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Mental health policies in Europe

Helen Vieth

Depression is the leading cause of years of healthy life lost to disability (YLD) for rich and poor countries alike across all regions in the world, and this burden is only likely to increase in proportion to other diseases over the coming decades.[1] The global burden of all mental ill health, coupled with the considerable economic burden it places on countries, brings a number of challenges not only in providing appropriate services for users but also in identifying effective mental health promotion and prevention strategies.

This Overview surveys some of the contextual issues shaping mental health policies across Europe and what is required to improve conditions and services. The case studies that follow provide snapshot surveys of the available evidence of best practice in a number of key areas.*

Burden of disease and prevalence

The global burden of mental ill health is considerable, not least because conditions such as depression are chronic diseases. Across the globe today, unipolar depressive disorders are the third largest cause of burden of disease as measured in disability-adjusted life years (DALYs); the leading cause of years of YLD; and the leading cause of burden of disease in middle and high-income countries, at 5.1% and 8.2% of total DALYs respectively. Neuropsychiatric disorders represent the most important causes of disability, accounting for around one third of YLD among adults aged 15 years and over and over 10% of the global burden of disease, rising to approximately 20% in Europe and the Americas.[1] Significantly, these figures are likely to increase: WHO's Global Burden of Disease project (2004) estimates that by 2030 unipolar depressive disorders will be the leading cause of burden of disease worldwide. After depression (5.5% of total European DALYs), other leading mental ill health contributors are alcohol misuse disorders (3%), suicide (2%), followed by schizophrenia, bipolar affective disorder and drug misuse disorders (approximately 1%).[1]

A special Eurobarometer investigation[2] was undertaken to describe the state of mental well-being in Europe. The survey results suggest that the majority of Europeans spend most of their time feeling positive, calm and peaceful, but a substantial minority (nearly 10%) rarely or never feel this way. Significant discrepancies in mental health were reported across European member states: while over 83% of those in the Netherlands reported they feel happy most/all of the time, this figure was 42% in Latvia and Bulgaria. Overall, the report suggests that older European member states have higher levels of mental health than newer Member states.

Other estimates highlight that approximately one third of the population is living with some form of mental illness over a given 12-month period, with major depression, specific phobias and somatoform disorders being the most common disorders (Table 1). Moreover, there has been an increase in the prevalence in all psychiatric disorders over time, particularly that of mood disorders.[3] Prevalence

* The articles in this issue draw on information presented in a wider report, *Mental Health Problems in Europe: What is the associated cost and what can health systems do to tackle them and promote mental well-being?* commissioned by Eli Lilly and prepared by a team at LSE Health, The London School of Economics & Political Science.

The Observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the World Bank, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

Table 1 Mental disorders in Europe

Diagnosis	Median 12-month prevalence (%)
Depression	6.9
Specific phobias	6.4
Somatoform disorders	6.3
Alcohol dependence	2.4
Social phobia	2.3
Panic disorder	1.8
Generalised Anxiety Disorder	1.7
Agoraphobia	1.3
Bipolar disorder	0.9
Psychotic disorders (including schizophrenia)	0.8
Obsessive-compulsive disorder	0.7
Illicit substance dependence	0.5
Eating disorders	0.4
Total	32.4

Source: Wittchen HU and Jacobi F. Size and burden of mental disorders in europe – a critical review and appraisal of 27 studies. *European Neuropsychopharmacology* 2005;15(4):357-76.

rates for children appear to be similar to those of adults, although the data is sparse and difficult to compare. One review[4] suggests a mean prevalence rate of 18% for mental illness among children, while a background paper released by the EU Health & Consumer Protection Directorate[5] notes that mental ill health is common among older people, with nearly a third of people over 50 showing at least one symptom of depression.*

The economic burden of mental ill health

Given such high prevalence rates and the effect of mental ill health on all aspects of life from relationships to employment, it is perhaps unsurprizing that the International Labour Organization estimates its total cost (direct and indirect) to society at approximately 3–4% of GNP in EU member states.[6] A growing number of national and sub-national estimates of the cost of this burden of illness are becoming available. Although cost estimates vary between studies as well as between countries, there is no question of the global significance of the economic burden of mental ill health.

A landmark European study[7] found that all psychiatric disorders taken together cost European society almost €300 billion annually with depression accounting for over one third (€120 billion) and affective disorders (depression and bipolar disorder together) represented nearly half of all costs, albeit with large differences between countries mainly due to differences in population size, underlying prevalence rates and differences in treatment. Schizophrenia was found to be the most expensive disorder (€7 500 per case in 2004), followed by bipolar disorder and alcohol addiction (€6 000), then depression and drug addiction (€4 000).

While health care system costs are clearly substantial, the vast majority of costs associated with mental ill health are incurred outside the health sector due to the impact on productivity, with the cost of depression alone estimated to amount to 1% of GDP in Europe.[7] One of the reasons depression is associated with the highest level of economic cost is because it is a common disorder that often affects people in employment. One study from England estimated that treatment costs accounted for only 4.11% (€636 million) of the total cost of adult depression[8] while Sobocki et al[9] have shown that on average 65% of the total cost of depression in Europe is due to lost productivity through decreased working capacity, rising to 80% and 90% in Portugal and England respectively.

