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Mental health in WHO's European Region

Several important initiatives have been taken in the past five years to make policy-makers in the European Region of WHO more aware of the burden imposed by mental illness. As a result, mental health is now higher on the political agenda throughout the Region. However, there are still wide differences in the provision of services and in the prevalence of and mortality from mental illnesses, as well as shortcomings with regard to policy development and national planning in this area.

This report reviews the situation, pointing out the achievements but underlining an important need for action. It describes the challenges and problems that have recently emerged, and it presents the aims and expected outcome of a WHO European ministerial conference on mental health to be held in 2005.

A draft resolution is attached for consideration by the Regional Committee.

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Recent trends and unmet needs in mental health

A region of diversities

1. According to statistics related to the United Nations human development index, the European Region of WHO has some of the richest and poorest countries in the world. There are huge differences in per capita gross domestic product (GDP), which range from US $500 to over US $30 000 per year. The percentage of GDP spent on health care also differs widely, from 2% to 11%, with the poorest countries allocating the smallest share. Equally, the percentage of the health care budget devoted to mental health varies enormously, from no budget at all to over 20%. Here, too, the poorest countries tend to spend the least.

2. There is over-hospitalization in some eastern European countries, where 60% of all patients are treated in large institutions (500+ beds). Owing to unacceptable conditions of care and shortcomings regarding human rights and integrity, high rates of mortality (up to 40 % per year) are found in some of these hospitals. Conversely, there is unacceptable neglect and abandonment of severely mentally ill people in some western European countries, with up to 50% of the homeless in some capital cities found to be psychotic.

3. The large variations in suicide are also a matter of increasing concern. Suicide rates in the European Region vary 10-fold among young females but 40-fold among young males, with very different trends in different countries, ranging from a 40% decrease of to an 80% increase over a 15-year period.

4. Generally speaking, the availability of services for the mentally ill seems to be insufficient. Services also have to be acceptable in terms of their professional quality and their capacity to avoid further stigma, discrimination and social exclusion. The latter aspect is a real risk in countries where registration as a mental patient leads to long-lasting and comprehensive legislative restrictions regarding education and the right to carry out certain professions, to obtain a driving license, to receive social support, to vote, etc. These restrictions can often be avoided only by seeking expensive private services that few people can afford.

Stress-related mortality

5. In the European Region, there are also great (<30%) differences in life expectancy, which to a large extent are related to societal stress, mental ill health and destructive lifestyles. Especially in societies and populations undergoing stressful change, these differences are attributable to a cluster of stress-related factors, including depression and suicide, addiction, violence, risk-taking behaviour and lifestyles, and cardiovascular and cerebrovascular morbidity and mortality.

6. In conjunction with the helplessness and loss of identity and social cohesion being experienced in these countries, numbers of avoidable deaths have increased and the basic structure of the society is being affected. In some Member States, overall life expectancy has fallen by 10 years, and the figure for males alone by 13 years, within one decade, due to increases in stress-related morbidity and mortality. Suicide rates have increased ninefold in some countries, reaching a level nine times higher than the European Union (EU) average. The number of alcohol psychoses in some countries has increased fourfold, while that of deaths due to external causes (including accidents) has increased from two to six times the EU average, and cardiovascular mortality has risen from 2.5 to five times the EU average.

7. In some newly independent states of the former Soviet Union (NIS), youth criminality has shown a 350% increase and juvenile addiction rates have increased sevenfold. Even in homicides (including child homicides) an increase from two to nine times the EU average can be seen. However, the return to more stable societal conditions is now starting to normalize these figures, as demonstrated by an increase in life expectancy in some of the Baltic countries, mirroring the financial and social stabilization since 1998.

8. In western European countries, too, mental ill health, depression and helplessness related to societal change, job insecurity and a weakening of social cohesion are taking their toll. Forty-one million adults are abusing or dependent on alcohol, about 66% of whom are untreated. The costs of alcoholism in some European societies are estimated to amount to about 3% of GDP. Twenty-five percent of all people develop a mental disorder at some time during their life. Fifty-eight out of 1000 adults, or 33.4 million people in Europe, suffer from major depression. Between 10% and 20% of all children have one or more mental behaviour disorder, and more than 25% have mental or behavioural problems.

