectify health financing to create incentives for the development of community based mental health services; and

      (k)   remove obstacles to access to services for the most deprived by evaluating transport, finance and availability.

49.   The following actions are proposed for the Regional Office:

      (a)   produce guidelines for the above actions applying the evidence base and experience, in partnership with professional associations;

      (b)   identify and disseminate good service models around the Region;

      (c)   bring together countries at subregional level on the basis of culture, resources and stage of development, and coordinate assessments, knowledge exchange and shared implementation;

      (d)   coordinate technical support to Member States to develop policies and implement services; and

      (e)   develop guidance on good management practices in mental health care.

Objective 4: People are entitled to respectful, safe and effective treatment

50.   The relationship between the mental health care sector and patients is the key to the effective delivery of mental health services. Staff planning and the delivery of mental health systems must take into account the legacy of communities' distrust and fear regarding mental health services. Only if people with mental health problems and their families trust that respect for dignity, confidentiality and safety are guaranteed will they have the confidence to approach mental health services for the first time, and to continue to engage with mental health services thereafter.

51.   People with mental health problems are entitled to receive treatments that are consistent with the best available evidence. Research has produced evidence on the safety, acceptability, costs and effectiveness of biological, psychological and social interventions. New approaches such as e-Health show great potential.

52.   Patients and families need to trust that the only criterion for selecting treatments is their health benefit. Any conflict of interest by treatment providers in the choice of treatment must be transparent and open to public scrutiny, including any material incentives that reward the prescribing of specific products to patients, whether in the form of salary, bonuses or benefits.

53.   Evidence-based safe and humane interventions and advances of treatment should be reflected in professional curricula and qualifications. Across the European Region standards have been developed and implemented for the qualification and further training of relevant professional groups. The diversity of clinical practice in Europe is still reflected in the diversity of curricula. Considering the extent of professional migration across the Region, reliable competencies need to be assured. Interventions for mental health problems need to be guided by professional codes of practice, as well as adherence to legal standards across the Region.

54.   Since person-centred care is founded on the respect and trust established between care providers and care recipients, the morale and commitment of the workforce will determine the quality of the care. Staff often work for long periods of time in challenging circumstances and experience pressures, role confusion, stigma and discrimination. Only a workforce that feels empowered and respected can provide empowering and respectful care. This should be reflected in supportive and respectful leadership and management styles and working conditions.

Outcomes

55.   Objective 4 aims to achieve the following outcomes:

(a)   all mental health treatments, whether medical, social or psychological are therapeutic, and respect the dignity and preferences of the service users and, where indicated, their families;

(b)   effective treatments are made available on criteria of both efficiency and fairness;

(c)   the workforce is properly qualified and competent, able to maintain a high morale; and

(d)   international cooperation is established between governments and professional stakeholders to benchmark training, competencies and standards of care.

Proposed actions

56.   The following actions are proposed for Member States:

(a)   put in place governance arrangements to ensure accountability by clinicians for the delivery of interventions that are respectful, safe and effective;

(b)   allow service users to share in decisions about the prioritization, development and implementation of innovative and effective treatments, at both system and individual levels;

(c)   conduct all practice according to ethical standards confirmed by professional associations;

(d)   include mental health competencies in undergraduate curricula for all doctors and other staff groups and ensure continuing education for the primary care workforce;

(e)   assure that all staff posts in services are filled by competent professionals, and offer lifelong learning opportunities to adjust staff to change; and

(f)   offer staff development opportunities and a stimulating working environment, fostering morale.

57.   The following actions are proposed for the Regional Office:

   (a)   assist with the development and dissemination of curricula for primary care staff, incorporating principles of recovery;

   (b)   organize international networks for exchanging information about best policy and evidence; and

   (c)   support, in collaboration with the Union Européenne des Médecins Spécialistes (UEMS) Section and Board of Psychiatry, measures to coordinate the international standardization of competencies and harmonization of postgraduate training and continuous medical education.