Indeed, what makes mental ill health almost unique is the broad impact it can have on all aspects of life, including substantial adverse impacts on physical health, family relationships and social networks, employment status and contact with the criminal justice system, all of which contribute to the economic burden (Table 2).

Mental health expenditure

Most European countries have national policies and integrated programmes in place to deal with mental illnesses, as well as legislation to protect the rights of the mentally ill, and widely-available community care and primary care services. However, despite high prevalence rates, substantial contribution to the global burden of disability, and the total cost of disease, funding for mental illnesses is a small proportion of the health systems budget of most countries. Analysis of available data on 22 European Economic Area and candidate countries[10] has found that only five countries spend at least 10% of their health budgets on mental health (England, Luxembourg, Germany, Malta and Norway). The lowest reported levels of under 2.5% and 3.5% of total health expenditure are seen in Bulgaria and Poland respectively.

A possible cause and/or effect of the lack of funding is the large unmet need in mental health services. Recent analysis[11] of data from the World Mental Health (WMH) surveys reported that overall only around one-third of those who could benefit from treatment actually made use of services, in part because of the stigma of having a mental health problem. Across Belgium, France, Germany, Italy, Netherlands, Spain and the USA an average of only 53% of people with severe mental disorders and 32% of people with moderate mental disorders received treatment in a one-year period.

This under-utilization of services is reported even in those countries where there is no need to make out-of-pocket payments to access services. Individuals appear to be fearful of being discriminated against if they are labelled as having a mental health problem. As members of the general population they are also exposed to common misconceptions surrounding mental disorders – for instance that they cannot be cured, that

* However, one symptom of depression does not indicate a diagnosis of depression.

Table 2 Type of cost incurred, by mental illness categories

	Health care as % of total	Direct non-health care as % of total	Indirect as a % of total
Addiction	29%	7%	64%
Affective disorders (Depression and Bipolar disorder)	27%	Not included	73%
Anxiety disorders (Panic disorders, phobias, OCD)	53%	Not included	47%
Psychotic disorders (Schizophrenia)	85%	15%	Not included

Source: Andlin-Sobocki et al 2005. See Reference (7)

Note: Indirect costs not included for schizophrenia; direct non-medical costs not included for bipolar disorder, depression, generalised anxiety disorder, panic disorder, agoraphobia, social phobia, specific phobia and obsessive compulsive disorder

they are dangerous, or that drug treatments do not work.

European policy trends

Despite the widespread social and economic consequences of mental ill health, there has been a certain lack of support for the development of national mental health policies and financing of mental health services and initiatives in Europe.[12]

Western Europe has witnessed a now well-established trend of deinstitutionalization and a tendency towards community-based services, which have been recognized as being more effective in promoting quality of life for most people without necessarily being more expensive. The vast majority of EU member states, 'old' member states in particular, have seen a decrease in psychiatric hospital bed numbers over the last few decades. However, institution-focused services continue to dominate in the European region as a whole and community-based support systems, where in existence, are not always of good quality.[12] For example, although France has seen some development of community-based support services, 80% of mental health expenditure still goes to full-time psychiatric hospitalizations.[13] Although evidence favours a transition to 'balanced care' (i.e. a mixture of community-based and hospital-based services)[14] not all European countries can finance this – indeed higher-resourced countries tend to adopt models before evidence of cost-effectiveness is available – and early stages of transition may lead to an increase in admissions. There is also a risk involved with deinstitutionalization that services may become fragmented.

A policy shift from curative mental care to mental health promotion and the prevention of mental illness is currently taking place and policy attention in higher-income western European countries is gradually turning to social inclusion, destigmatization and empowerment as the concept of need changes.[12] The importance of addressing social determinants of mental health should not be overlooked.

Although there is no comprehensive mental health policy at the European level (a 2005 EU Green Paper[15] failed to translate into legislation), significant initiatives have been developed in recent years to tackle the challenge of reforming Europe's mental health systems. WHO's 2005 Mental Health Declaration for Europe and the Mental Health Action Plan for Europe (the Helsinki Declaration)* gave impetus to the development of mental health care in the European region and aimed to support the implementation of policies and activities to improve mental health promotion, prevention, care and treatment.

The 2008 EU Pact on Mental Health and Well-Being, though a statement of intent rather than a legally binding document, represented an important step in commitment to working together on mental health and well-being at EU level and is an example of a truly intersectoral, cross-policy initiative. The Pact details five horizontal areas in which policy makers and stakeholders are invited to take action: mental health in youth and education; mental health of older people; mental health in workplace settings; prevention of depression and suicide; and addressing stigma and social exclusion. The 2008 Pact was followed up on 19 February 2009 by a European Parliament resolution on Mental Health,[16] which underscored commitment to the Pact, calling for a fostering of action between EU institutions to tackle the five key priority areas.

Best practice

A number of European countries have implemented successful policies, interventions and campaigns to prevent and treat mental ill health. Many of these reflect the main policy trends of deinstitutionalization and mental health promotion and mental ill health prevention. However, much still needs to be done to gather evidence to determine best practice approaches (See Case Studies in this issue).