9. Measured in disability-adjusted life–years (DALYs), most years are lost due to depressive disorders, and this burden is expected to have doubled by 2020. In many countries, suicides now exceed traffic deaths, and in countries with a medium to high suicide rate, their costs amount to 1.5% of annual GDP.

Social exclusion

10. Throughout Europe, taboo, stigma, discrimination and social exclusion can be found to differing degrees and afflicting different groups with mental problems in different countries. Adolescents, including their families in a situation of unemployment, are often at high risk. Males also suffer heavily, especially in relation to workplace stress and insecure job situations, which threaten their status and identity as family providers in more traditional societies.

11. Factors behind the marginalization of mentally vulnerable persons are psychological and social attitudes that are firmly anchored in society, supported by disbelief and prejudice. Legislation and administrative routines are often strong obstacles to processes of reintegration, normalization and humanization.

12. An investigation carried out by a WHO task force on destigmatization shows that schizophrenia is heavily stigmatized in most parts of the European Region. The general perception of mental illness is rather negative, even though people now have a slightly better understanding of depression, mental retardation and dementia. Nonetheless, there is still a strong (and growing) perception of mentally ill people as violent and aggressive. Depression, addiction, senile dementia and epilepsy also still lead to exclusion from or denial of human rights, decent living conditions, an integrated place in society and adequate education in many countries. Levels of stigmatization and quality of care are not reported to be better for adolescents and children than for adults. One positive change, however, is the increasing engagement of patients' and family organizations.

13. In some western and northern European countries, respected public persons have openly declared that they have temporarily needed mental health support, especially for depression, thus destigmatizing the situation in the eyes of many. But stigma and taboo are still one of the most important obstacles in Europe to early intervention and reintegration of mentally vulnerable people, which is crucial for their prognosis.

14. The treatment gap is still considerable. In some European countries, more than 60% of people with epilepsy are untreated, up to 45% of cases of schizophrenia are not treated either, and 50% of depressions in primary health care settings are unrecognized, despite the fact that 30% of consultations with general practicioners are for mental health problems.

The WHO European Mental Health programme

Task forces

15. The regional Mental Health programme was restarted in 1998, using the existing networks of WHO collaborating centres and the WHO Multicentre Study on Parasuicide to identify and commit human resources for collaboration.

16. Focusing on four main problem areas and drawing on the resources of WHO collaborating centres, four task forces have been created:

1) a task force on **premature mortality and excessive morbidity** linked to stress and mental ill health, mainly focusing on the situation in Member States undergoing dramatic change;
2) a task force on **destigmatization**, focusing on human rights and exclusion, and developing strategies to reintegrate mentally vulnerable people into society;
3) a task force on **assessments**, offering Member States the possibility of carrying out audits, national assessments and analyses adapted to their needs, and assisting with the necessary processes of formulating, ratifying, implementing and monitoring national mental health policies and strategies; and, most recently
4) a task force on **child and adolescent mental health**, created to meet increasing demands, analysing specific problems and formulating guidelines on how to cope with different aspects of child and adolescent suffering and mental and behavioural pathology.

Networks

WHO European Network on Mental Health

17. A network of ministerially nominated national counterparts has been formed to assist the programme in its work. It now includes all Member States in the Region. This network has proved to be a most valuable tool by giving information, suggestions and feedback to the programme. It also receives information and facilitates technical assistance to country structures on mental health. In particular, it has been an important carrier of information and generator of initiatives leading to the formulation of *The world health report 2001*,[1] as well as transmitting data to the related WHO project to compile an atlas of mental health resources and proposing important topics for action. At the same time, it functions as a peer support and review group, bringing together expertise in a real European forum on mental health. The network meets twice a year.