Objective 5: Health systems provide good physical and mental health care for all

58.   The high burden of disease posed by mental health problems is exacerbated by many co-morbidities and interactions between mental and physical (ill) health. High proportions of people with cardiovascular diseases, cancer and diabetes suffer from depression, increasing their mortality rates significantly. NCDs and other disease groups, in turn, are risk factors for mental disorders.

59.   People with severe mental health problems, such as schizophrenia, bipolar disorder or severe depression, have a life expectancy 20–30 years lower than that of the general population, and their poor physical health accounts for 60% of this excess mortality. They have not benefited as much as the general population from the recent favourable trends in mortality resulting from improvements in prevention and treatment of diseases such as ischaemic heart disease, cancer and diabetes.

60.   The poor physical health among people with mental disorders results partly from such risk factors as smoking, physical inactivity, poor diet, alcohol and substance misuse. Some psychotropic medications affect the incidence of obesity and type 2 diabetes mellitus. Disparities in health care access, provision and utilization, however, have a role in determining the morbidity and mortality gap between people with mental disorders and the rest of the population, a gap that is increasing and is more pronounced in high-income than in middle- and low-income countries.

61.   Conversely, mental disorders are risk factors for a range of physical diseases. In particular, depression is highly prevalent among people with cardiovascular diseases, diabetes and cancer, and is underdiagnosed and undertreated. Poor mental health adversely affects the course and outcome of many physical diseases: it negatively affects people's adherence to treatments and contributes significantly to their disability and the impairment of their quality of life.

Outcomes

62.   Objective 5 aims to achieve the following outcomes:

   (a)   people with mental health problems have a life expectancy equal to the age-/sex-matched general population;

   (b)   access of people with mental health problems to physical health services such as cardiovascular diseases, diabetes, cancer and dental care and the quality of the physical health care they receive is equal to access for the general population; and

   (c)   mental health problems in people with physical diseases are recognized and treated adequately.

Proposed actions

63.   The following actions are proposed for Member States:

   (a)   ensure that people with severe mental health problems are prioritized in health strategies;

   (b)   ensure that all people have access to physical and mental health care of equitable quality;

   (c)   take actions to improve access of people with mental disorders to physical health care, particularly to emergency care;

   (d)   ensure that services are in place to monitor health indicators and their risk factors and any adverse effects of medication among all people with mental health problems in community services and hospital facilities;

   (e)   include lifestyle modification in education and treatment programmes for people with mental health problems;

   (f)   assess periodically the mental health status of people with chronic physical diseases; and

   (g)   offer training for all primary care practitioners on the detection and management of depression and anxiety in people with physical diseases.

64.   The following actions are proposed for the Regional Office:

   (a)   coordinate the development of good practice guidelines for physical health assessments in mental health services;

   (b)   coordinate the development of good practice guidelines for mental health assessments in physical health services; and

   (c)   assure the inclusion of mental health in WHO's work on other disease areas.

Objective 6: Mental health systems work in well coordinated partnership with other sectors

65.   A combination of services working in partnership is essential for mental health and the care and treatment of people with mental disorders. However, in each country various levels of national, regional or local government – and often several departments within each of these – are responsible for such activities. Agencies need to determine their roles and responsibilities and organize appropriate coordination systems. Leadership need to be identified and agencies empowered to work in an integrated manner.

66.   The procedures for referring a service user from one service to another can be complicated, involving different access routes and assessment processes. Few personnel understand the procedures of other agencies, even in the same geographical area. Single assessment procedures can be agreed, provided staff are trained in the requirements of other agencies.

67.   In many countries, funding streams for mental health, public health and social care services originate from different sources and budgets, resulting in payment or reimbursement rules that can hinder good practice. Agreements should be reached between funding agencies about reimbursing new ways of working or even pooling some budgets, improving efficiencies and equity. In some circumstances, service users and their families know best how to allocate resources effectively and efficiently, and this also empowers them.