Finland saw a rapid shift towards deinstitutionalization and community-based care in the 1990s, a decade later than many other western countries, which was motivated in part by evidence of best practice but also necessitated by economic recession. Municipalities responded promptly with increases in outpatient resources, which have been maintained by national and municipal services and programmes incentivized by a reduction in state subsidies for psychiatric hospitalization. The number of patients who were discharged and lost all contact with psychiatric services decreased despite the rapid discharge, and efficacy in reaching patients in need of care was high: less than 10% of those discharged lost touch with services. However, higher rates of discharge demon-

* See http://www.euro.who.int/mentalhealth/publications/20061124_1

strated the need for follow-up policies and programmes as only 15% of those discharged were able to live outside the hospital without some form of support.

In the Netherlands, standardized guidelines outlining approaches and methods to diagnose and treat illnesses such as depression and schizophrenia have proved to be very successful. Additionally, one of the main themes in the Dutch mental health care system is prevention of mental health, for which there is a body of government policy providing guidelines for implementation largely at the regional level in mental health care centres. These guidelines take into account evidence of effectiveness and ideally also cost-effectiveness in the prevention and treatment of diseases such as depression.

Mental health promotion has also enjoyed success in Spain through programmes such as Health and School in Catalonia, which aims at improving adolescents' mental health through the implementation of health promotion in schools and early detection of mental health disorders or risk situations.

What requires work?

Reducing the significant contribution of mental ill health to the global burden of disease, and the associated economic and social costs, is possible but will require, above all, political commitment to fill the gap between recognized good practice and what is actually available in countries. For example the established trend in deinstitutionalization in some developed countries has not always been accompanied by adequate development of community-based support services, detection and treatment of mental disorders in a primary care setting remains poor, and there exists a tension between demands for general and specialist services.[17]

According to Knapp et al[12] mental health policy-makers now face a number of key questions and challenges: (1) combating stigma and discrimination; (2) moving the balance of care away from old institutions; (3) fostering better community-based systems of support and treatment; (4) promoting quality of life; for example, through emphasising and encouraging access to employment and other valued social roles; (5) developing an evidence-based decision-making approach; (6) balancing the choice and control of service users; (7) understanding the economic costs associated with often complex and chronic mental health problems and the need to increase expenditure; and (8) understanding the need for a joined up approach to policy-making and implementation. Additionally, a recent review[18] of trends in treatment of individuals involuntarily admitted to psychiatric institutions shows that while treatment is now found to be less focused on the theoretical threat patients may pose to society, mental health legislation still pays insufficient attention to the human rights of people with mental ill health.

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Helen Vieth is External Affairs and Project Development Manager at LSE Health, The London School of Economics & Political Science.

Case studies: best practice in mental health care

Early identification of mental health problems

Early identification of mental health problems offers an opportunity to introduce treatments that may improve short- and long-term outcomes.

Depression
A number of screening instruments have been developed to improve detection and management of depression in non-specialist settings, such as primary care and the general hospital, yet the evidence suggests that their minimal impact may not justify the cost.[1]

Schizophrenia
Duration of untreated psychosis (DUP) is now established as a predictor of poorer outcome in schizophrenia,[2] and this has fuelled enthusiasm for investment in Early Intervention Services (EIS) across Europe, the US and Australasia. Although there is evidence that EIS can buffer the severity of deterioration and reduce hospitalization[3] there are insufficient randomized controlled trials to warrant the pace of implementation.[4] More evidence is emerging on the effectiveness of cognitive behavioural therapy in a range of clinical situations.

Bipolar affective disorder
Early intervention has been relatively neglected and often the presenting episode is misdiagnosed as unipolar depression. For some patients there may be an opportunity to identify a prodromal phase in the few months preceding the first-episode mania that could assist in early pharmacological (particularly lithium) and psychosocial interventions.[5,6]

Dementia
Early recognition is hampered by its insidious onset, but clinical and radiological factors offer potential in predicting conversion from minimal cognitive impairment (MCI) to Alzheimer's disease.[7] The benefits of early detection lie in treating physical and psychiatric causes and any co-morbidities, arranging psychosocial support, and commencing pharmacological symptomatic treatments.[8] For longer-term care in dementia NICE (UK) have produced evidence-based guidelines, including recommendations for investment in memory services and services for carers.[9]

Eating disorders
The young age of onset of most eating disorders, or of abnormal attitudes to eating preceding established illness, suggests that preventive work targeting eating behaviour in children and adolescents would be worthwhile, yet the evidence does not support this approach.[10] It may be that effective primary prevention of eating disorders through work in schools offers the most benefit.[11]

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Policy Brief on Mental Health

This three part policy brief provides an overview of key challenges in development of policy and practice across Europe, looks at the balance between institutional and community based care, analyses current financing arrangements and considers how barriers to system reform may be overcome.