WHO European network on suicide prevention and research

18. During the 1980s and 1990s, the former WHO European Multicentre Study on Attempted Suicide included suicide research centres in several European Member States. This network was reorganized and strengthened during 2001 and 2002, and it has now been expanded to cover an increasing number of central and eastern European countries, where there is an urgent (and growing) need for suicide prevention. The network meets annually and has facilitated national strategies on suicide prevention in 10 countries during the past three years.

Partnerships

Within WHO

19. Within the Regional Office, the Mental Health programme has collaborative activities with the programmes on Alcohol and Substance Abuse, Disaster Preparedness and Response, Noncommunicable Diseases, the Regions for Health Network, Nutrition, and Evidence-based Strategies.

20. Collaboration with WHO headquarters covers the fields of suicide prevention and depression, and includes work under the Global Action Programme for the elaboration and dissemination of guidelines and strategies, mainly on policy, legislation and advocacy. There was intensive cooperation on developing, presenting and disseminating *The world health report 2001*.

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[1] *The world health report 2001. Mental health: new understanding, new hope.* Geneva, World Health Organization, 2001.

21. Generally, experience shows that the global and normative functions of the Mental Health programme at WHO headquarters and the country-focused work of the Regional Office need and presuppose each other for mutual input, development and dissemination of models of good practice in interactive global, regional and national strategies.

Outside WHO

22. Collaboration with other intergovernmental and integrational organizations has mainly focused on the development of common strategies and the organization of joint meetings, including an exchange of knowledge and resources with the European Commission following a WHO/EU declaration on the continuity of mental health promotion and mental health service provision. The EU accession countries, in particular, are a focus for mutual support, thus forming a bridge between the mental health situation in western and eastern Europe, as well as in the EU and WHO's European Region. Collaboration with the Council of Europe is through a common programme directed at stability, social cohesion and mental health in the post-conflict countries of south-eastern Europe.

23. Nongovernmental organizations are important partners of WHO in, for example, developing evidence-based indicators and national suicide prevention strategies (Mental Health Europe), restructuring and humanizing mental health services in eastern Europe (the Geneva Initiative on Psychiatry), establishing community-based mental health services in the Baltic States and Balkan countries (the Swedish East Europe Committee), and developing appropriate funding mechanisms to support decentralized and humanized mental health services (the European Network for Mental Health Service Evaluation – ENMESH).

Policy development and awareness-raising

Background documents and working papers

24. In order to support the development of national mental health strategies and to increase awareness of the burden of mental ill health in Europe, various documents have been produced. They reflect not only the diversity of problems and the need for individual, country-specific strategies but also the features countries have in common, their emerging capacity to deal with their problems and the feasibility of solutions.

25. These documents include:

- a report containing an analysis of the regional situation and the activities carried out by the programme to respond to its demands;[2]
- regional and country analyses on the situation with regard to suicide,[3] its background and the state of development of national strategies for suicide prevention in the countries;[4]
- a review of the mental health situation in the majority of Member States, compiled following a survey of all national counterparts.[5]

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[2] *Mental health in Europe: stop exclusion – dare to care.* Copenhagen, WHO Regional Office for Europe, 2001 (http://www.euro.who.int/document/e72161.pdf, accessed 25 June 2003).

[3] *WHO/EURO multicentre study on parasuicide: facts and figures.* Copenhagen, WHO Regional Office for Europe, 1999 (document EUR/ICP/HPSA 01 06 03, http://www.euro.who.int/document/e68262.pdf, accessed 25 June 2003).

[4] *Suicide prevention in Europe: the WHO European monitoring survey on national suicide prevention programmes and strategies.* Copenhagen, WHO Regional Office for Europe, 2002 (document EUR/02/5034834, http://www.euro.who.int/document/e77922.pdf, accessed 25 June 2003).

[5] *Mental health in Europe: country reports from the WHO European Network on Mental Health.* Copenhagen, WHO Regional Office for Europe, 2001 (document EUR/01/5017227, http://www.euro.who.int/document/e76230.pdf, accessed 26 June 2003).

26. The information and knowledge obtained have made an important contribution to elaboration of *The world health report 2001* and its Atlas project.