Outcomes

68.   Objective 6 aims to achieve the following outcomes:

(a)   people with mental health problems receive the benefits and services to which they are entitled;

(b)   patients can access care, including specialized services, through an integrated assessment procedure;

(c)   funding systems offer incentives for efficient ways of working; and

(d)   the expertise of service users and family members is used to allocate resources for their care.

Proposed actions

69.   The following actions are proposed for Member States:

(a)   specify roles and responsibilities of generic and specialist mental health agencies across sectors. Generic agencies can nominate lead staff for mental health related issues;

(b)   ensure that the coordination of welfare, employment, housing and education opportunities is an accepted responsibility for mental health services;

(c)   establish unified assessment procedures between mental health and social care agencies;

(d)   offer incentives to pool budgets of agencies that need to work in close partnership; and

(e)   create opportunities for services users and/or families to plan their own services by providing budgets, with clear accountability.

70.   The following actions are proposed for the Regional Office:

(a)   disseminate effective policies and practices, facilitating learning across Member States; and

(b)   assess the impact of measures to improve partnership networks between Member States.

Objective 7: Mental health governance and delivery are driven by good information and knowledge

71.   Correct, relevant and recent knowledge and information are essential for any part of the mental health system to assess population mental health; assess the outcome of public health interventions; assure the quality, effectiveness and efficiency of mental health services; monitor the numbers, distribution and migration of staff; and evaluate the gains achieved by innovation.

72.   Different stakeholders and parts of the system require different information. In a field as wide ranging as mental health, some input, process, output and outcome data on health, socioeconomic and environmental variables are needed. Such data should only be requested if they can be reliably collected and meaningfully used, since inefficient demands for data can compete with the capacity to offer good quality care and result in demoralization.

73.   Transparency and accountability are critical for demonstrating and upholding the safety and quality of mental health services and the rights of service users and their families.

74. Innovation needs research to evaluate effectiveness and identify essential components, followed by dissemination to decision-makers. Since innovation occurs across the Region, coordinating research and dissemination across the Region will benefit all Member States. Special attention is to be paid to ethical and other issues relating to research involving people with mental disorders, especially children.

75. The sometimes confusing and ambiguous terminology used in the mental health field can hinder the collection and interpretation of information and hamper the achievement of consensus between stakeholders.

Outcomes

76. Objective 7 aims to achieve the following outcomes:

   (a) indicator sets for outcomes are selected, relevant to the needs of the target audience;

   (b) quality and safety is independently inspected, involving service users and families;

   (c) research is coordinated and disseminated internationally;

   (d) staff numbers, distribution and their causes are known; and

   (e) definitions of terminology are internationally agreed.

Proposed actions

77. The following actions are proposed for Member States:

   (a) complete and return the indicators of the Global Mental Health Action Plan (Appendix 1);

   (b) assess quality and safety by agencies independent of providers, producing transparent reports;

   (c) take measures to share information between clinicians and agencies while protecting the confidentiality of individuals;

   (d) evaluate effects of public health measures with mental health impact assessments;

   (e) support research capacity to assess needs, discover effective innovation and evaluate outcomes; and

   (f) make service users and family members an integral part of quality control.

78. The following actions are proposed for the Regional Office:

   (a) work in partnership with WHO headquarters, the European Commission and other intergovernmental organizations towards the development of a set of indicators fit for European expectations;

   (b) develop and publish a set of definitions of mental health terms in partnership with stakeholders; and

   (c) monitor involvement of service users and their families.