Mental Health I – Key issues in the development of policy and practice across Europe

Mental Health II – Balancing institutional and community-based care

Mental Health III – Funding mental health in Europe

Available from the Observatory's website: http://www.euro.who.int/observatory/Publications/20050126_1

Active primary care engagement

Historically in Europe consultation rates for psychiatric problems have been highest in primary care,[1] where patients perceive there to be a more holistic approach, improved continuity of care, and reduced stigma. In the UK and other parts of Europe there has been a shift towards shared care to the degree that primary care services are increasingly being encouraged to take on responsibility for developing and delivering mental health services.[2] A number of models have been proposed for joint working, including a 'shifted outpatient clinic model' in which psychiatrists hold clinics in primary care, and the 'attached mental health workers model' in which secondary care staff are attached to, rather than employed by, the primary care practice. There is no clear consensus over which model is the most successful, and all face barriers in terms of communication and competing priorities.[3,4]

Concerns about the physical health care needs of psychiatric patients[5] have indicated a need for policy clarity over monitoring responsibilities. Since 2003 financial incentives have been in place for UK general practitioners who monitor the physical healthcare of their patients with severe mental illness, a system which also serves to check on coordination arrangements with secondary care.[6] Evidence from the US highlights that improvement in the quality of primary mental health care comes at an increased cost, but one which may be offset against gains in contribution to the labour market;[7] however this analysis would need to be re-modelled if applied to European health care systems.

In England and Wales the National Institute for Clinical Excellence (NICE) has produced clinical guidelines for the management of depression[8] and anxiety[9] which suggest a strong role for primary care, provided there is access to psychological therapies for which there is an evidence base.[10] In the management of depression a stepped care approach is suggested in which only cases of treatment-resistant, atypical and psychotic depression and those at significant risk are managed in secondary care. For the management of anxiety a stepped care approach is also suggested in which referral to secondary care only occurs where two interventions (any combination of psychological therapy, medication or bibliotherapy) have failed.

These guidelines have underpinned the drive towards improving access to psychological therapies (IAPT) in primary care, often provided in intermediate settings. Computerized Cognitive Behavioural Therapy (CBT) provided in libraries is one example of this, which theoretically may be more acceptable to users in terms of avoiding stigma. There is evidence to support its effectiveness but considerable drop-out rates raise doubts about acceptability.[11]

Economic evaluations find little justification for delivering psychological therapies within primary care[12,13] although provision of on-site mental health workers may cause a modest reduction in primary care consultations, psychotropic prescribing, prescribing costs, and rates of mental health referral.[14]

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Support for carers

The move towards community-based care for mental disorders has placed an increasing burden on the families and carers of people with severe mental illness and dementia. This places financial,[1] emotional and physical demands on a largely untrained workforce, many of whom have their own needs for physical and mental health care.[2]

While increasing attention is being paid to carers' well-being and their needs for professional support,[3] and there is awareness that interventions like respite care benefit both carers and patients, there is often a lack of policy clarity over where responsibility for this provision lies.[4]

Support for carers starts at the national level, and European countries vary in the extent to which they involve or consult carers in the process of legislative reform.[5] Service frameworks and clinical guidelines affect carers on an individual level where they recommend carers' assessments or family interventions, or where they provide services specifically for carers. Following implementation of such policies in the UK there has been an increased level of spending on carers and a greater range of services on offer to them.[6] Studies of effectiveness and cost-effectiveness are now required for these services to be implemented elsewhere, including studies of carers' assessments; breaks from caring; family support; educational and training programmes; carer support groups; telephone and computer-based technology; provision of information and advice; and independent advocacy.

Interventions to relieve stress on the carers of people with dementia have been found to be as effective as drug treatments[7] which has facilitated their implementation into national policy; for example, the National Dementia Strategy in England.[8] However, this is in spite of a general under-funding of dementia services in countries such as France, Germany, Italy, Poland, Spain and the UK.[9] Economic pressures may force this to change given the increasing prevalence of Alzheimer's disease in an ageing population and the rising societal costs of long-term care.

Considerations of carers' needs have tended to focus on those caring for people with dementia or severe mental illness, neglecting the children of patients with severe mental illness. These have now emerged as a policy concern given the evidence that their caring role can impact on their own social functioning and mental health, and that mental health policy can have a key influence on this.[10,11]Parental mental health services are emerging in the form of isolated initiatives, often in collaboration with the voluntary sector, but many have not yet been evaluated adequately.[12]

Stigma campaigns may offer benefits to carers given evidence that level of carer distress is related to the stigma of mental illness for conditions such as schizophrenia[13] and eating disorders.[14] Where health and social care is better integrated carers report reduced anxiety about care,[15] and this suggests a need for policy initiatives regarding service integration.

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Rehabilitation/Return to normal role

The priority in rehabilitation psychiatry is to address social disability and disadvantage in those with severe and enduring mental illness, including management of any co-morbidities (particularly substance misuse) and offending behaviour. Rehabilitation places a heavy financial burden on mental health services, social services, informal carers and society as a whole. Care is provided in inpatient units (secondary care inpatient units, continuing care units and tertiary inpatient units) as well as in community rehabilitation teams, and in functional mental health teams providing early intervention for psychosis and assertive outreach. Particularly high-cost placements are those providing complex community care packages and tertiary care units for patients with challenging behaviours and forensic histories.

Since 2007 the European Commission has funded the DEMoBinc (Development of a European Measure of Best Practice for People with Long Term Mental Illness in Institutional Care) Study to improve the understanding of health determinants in this group, and particularly the quality of their institutional care. It will review the living situations, care and treatment practices for mentally ill and disabled persons in psychiatric and social care institutions in the European Union, with a particular focus on human rights, the protection of the dignity of residents, the use of restraint and the scope for health promoting measures. Results are expected by March 2010. The utility of this project lies in identifying best practice and value for money, allowing commissioners and providers of services to plan future services.