27. The final recommendations of *The world health report 2001* with regard to the obstacles to be overcome and the need to support research, carry out advocacy work and establish community-based mental health services in Europe have been presented, discussed and reviewed for implementation at country level during ministerial meetings held in many Member States.

Guidelines

28. The WHO network on suicide prevention and research in Europe is in the process of further reviewing and following up the situation concerning suicide prevention programmes in Europe, and it will issue guidelines for the development and implementation of comprehensive, intersectoral and interdisciplinary programmes at national, regional and local levels. By doing so, it will provide the basis for strengthened implementation following the Ministerial Conference in 2005.

29. The WHO task force on national assessments has also elaborated guidelines on how to assess the mental health situation in a country. These guidelines have been reviewed, accepted and initially implemented in activities in the countries of south-eastern Europe covered by the Stability Pact.

30. Normative guidance is also given by WHO headquarters, especially with regard to policy development, legislation, human rights, advocacy and financing mechanisms, in the context of the mental health Global Action Programme (mhGAP). The various models developed have been presented, discussed and used as a basis for programmes to train experts from both eastern and western European countries, and especially from the Stability Pact countries and the network of counterparts.

Resolutions and declarations

31. After the European Conference on Promotion of Mental Health and Social Inclusion, organized by the Government of Finland in October 1999, and strongly reinforced by global and European activities linked to World Health Day and the WHO year of mental health in 2001, there is an ever-broadening interest in mental health issues. An increasing number of European governments have put mental health on their political agenda and expressed their commitment in a number of declarations and resolutions:

- the **Athens Declaration,** issued in June 2001 following a WHO meeting on mental health and man-made disasters, stigma and community care hosted by the Greek Ministry of Health and attended by participants from countries of south and south-east Europe;
- **resolution EUR/RC51/R5** adopted by the Regional Committee for Europe at its fifty-first session (September 2001), inviting Member States to give effect to the policy laid down in the Athens Declaration and requesting the Regional Director to include mental health as a technical subject on the agenda of the fifty-third session of the Regional Committee;
- the **conclusions** of the conference on "Coping with stress and depression-related problems in Europe", organized by the Belgian Government, the European Commission, the Regional Office for Europe and WHO headquarters in 2001, which led to **conclusions** adopted by the European Council of Health Ministers (2001) and furthermore resulted in Executive Board **resolution EB109.R8** and the World Health Assembly **resolution WHA55.10** in 2002.

32. An "exchange of letters" between the Director-General of WHO and the European Commission in 2001 has also intensified cooperation in the field of mental health, reinforcing joint activities on mental health promotion, mental health policy development, stress, depression and premature mortality, as well as mental health in the EU accession countries. The recent Community Action Programme on Public Health, adopted by the European Parliament and the Council in September 2002, also includes mental health activities and calls for intensified cooperation with WHO.

33. In 2001, health ministers from south-east Europe signed the **Dubrovnik Pledge,** expressing unprecedented political agreement on meeting the health needs of vulnerable populations, in particular after conflict. One of the health topics given highest priority was mental health, and the ministers agreed to intensify social cohesion in south-eastern Europe by strengthening community mental health services.

34. Following an expert meeting on mental health and human rights in 2003, jointly organized by WHO and the Council of Europe, **conclusions** were drawn up recommending basic principles for the human rights of mentally vulnerable persons.

35. These declarations and conclusions have been important steps in raising awareness and laying the foundation for mental health strategy development in Member States. They have given countries the political motivation to take action, both in collaboration with the Regional Office for Europe and globally.

Main strategies and focuses of action

Country work

36. In order to raise awareness about the burden related to stress and mental ill health, to explore the possibilities afforded by recent progress in promotion, prevention and treatment, and to identify the obstacles faced in several Member States, ministerial meetings have been held to discuss WHO's recommendations and ways of acting on them in a national context. In most countries, intersectoral and multidisciplinary national bodies have been set up and have begun work.