Information on a resolution

79. A draft resolution will be presented to RC63.

Annex 1. State of mental health in the European Region

The WHO European Region includes 53 Member States and nearly 900 million people who live in diverse cultural, economic, social and political circumstances. Significant inequalities remain within and between countries in the WHO European Region: there is a 100-fold variation in per capita GDP between countries and average life expectancy differs by up to 20 years for men and 12 years for women.[1]

Mental disorders are one of the most significant public health challenges in the European Region as measured by prevalence, burden of disease or disability. It has been estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. Depressive disorder is twice as common in women as in men. About 1–2% of the population are diagnosed with psychotic disorders, men and women equally, and 5.6% of men and 1.3% of women have substance use disorders. The ageing population is resulting in increasing prevalence of dementia, typically 5% in people over 65 and 20% of those over 80. In all countries, mental disorders tend to be more prevalent among those who are most deprived.

Across the European Region, neuropsychiatric disorders are the second largest contributor to the burden of disease (disability-adjusted life years – DALYs), accounting for 19% of the total. There is considerable variation across the Region associated with the different socio-economic conditions. In terms of burden of disease, mental disorder ranks highest in many high income Western European countries, while it takes fourth or fifth place in some low income countries due to the high prevalence of perinatal and cardio-vascular diseases.

An important indicator of the disease burden on society and health systems is the contribution of specific groups to all chronic conditions (years lived with disability – YLDs). Mental disorders are by far the most significant of the chronic conditions affecting the population of Europe, accounting for just under 40%. Unipolar depressive disorder alone is responsible for 13.7% of the disability burden, making it the leading chronic condition in Europe. This is followed closely by alcohol-related disorders (6.2%) in second place, Alzheimer's and other dementias in seventh (3.8%), and schizophrenia and bipolar disorders in eleventh and twelfth position, each responsible for 2.3% of all YLDs.

A high percentage of people who receive social welfare benefits or pensions because of disability have, as their primary condition, a mental disorder. This increases the financial burden of mental health problems on a country. Mental disorders account for 44% of social welfare benefits and disability pensions in Denmark, 43% in Finland and Scotland and 37% in Romania. In the Republic of Moldova, one of Europe's poorest countries, mental disabilities account for 25% of all government funded social welfare benefits and disability pensions. These differences may also reflect the extent of discrimination and exclusion of people with mental health problems from employment in different countries. Rates of employment for people with mental health problems in Europe vary from 18% to 30%. Some of this variation is by diagnosis, with lowest rates for those with psychotic disorders, but part of it is by country[2].

Mental disorders are strongly related to suicide. Suicide rates in the European Region are very high compared with other parts of the world. The average annual suicide rate in the European Region is 13.9 per 100 000, but there is a wide variation. The 9 countries with the highest

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[1] The European health report 2009: Health and health systems. Copenhagen, WHO Regional Office for Europe, 2009.
[2] Europe in figures. Eurostat yearbook 2010. European Union, 2010.

suicide rates in the world are all in the European Region. In several countries the number one cause of death of adolescents is suicide. Men are almost 5 times more likely to commit suicide than women in Europe. Depression, alcohol abuse, unemployment, debt and social inequality, are all risk factors and are all closely related. Changes in suicide rates coincide with changes in unemployment and the insecurity caused by anticipating job loss. There are some reports that suicide rates have risen since 2008, with the greatest increases in those countries most affected by the economic recession.

People with mental disorders tend to have earlier mortality than the general population, often dying more than 20 years younger. One reason is the high suicide rate, but the main factor is the high prevalence of chronic diseases such as cardiovascular diseases, cancer and diabetes, and poor access to and quality of treatment for those conditions in people with co-morbidities. In turn, people diagnosed with chronic conditions suffer from very high rates of depression, often remaining undiagnosed, and associated with higher mortality.

Most countries now have mental health policies and legislation, and many are making progress with the implementation of community-based mental health services. But capacity and quality of services and workforce are very diverse across the Region, whether one considers number of beds, coverage of community services, number of psychiatrists, nurses or investment. Some European countries lead the world in vision and quality of activities. Several countries in the European Region provide a comprehensive network of community-based services. Others, however, still rely heavily on the use of large mental hospitals for their mental health services, and are struggling to implement their strategies.