Assertive community treatment (ACT)
For patients with severe and enduring mental illness there is evidence that ACT can substantially reduce the costs of hospital care whilst improving outcome and patient satisfaction.[1,2]

Return to work
Interest in facilitating a return to work for people with severe mental illness in Europe have been fuelled by the high cost of social security, and an increasing population of patients stuck in a benefits-trap. The favoured model is supported employment (SE) which offers benefits to patients and health services in terms of enhanced self-esteem and improved symptom control.[3] A number of studies within the Eqolise (Enhancing the Quality of Life and Independence of persons disabled by severe mental illness through Supported Employment) Project have evaluated traditional structured vocational rehabilitation against independent placement and support in six European countries. These found the latter to be twice as effective in obtaining employment, without any increased risk of hospitalization, but the size of the effect is dependent on local unemployment rates.[4] There is no evidence demonstrating effectiveness or ineffectiveness of life skills programmes.[5]

Supported housing
Evidence is awaited for optimum housing arrangements for people with severe and enduring mental illness, balancing their care needs with their rights to autonomy and independence.[6] Current provision is extremely varied, with a continuum ranging from care homes, supported housing services and floating support services, each with differing costs.

Reduction in coercive treatments
There has been considerable interest in a reduction in the use of coercive treatment in mental health care in Europe, which is a part of wider attempts to challenge stigma. This has led to the development of guidelines on the use of coercive measures, but given variations in civil law cross-national harmonization of best clinical practice may not be feasible.[7] Patients are split in their views on coercive practice[8] but there is an acknowledgement that good practice would involve opening up communication with patients regarding the need for coercion in some circumstances.

There is mixed evidence for the use of advance directives for treatment preferences in crisis, which has been shown to reduce compulsory admissions and compulsory treatment in patients with severe mental illness.[9] This is probably inadequate to justify policy implementation,[10] but nevertheless advance directives are now part of the UK's NICE guidelines on the management of schizophrenia.[11]

Psychological interventions: Compliance therapy has been advocated for improving adherence to prescribed drug treatment among patients with schizophrenia yet the evidence shows that it is no more effective than non-specific counselling[12] and that it does not improve patients' quality of life.[13] Meta-analyses on the efficacy of psychological interventions for schizophrenia have shown that family therapy should be offered to those with carers, and CBT may be useful for those with treatment resistant symptoms[14] but that social skills training and cognitive remediation offer no clear benefits.[15]

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Coordination of health and social care

European countries differ greatly in the relative roles of their Departments of Health and of Social Welfare in the care of those with severe mental illness, and this has an impact on the coordination of care provided at the macro- and micro-levels. Many important aspects of the care and rehabilitation of patients with mental illness lie outside the remit of health services – benefits, housing, transport, employment, and education – and these are sometimes neglected in the design of arrangements for inter-agency working.[1]

The shift towards community-based mental health care has increased the requirement for seamless coordination of care between statutory, independent, and voluntary agencies, yet this may be difficult to achieve in systems such as Sweden where divisions are clear,[2] and Germany where the health and social care systems are decentralized and multi-layered.[3]

Throughout Europe there are also differential degrees of care provision from the voluntary sector, and from informal carers, which are explained by cultural and economic factors. Another factor which is becoming increasingly relevant given European migration patterns is the population's demographic structure. Those countries with greater ethnic diversity tend to encounter barriers to effective coordination. However, the factor with the greatest influence on the ease or quality of joint working is the national system of funding arrangements.[4]

Efforts to formalize multi-agency working may result in an increase in total spending on mental healthcare,[5] but benefits may be seen in terms of clinical improvements, more appropriate use of health services, and patient and carer satisfaction.[6] Policy makers need to consider whether the incremental cost per unit of effectiveness warrants implementation.

In France, Germany and the UK the proposed shift towards a system of Payment by Results, following the US and Australia's use of payment on the basis of Diagnosis Related Groups (DRGs), may serve to formalize multi-agency working and improve commissioning.[7] However, there are ongoing concerns about the appropriateness of its use in mental health which have limited its implementation and thrown up ethical obstacles to its evaluation. The research agenda for mental health care currently places outcome measures such as effectiveness and efficiency above measures such as coordination and accessibility[8] which has left the research base for coordination of care lacking.

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Anti-stigma measures

Stigma can exacerbate the profound personal, social and economic problems encountered by people with mental health problems, limiting access to health care services, employment or housing, harming social relationships and reducing self-esteem. Access to health care services may be critical given that those with mental health problems are at increased risk of having physical health problems compared to the general population.[1] Stigma is characterized by a lack of knowledge about mental health, fear, prejudice and discrimination. Consistently, the evidence points towards strongly negative attitudes towards people with mental health problems: in particular, there is an inaccurate view that they represent a danger to the community, a view strongly reinforced in the media. The general public may also believe that people with mental health problems cannot be treated within the health care system.[2]