37. At the request of Member States, the regional Mental Health programme has provided expertise to make assessments, give advice to governments and help them monitor the implementation of national strategies. In most countries, processes are being catalysed to create comprehensive national mental health programmes oriented towards community-based services. These involve primary or family health care and include action strategies on suicide prevention, addiction, legislation and human rights, as well as epilepsy and neurological diseases. Most of these activities are being financed through biennial country agreements (BCAs).

38. In most countries, this assistance – often offered in situations where few resources are being allocated to mental health or even where a society is in crisis – has led to ongoing activities to develop and implement mental health policy and strategy. However, there are additional demands to continuously monitor and evaluate these processes, and the crucial question of sustainability must be considered here.

Multicountry activities

39. Countries acceding to membership of European Union are of special interest to both the Regional Office and the European Union. The regional Mental Health programme is helping these countries to participate in the EU's mental health activities and structures and is engaging them in international activities supported by the Regional Office or/and WHO headquarters. By doing so, countries have gained experience concerning the mental health consequences of the enlargement process and the societal transition linked to it. Attention here has been focused on gender issues and certain risk populations (e.g. agricultural workers).

40. In the countries of the Stability Pact, mental health policy development has begun, taking forward ongoing activities to develop community-based care and, in some of them, to tackle reconciliation, post-war crises and the rebuilding of civil society. The "platform" that has been created integrates activities already in process and respects the diversities of the different countries, while drawing on a common cultural background and meeting common needs.

41. One main aspect of the programme's multicountry activities has been to support and facilitate international ministerial meetings and expert conferences. Topics discussed have included stigma

(Athens, 2003, in cooperation with the Government of Greece), community-based mental health (Athens, 2001, in cooperation with the Ministry of Health), mental health policy development (Tunis, 2002, in cooperation with WHO headquarters), stress, suicide and premature mortality (Brussels, 2001, in cooperation with the Belgian Government, and Luxembourg, 2002, in cooperation with the European Commission), and human rights and mental health (Copenhagen, 2003, in cooperation with the Council of Europe). In addition, mental health has been considered a public health issue ("Mental health impact assessment", Brussels, 2001, in cooperation with the European Commission; "Mental health as public health", Ljubljana, 2003, in cooperation with the Slovenian Ministry of Health). An important facilitator for these activities has been the human resources made available through the European task forces and networks.

Achievements

42. In 2001, mental health legislation was non-existent or outdated in 35% of WHO's European Member States, 25% of the countries had not initiated mental health reforms, and in only 50% were reforms partially ongoing.

43. Some figures reflect recent policy developments and heightened awareness since 2001:

- Eight Member States have assessed their mental health situation with the help of WHO expertise, and four are planning to do so in the near future.
- National ministerial conferences on mental health have been held in 10 countries, and in seven of them national bodies on mental health development have been established.
- Four more countries have updated, modernized and humanized their mental health legislation, and all countries have now joined the European network of national counterparts.
- Ten Member States have developed national strategies on suicide prevention, and 14 additional countries, especially from eastern Europe, have joined the WHO European network on suicide prevention.
- In the context of their presidency of the EU, five Member States hosted ministerial meetings on mental health and six governments hosted regional meetings of national counterparts.
- In 10 Member States, *The world health report 2001* or specific parts of it (on epilepsy, suicide, mental health policy or public health) have been presented at national meetings.

The challenge: no public health without mental health

44. Statistics from the Regional Office's Health for All database show how morbidity and mortality in European Member States with regard to conditions related to stress, mental ill health and destructive lifestyles "seismographically" reflect the stress load in society. The most important determinants of mental health seem to be those regarding control over one's own life, identity and dignity, social connectedness and feelings of cohesion or meaning.[6] They are often negatively influenced by societal change and an adverse societal environment, but they can also be influenced positively by improvements and stabilization of societal stress.