Annex 2. Policy developments

Mental health was put as a priority on the global agenda by *The world health report 2001 – Mental Health: New Understanding, New Hope* adopted by the World Health Assembly of WHO in 2002.

In Europe, Member States of the European Region adopted the European Declaration and Action Plan at the Ministerial Conference held in Helsinki in 2005, co-signed by the European Commission and the Council of Europe and endorsed by the Regional Committee (EUR/RC55/R2). This set an agenda for action to tackle stigma and discrimination and develop community-based services.

In 2008, the WHO Regional Office for Europe, with co-funding by the European Commission, published a report mapping the diverse state of mental health systems in Europe.[3]

The European Commission launched its European Pact for Mental Health and Well-being in 2008, focusing on 5 priority areas – mental health in youth and education, prevention of depression and suicide, mental health in older people, promoting social inclusion and combating stigma, and promoting mental health in workplaces – each resulting in a set of recommendations.

2008 saw the entry into force of the United Nations Convention on the Rights of Persons with Disabilities, now ratified by the majority of Member States in the European Region and by the European Union. The Convention entitles people with disabilities, including disabilities caused by mental impairments, to full and effective participation in society, protected from stigma and discrimination.

In 2010, the WHO Regional Office for Europe and the European Commission completed a co-funded project that strengthened the empowerment of people with mental health problems and their families, involving user and family organizations. A WHO statement on user empowerment was issued, with indicators of progress towards empowering mental health service users.[4]

Conclusions were adopted by the Council of the European Union in June 2011, under the Hungarian Presidency, inviting its Member States to make mental health and well-being a priority, inviting the European Commission to continue to address mental health and well-being and support its Member States in carrying out research in mental health and its determinants, taking into account the work done by WHO and the Organisation for Economic Co-operation and Development. The Joint Action on Mental Health and Well-being, co-funded from the EU-Health Programme, started in 2013.

Some global activities have focused on encouraging good clinical practice. In 2008, WHO launched the Mental Health Gap Programme[5]. This programme summarizes the best scientific evidence for effective interventions. It addresses a range of mental conditions and forms the basis for activities to scale up care for people with mental, neurological and substance use disorders.

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[3] *Policies and practices for mental health in Europe – meeting the challenges.* Copenhagen, WHO Regional Office for Europe, 2008.
[4] *User empowerment in mental health – a statement by the WHO Regional Office for Europe.* Copenhagen, WHO Regional Office for Europe, 2010.
[5] *mhGAP Mental Health Gap Programme. Scaling up care for mental, neurological, and substance abuse disorders.* World Health Organization, 2008.

Advocacy and prevention are main objectives in the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (EUR/RC61/12) and the European action plan to reduce the harmful use of alcohol 2012–2020 (EUR/RC61/13). The Action Plans have been developed following respective Global strategies of 2009[6] and contributed to the United Nations High-Level Meeting on Noncommunicable diseases in 2011.

The resolution on Global Health and Foreign Policy, adopted by the United Nations General Assembly at its 65th session in 2011 (A/RES/65/95), recognized that "mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social cost"[7] and welcomed the WHO report on mental health and development. The World Health Assembly passed a resolution in 2012 (WHA65.4)[8], requesting a comprehensive Global Mental Health Action Plan covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower people with mental disorders to live a full and productive life in the community. This comprehensive Mental Health Action Plan was adopted in May 2013 by the World Health Assembly (WHA66.8).[9]

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[6] WHA61.4 Strategies to reduce the harmful use of alcohol.
WHA61.14 Prevention and control of noncommunicable diseases: implementation of the global strategy.
[7] A/RES/65/95 Global health and foreign policy.
[8] WHA65.4 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level.
[9] WHA66.8 Comprehensive mental health action plan 2013–2020.