The issue of discrimination has been garnering some attention from policy makers in recent years; a number of different initiatives has been undertaken at both an international level, for example, the World Health Organization's 'Closing the Gap Programme', and at national level, for example, the 'See Me' campaign in Scotland (http://www.seemescotland.org.uk/), the Italian Ministry of Health campaign (http://www.campagnastigma.it/) or the National Institute for Mental Health in England strategic five-year programme to tackle stigma and discrimination (SHIFT).[3]

Campaigns

Campaigns targeted at the general population, intended to counter negative stereotypes and attitudes towards people with mental health problems, do not appear to have much effect. Few rigorous evaluations exist: qualitative evidence suggests they may have an effect but these are usually based on cross-sectional data rather than longitudinal data over time.[4]

One rare exception is an evaluation of the German version of the World Psychiatric Association's 'Open the Doors' programme.[5] Implemented from 2001 it involved a range of anti-stigma interventions targeted at the general public, including lectures at adult education centres, art exhibitions, cinema events, media reporting workshops and charity concerts. Most events included contributions by people with mental health problems. Attitude surveys in intervention and control cities before the introduction of the campaign in 2001 and in 2004 indicated no difference in beliefs about the causes of schizophrenia or the role for psychotropic drugs, but fewer people thought people with schizophrenia to be dangerous to the public.

Improved direct social contact with people with mental health problems has been shown to reduce stigmatizing attitudes and fear of violence.[6,7] Targeted measures that can help reduce social distance between elements of the general public and people with mental health problems may be more appropriate.[8] Target professional groups may include health and social care professionals, teachers and the police.

Initiatives that improve awareness in school children about mental illness suggest that in the short term interventions in school settings can improve attitudes towards people with mental health problems.[9]

Countering discrimination in the workplace

Improved understanding of mental health issues is critical in companies and among co-workers if efforts to reintegrate people with mental health problems into the workforce are to be successful; there can be strong opposition to working alongside people with mental health problems.[10] Employment has many benefits including a reduced need for health care services, increased levels of social inclusion and improved quality of life. Active return-to-work policies combine a range of regulatory measures and economic incentives for individuals and employers. They exist in a number of countries across Europe including the UK, Ireland, Sweden, Norway and Poland. Interventions which help people with mental health problems directly re-enter open employment and then provide support and accommodations at the workplace do appear to be more effective and cost effective than the use of traditional vocational rehabilitation schemes where individuals receive training within a sheltered environment.[11,12] Critical to the success of such programmes is the willingness of employers to participate and also of mental health professionals to be supportive of individuals seeking employment.

Access to services that best meet needs

Another way of overcoming stigma and discrimination is to empower individuals to have more control on the choice of services that best meet their needs. Personalization mechanisms, whereby individuals are given cash to purchase needed services, including help in vocational rehabilitation, have now been introduced in several countries including England, Scotland and the Netherlands. Evaluation to date has been limited and further research is needed.

Anti-discriminatory legislation

Legislation also can play a role, although to date, its impact has not been well evaluated.[13] Legislative instruments from the UN, the Council of Europe, the EU and others are intended to protect the human rights of people with mental health problems. At national level, policies and legislative measures also cover a number of specific themes, such as access to health and social care services and prevention of discrimination in the workplace.

Legislative measures will only be effective in promoting social inclusion if they enjoy some measure of public support and are effectively monitored with adequate sanctions or incentives to help facilitate change. In some countries, Germany and Portugal for example, employers may receive a tax rebate if they employ an individual with a mental health problem. In other countries, grants are available to help with workplace adaptations for people with physical and mental health problems.

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Balance of care

Eastern European countries trail Western European countries in the transition from asylum mental health care to a system of 'balanced care' with a mixture of community-based and hospital-based services.[1] Although reviews of the evidence co-ordinated by WHO favour the 'balanced care' approach, not all countries can allocate the resources to achieve this.

Consequently lower-resource countries are advised to focus on improving the mental health care provided within primary care settings, using specialist services for consultation and for the care of the most severely ill. Medium-resource countries are advised to build on primary care by providing the components of mainstream mental health care: outpatient clinics, community mental health teams (CMHTs), acute inpatient care units, long-term community-based residential care, and rehabilitation services. Higher-resource countries may choose to build on mainstream services by adding a wider range of more differentiated services, depending on local needs and the generalizability of the existing evidence.[2] These services would include more specialized ambulatory clinics and community mental health teams, assertive community treatment, and alternatives to acute inpatient care, long-term community residential care and vocational rehabilitation.

Negotiating the transition from asylum-based to community-based care is difficult economically and organizationally. Australia and the US showed early success with 'functional teams', in the form of assertive community treatment (ACT), crisis resolution teams (CRTs) and Home Treatment Teams (HTT). These models, or variations of them, have now been adopted in parts of Europe even before evidence of their effectiveness has become available. Although there is evidence that home treatment models of care may reduce hospitalization there is as yet insufficient evidence to demonstrate its cost-effectiveness.[3]

Day hospitals

The day hospital model was an early alternative to inpatient treatment but models vary from country to country.[4] The evidence for its effectiveness when compared to inpatient care favours it over the day centre model.[5] However, day hospitals have become unfashionable and superseded by novel approaches like crisis intervention and home-based care, which appear to be equally effective to day hospitals.[6]