45. The burden of mental ill health is related not only to mental disorders in the strict sense of the term, but also to the consequences of stress, leading to patterns of stress-related morbidity and mortality in a wider meaning. While mental disorders *per se* currently account for 15% of health care expenditure in a country, the total cost of disease and death related to stress and mental ill health can easily amount to

[6] Wilkinson R, Marmot M, eds. *Social determinants of health – the solid facts.* Copenhagen, WHO Regional Office for Europe, 1998 (document EUR/ICP/CHVD 030901, http://www.euro.who.int/document/e59555.pdf, accessed 26 June 2003).

30–50% if conditions of "burn-out", psychosomatic stress and depression related to violence and addiction are included.

46. Even legislation and regulations on housing, taxation, public service, employment, roads and traffic, etc., can easily be seen to have an impact on the mental health of a population. Political decisions and policies can have as great an impact on mental health as on the environment, in terms of the financial burden and human suffering they may entail.

47. There is thus a need to rethink the concept of public health and to acknowledge that mental health is the most crucial part of public health. Strategies on the environment and health should obviously take account of the effects that the environment and mental health can have on each other, in a public health perspective. Strategies on investment in health should include investment in mental health, as a society's most valuable capital. Programmes focusing on the impact of political decisions and social changes on health should clearly also raise awareness about their impact on mental health and lead to demands to carefully analyse the consequences of such decision-making.

48. The functions responsible for giving governments at local, regional and national levels advice and analysis on mental health impact need to be set up in the near future, in the same way as already exist regarding the impact on the environment. Seen from the perspective of avoidable premature mortality and morbidity in Europe, no government, rich or poor, can afford not to invest in, to promote and to protect mental health.

Emerging topics

49. In recent years, some areas of mental health have aroused more interest as a result of changing demands from Member States and the changing situation in Europe.

Disasters and threats

50. Owing to the magnitude and specificity of their repercussions on mental health, man-made and natural disasters are an area that deserves closer analysis. Research in the post-war societies of south-eastern Europe has shown long-lasting consequences on people's mental health in the form of post-traumatic reactions to violence and humiliation, leading to changes in personality and behavioural patterns that manifest themselves as aggression, risk-taking behaviour, addiction and suicide. Furthermore, the societal consequences of internal conflict and warfare can be seen as obstacles to rebuilding mutual trust in civil society.

51. Further research is needed to meet the increasing demand from Member States for assistance and advice in tackling this situation.

Poverty

52. Poverty and mental ill health form a vicious circle: poverty is both a major cause of poor mental health and a potential consequence of it. Widening disparities in society or economic changes in individuals' life courses seem to be of particular importance here. Whether defined by income, socioeconomic status, living conditions or educational level, poverty is an important determinant of mental disability and is associated with lower life expectancy and increased prevalence of alcohol and drug abuse, depression, suicide, antisocial behaviour and violence. As a cause of poverty, loss of status and mental distress, unemployment is a major issue in all European Member States. Raising awareness about the impact of political decisions and policy changes on the mental health of a population, especially with regard to unemployment and poverty and its association with depression, suicides and substance abuse, is one of the priorities for WHO's Mental Health programme in Europe.

Violence

53. The *World report on violence and health*[7] brings an integrated perspective on destructive behaviour and lifestyles, aggression and violence, including self-harm and suicide. Connections are made with depressive conditions, alcohol abuse and other addictions, and violence in societies and families. A review recently carried out in one of the eastern European Member States undergoing dramatic societal change, and with a high prevalence of morbidity and mortality related to stress and mental ill health, presents evidence that one of the ways to reduce violence in a country is to improve people's mental health, especially by counteracting helplessness and destructive risk-taking in behaviour and lifestyles.

Evidence

54. There is an increasing demand, both from Member States and from within the Organization, for a sound evidence base to underpin the recommendations and advice WHO gives. This demand, however, sometimes runs counter to other calls on WHO to react proactively and quickly in an emergency, or to take responsibility for issuing warning signals and immediate advice to Member States in a crisis. Furthermore, the concept of evidence itself is still under discussion in the comprehensive and complex field of mental health: the exclusive validity of randomized controlled trials and quantitative evidence is questioned, and a broader conceptualization is proposed including qualitative factors and individual experience. Consumer and family organizations, in particular, are interested in claiming their experiences as evidence.