Annex 3. Model: The cycle of mental well-being

The social gradient in mental disorders and levels of mental well-being shows a strong relationship between mental health and the material circumstances of people's lives. Factors such as poverty, unemployment, poor working conditions, substandard housing and poor school education, all have a negative impact on well-being, as well as significantly increasing the risk of mental disorders.

Furthermore, poor mental well-being and low social status are independently associated with exposure to risk factors such as poor diet, smoking, alcohol, substance misuse and violence. Incidence of mental disorders increases due to such risk factors. Poor mental health contributes to poorer outcomes in most areas of life, often reinforcing inequalities, because those in the most disadvantaged groups are most likely to experience mental illness and poorer mental well-being. So, mental health is both a consequence and a cause of inequalities.

While evidence suggests an association between life circumstances and mental health outcomes at the population level, at the individual level the evidence is more complex. Mental well-being is also strongly influenced by factors such as age, gender, personality and resilience. Many people who face challenges and disadvantages have good mental health and thrive throughout their lives, demonstrating remarkable resilience, whereas others suffer from poor mental health despite favourable circumstances. Understanding why some thrive and others struggle, and why some people are susceptible to risk behaviours and others not, are some of the continuing challenges to be addressed.

Importantly, mental ill health and physical ill health share a large number of risk behaviours and risk factors such as alcohol, tobacco and violence. These are associated with both mental disorders such as depression, psychosis and suicide and the incidence of NCDs such as cardio-vascular diseases, cancers, asthma and diabetes. NCDs themselves are a major risk factor for mental disorders and the prevalence of mental disorders is associated with mortality rates of NCDs. It is clear that mental and physical health have to be seen in unity.

Access to effective health care is vital to reduce morbidity and mortality due to NCDs and suicides by breaking the vicious circle. Effective health systems aim to produce recovery and good health, increasing well-being and social functioning. However, socioeconomic factors such as age, gender, sexual orientation, wealth, status and ethnicity, powerfully determine health system characteristics such as access, availability, affordability and quality and outcomes of interventions. People with poor mental health find it hard to access good quality services, be they physical or mental.

Having a mental disorder has a powerful adverse impact on every element and interaction within this cycle. Mental disorders influence well-being: people with mental disorders have poorer access to education, have very high levels of unemployment, low incomes, and are often socially isolated. The presence of mental disorders is very likely to increase risk behaviours: smoking, alcohol abuse, poor diets and low levels of exercise are all much more common in people with mental health problems. A person with mental disorders is at higher risk of obesity, cardio-vascular disease, cancers, diabetes and suicide, due to factors such as consequences of the disorders, risk behaviours and the side effects of medication. People with mental disorders are also at risk of human rights infringements, both of their universal rights and those related to people with disabilities. They experience negative consequences in the community, such as stigma and discrimination, and in institutions, where they can suffer from neglect and abuse. The presence of mental disorders can reduce the accessibility, provision and quality of services in public and private service sectors and can increase suffering, exclusion, morbidity and

mortality. But evidence now exists that enables the planning of interventions that prevent, alleviate and even reverse these damaging and undesirable consequences.

Figure 1: The cycle of mental well-being

Socioeconomic position
Gender
Age
Ethnicity
Disability
Sexuality
Physical health

Material conditions
(Economic assets)
Income, wealth, Environment

Psychosocial conditions
(Social/cultural assets) Human & social capital, Community ties, Family life, Education, Autonomy, Control over life, Capability

Political voice
Governance, Influence on decisions, Participation in civic life

Meeting needs for status, control and social inclusion
Trust in people; trust in institutions

Health System
Accessible
Acceptable
Affordable
Quality
Equitable

Mental Disorders
Mental disorders in children
Stress and anxiety
Depression and bi-polar disorder
Schizophrenia
Alcohol dependence
Substance use disorders
Dementia

Risk factors
Alcohol
Smoking
Poor diet
No exercise
Substance misuse
Violence
Lack of inclusion

NCDs and Suicide
Prevalence
Morbidity
Disability
Mortality