Community-mental health teams

In Western Europe the commonest model of community mental health care is that provided by sectorized community mental health teams (CMHTs), for which funding may be liberated from hospital closure, yet there are doubts about the evidence base for the CMHT model,[7] which is now giving way to the care pathway model, despite weak evidence for its own effectiveness.[8]

Crisis resolution teams

For patients in crisis there is evidence that home care packages help avoid repeat admissions but further evaluations are needed.[9] In the UK this model of care is evolving away from the notion of 'crisis' towards a wider remit, in which a crisis resolution team provides gate-keeping assessment and home treatment, with

access to crisis beds and respite provision, as well as facilitating earlier discharge.[10]

Assertive community treatment (ACT)
ACT teams (also known as Assertive Outreach Teams) are used to meet the needs of patients with severe and enduring mental illness, often with treatment resistant schizophrenia and co-morbid substance misuse problems. The evidence suggests that intensive case management of this type works best where the patients are already high consumers of inpatient care, and may therefore be of interest to countries where low rates of bed use have not yet been achieved.[11]

Services for people with intellectual disability
Deinstitutionalization has also taken place for this group but their mental health service needs often escape policy attention because physical disability issues tend to overshadow mental health needs.[12] Service delivery models not shown to be cost-effective in mainstream mental health may in fact be beneficial for sub-groups with intellectual disability, with intensive case management providing the best example of this.[13]

Services for the elderly
Evidence on the effectiveness of old-age mental health services is stronger for community multi-disciplinary teams than for acute hospital care, yet this is primarily due to a lack of controlled studies rather than measured ineffectiveness. Where level I or II evidence exists this would support the implementation within Europe of multidisciplinary individualized community services; primary/specialist care collaborations for treatment of late life depression; outreach services for patients in residential care; and integrated post-discharge mental health services.[14]

Impact of deinstitutionalization
The move from asylum to the community was more a product of political process than of empirical research. It has placed a significant burden on carers and the voluntary sector, raising ethical issues about the devolution of responsibility and the need to provide the necessary financial and psychosocial support. Of additional concern are tendencies towards 'reinstitutionalization' during the transition stages, characterized by an increase in the number of forensic beds, supervised/supported housing placements, and the prison population.[15] These trends, and the development of highly specialized teams and novel ways of working, risk fragmenting community care. Communication and cooperation between teams is of utmost importance to overcome the potential for discontinuity of care (particularly loss of follow-up) and needs to be supported by reliable and secure electronic record systems. Integrated models which augment the Community Mental Health Teams with home treatment capacity may be the best way of improving continuity whilst retaining good quality staff.

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Mental health promotion

Mental health promotion encompasses the encouragement of optimum emotional well-being, and the prevention of mental ill-health in terms of both onset and worsening of function. Primary prevention refers to the prevention of a disease before it occurs, secondary prevention describes the prevention of recurrences or exacerbations of a pre-diagnosed disease, and tertiary prevention describes the reduction in the amount of disability caused by a disease to achieve optimum functioning. These latter two are embedded in the provision of effective mental health services and it is primary prevention that has come to dominate the policy agenda in mental health promotion. Although there is felt to be sufficient evidence of effectiveness to justify spending on primary prevention of mental ill-health not all implemented health promotion interventions are evidence-based.[1,2]

The European Commission's 2005 Green Paper on Mental Health[3] takes a dual-pronged approach to both the promotion of positive mental wellbeing, and the prevention and treatment of mental illness, in an effort to reduce the social and economic cost of mental ill-health. It places responsibility for detecting and responding to mental ill health on staff in social, educational, occupational, housing, criminal justice and other settings, as well as patients, their carers and health workers. Its guidance does not clearly state the level of evidence for each recommendation, which limits the justification for implementation.[4]

Each member state is encouraged to develop and fund an Action Plan for mental health promotion and mental disorder prevention based on its own needs and priorities. A case is made for ten areas of concern, ranging from stress at work to youth violence, with a list of suggested actions to be taken. There are some concerns over the generalizability of the recommendations given that the vast majority of evidence demonstrating the effectiveness of early years' interventions for children, workplace mental health promotion programmes, urban regeneration schemes and return to work strategies is from the United States.

Mental health promotion continues to be a low priority in many European countries, particularly in Central and Eastern Europe where the emphasis is on treatment of severe and enduring mental illness rather than on broader population impact of environmental and social factors. Some countries, notably Scotland, Finland and the Netherlands, have been able to develop comprehensive mental health promotion programmes.[5] More evidence of cost-effectiveness across the range of initiatives may be needed before other states are prepared to invest their limited resources in this policy area.

One area that has attracted particular attention is the promotion of emotional well-being in children and adolescents, with evidence for the effectiveness of school-based interventions[6] and the cost-effectiveness of home based interventions to promote the psychosocial well-being of children.[7] This evidence post-dates the mass approach taken by the WHO's European Network of Health Promoting Schools, and systematic reviews suggesting that whole schools approaches are more effective than targeting those at risk.[8]

Some favoured approaches in mental health promotion may not always be consistent with the evidence of their effectiveness. Amongst interventions to improve maternal mental health a number have been shown to have no effect.[9] Despite evidence for short-term gains with group-based parent-training programmes in the emotional and behavioural adjustment of young children, there are doubts about whether these effects are maintained in the medium-term, suggesting a need for ongoing input.[10]

The European workforce, whether employed or unemployed, also has been a focus for promotion initiatives, with evidence that supporting job seekers reduces their risk of depression[11] and evidence that work-place health promotion reduces sickness absence.[12] Workforce interventions tend to focus on increasing an individual's sense of control, which also has applicability to settings such as elderly residential care.