55. The Health Evidence Network (HEN) project of the Regional Office has been working on the criteria for evidence, with attention strongly focused on mental health. As one of the first joint efforts, an expert paper is being produced, describing and evaluating the evidence for community-based approaches to mental health. It strongly supports a balanced approach, building up the necessary institutional and specialized care on a foundation of community-based mental health services and primary health care, adapted to each country's resource situation.

Ethics

56. Experience shows that political decisions about health are often based on values rather than on evidence. Even from a scientific point of view, the concept of evidence is being complemented by concepts of values, since the latter also play a decisive role in the decision-making of individuals, both privately and in political positions, thereby influencing structures and organizations. "Value-based medicine" thus seems increasingly to be a necessary complement to evidence-based medicine. This is especially important in situations where ethical considerations play an increasing role, based on moral, philosophical or religious values.

57. Issues for discussion here include the quality of life and human rights of mentally vulnerable people, euthanasia and assisted suicide. A related question is the cost/benefit evaluation of mental health services, which all too often is carried out without defining the basic levels of human rights and individual integrity that should be respected.

58. Other aspects of the ethical dimensions of mental health concern genetic counselling, as well as legislation and regulations designed to favour security and risk avoidance in society over promoting the quality of life of mentally ill people.

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[7] Krug EG, Dahlberg LL, Mercy JA et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002.

WHO Ministerial Conference 2005: "Facing the challenges, building solutions"

59. Reacting to the panorama of problems and challenges described above, the events launched in the WHO year of mental health and the release of *The world health report 2001* helped to move mental health higher up society's scale of values, to awaken people's enthusiasm and buttress their commitment, and to foster the establishment of strategic partnerships, which have since found expression in many concrete activities. Mental health care personnel, consumers, families and other interested parties have been empowered, awareness has been heightened across all sectors of society, and guidelines for action have been drawn up.

60. Against this background, it is planned to hold a WHO European ministerial conference on mental health in 2005, focusing on the issues raised in this paper. The Conference will be a milestone in the development of mental health policy in Europe.

61. European governments or intergovernmental partners will host a series of pre-Conference events. These will focus on mental health in stressful societies; transition; child and adolescent mental health; suicide; and stigma and its consequences. Case studies are being prepared, evidence is being collected and evaluated, and background material will be elaborated. All these activities will provide input to the Conference.

62. To prepare the Conference, a steering committee has been appointed, composed of representatives of the host governments of the main event and those hosting pre-Conference events, as well as of partners in the organization of the Conference such as the European Commission and the Council of Europe. An organizing committee is also being established in the host country.

63. The aims of the Conference are:

- to review the status of European policies for mental health, mental ill health and mental health care;
- to explore the settings and age groups in which mental health and inclusion should be promoted and mental ill health addressed, such as schools, workplaces, health services;
- to identify the barriers to the promotion of mental health and the prevention and treatment of mental ill health in communities and individuals;
- to suggest evidence-based solutions that could be shaped into common and sustainable policies, setting a priority agenda for European Member States; and
- to point out priorities and develop future strategies for further implementation or reorientation of European policies.

64. The Ministerial Conference will address key issues of mental health care, mental disorder prevention and mental health promotion. The programme will use both life course and mental health setting approaches. Experience in the development of country mental health policies, good examples of improved services and other lessons learned will be presented. The issues of stigma and human rights attached to mental ill health and care services will be a constant theme running through all parts of the Conference.

65. The Conference will set out policy recommendations in a priority agenda with a specific time frame and will call for initiatives to be supported by the Regional Office over the years to come.

66. The Ministerial Conference will give a major stimulus to maintaining and spreading, across the Region, the unique momentum that has been built up in recent years. Furthermore, it is expected that its dual purpose, of giving recognition to the work already done with regard to mental health in the political, scientific, technical and sociocultural arenas, and of opening new courses of action, will most appropriately serve the objectives and strategies that have been collectively laid out by the European countries.