Challenging stigma is perhaps the most important component of a successful mental health promotion policy. Public stigma campaigns have been used with success in Norway[13] but have not shown an immediate impact on attitudes in the UK perhaps due to the media's persistent use of negative stereotypes.[14] A wide-scale stigma campaign has been mobilized by the World Psychiatric Association, involving Italy, Greece, Slovakia, Germany, Austria and the UK; however smaller scale anti-stigma interventions have shown success in schools.[15]

Successful mental health promotion interventions in adults appear to be those that take a highly focused or targeted approach by modifying known risk and protective factors.[16] Examples of interventions to modify known risk factors would include those to prevent depression following a family bereavement or divorce; to reduce stress in those who care for elderly, disabled or mentally ill persons; and to prevent depression in the unemployed. Examples of interventions to modify known protective factors would include those to improve the chances of the unemployed finding a job; and those to improve communication and problem solving skills in marital relationships. However, the apparent success of these interventions may be because a tight focus on specific outcomes (for example, relationship satisfaction) permits effect sizes to be demonstrated.

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Suicide prevention

Suicide alone accounts for 2% of all years of life prematurely lost.[1] In 2006, about 59 000 individuals – 45 000 men and 14 000 women – completed suicide in the European Union. As many as 90% of all suicides may be associated with mental disorders, most often major depression, or linked to alcohol and substance use disorders.[2] The impacts of suicide and non-fatal suicide attempts are profound. The costs and consequences go far beyond their immediate impacts in respect of emergency services, coroner investigations, funerals etc; most fundamental of all is the loss of the future opportunity to experience all that life holds. The pain and grief caused to family and friends can be immense, take many years to subside and have detrimental impacts on their own mental health. For individuals who survive a suicide attempt, lengthy physical and psychological rehabilitation may also follow.[3]

Many different factors potentially impact on the risk of suicide. Income, rapid economic and social change, as well as unemployment have all been linked with suicide. For instance, a positive relationship has been observed between increasing unemployment and increased rates of suicide in Denmark and Sweden.[4,5] Yet in other studies, for example in Germany, the opposite relationship can be found.[6] This illustrates the need for careful consideration of local contexts – for instance, the extent to which differing social welfare safety nets may cushion the economic impacts of recession.

Another potential risk factor is divorce, while birth and marriage rates may be protective. Again, these relationships are complex; work in Sweden suggests that increased divorce had a significant negative effect on female suicide rates.[5] Alcohol has also been associated with poor mental health and increased risk of suicide for both men and women.[7]

Suicide prevention strategies

Evidence on the effectiveness of suicide prevention strategies remains sparse. The most robust evidence suggests that restrictions on access to the means to complete suicide (such as firearms restrictions and limits on access to poisons), as well as better training for front-line professionals to better identify individuals potentially at risk of suicide, can be effective.[8,9] Even less is know about the cost effectiveness of preventive interventions, although work in Scotland suggests that potentially they could be highly cost effective: if just 1% of suicides could be avoided then the national programme would actually be cost saving.[10]

One promising approach is an area-wide multi-level intervention to tackle depression and suicide that was first evaluated in Nuremberg, Germany. This initiative, which involves awareness campaigns, training for front line professionals, cooperation with community leaders and support for self help groups, has been associated with a reduction in suicidal thought compared with another control

city.[11] Subsequently, the approach has been rolled out to sites in 17 countries across Europe and an economic evaluation is now also being conducted.[12]

There has been some limited economic analysis of specific interventions to reduce the risk of suicide, including various safety measures (such as safety nets) and restriction of access to means such as firearms and poisons. Some simple but effective measures, such as the erection of signs for support services in some areas known to be suicide black spots, are clearly cost saving.[13]

For those identified as being at high risk of suicide, there is some emerging evidence on effective interventions. In England a home based social work intervention targeted at children who had previously deliberately poisoned themselves reported lower rates of suicidal ideation after six month in the intervention group.[14] Another study looked at the use of cognitive behavioural therapy (CBT) for people with a history of deliberate self harm in centres in both England and Scotland. It suggested that manual CBT was likely to be cost effective in reducing the number of deliberate self harm events, although it did not explicitly look at suicides averted.[15]

The links between suicide and the utilization of health care services, in particular antidepressants, also have been examined. While the impact on the use of selective serotonin re-uptake inhibitors (SSRIs) and suicide are complex and subject to debate,[16] some studies indicate that their use may have a strong effect on suicide, with rates falling fastest in those countries that experienced the most rapid rate of growth in SSRI sales.[17] Some of these evaluations have also assessed the economic impact of suicides averted.[18] For instance, one study estimated that an increase in the use of SSRIs would reduce suicide mortality rates by around 5%, generating cost savings.[17] Overall, however, findings are mixed, with studies coming to contrasting conclusions.[19,20]

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Tel: +32 2 525 09 33
Fax: +32 2 525 0936
Email: info@obs.euro.who.int
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