EUROPE

Fact sheet
Copenhagen, London, 10 October 2008

New WHO report
Policies and practices for mental health in Europe – meeting the challenges

A report published by WHO Regional Office for Europe and co-funded by the European Commission provides data not hitherto available on mental health policy and practice across the European Region. It also highlights important information gaps. Extracts below give an indication of the kinds of data the report presents from 42 Member States.

- Activity in policy and legislation has flourished in recent years. Since 2005, 57% of countries have adopted new mental health policies or updated existing ones, and 47% have introduced new legislation or updated existing legislation. Only four countries do not yet have a strategy. Five of the countries still have legislation that is more than 10 years old.
- The number of psychiatrists per 100 000 population varies widely: from 30 per 100 000 in Switzerland and 26 in Finland to 3 in Albania and 1 in Turkey. The median rate of psychiatrists per 100 000 population in the 41 countries that provided information is 9.
- Few countries provide figures on spending on promoting mental health and preventing mental disorders, but the data available are consistently very low, at most about 1% of the mental health budget.
- Data on the proportion of disabled people who are receiving social welfare benefits or pensions as a consequence of mental health problems are available for 17 of 42 countries. The countries for which data are available report proportions ranging from 44% in Denmark to 8% in the Russian Federation.
- Social institutions are where care varies most: social institutions for children and adolescents are provided in 31 of 42 countries (74%), in comparable proportions across the groups of countries. This is the area with the largest variation in care. In countries in western Europe, children are often placed in foster homes or small residential facilities. In many countries in south-eastern Europe and of the Commonwealth of Independent States, children with any form of disability are placed in sometimes large and often underfunded social care homes.
- Prescribing of antidepressants – little information and large variation: the survey enquired about the proportion of the population that had been prescribed antidepressants in the last year available. Many countries (26 of 42) reported that they had no information available. Further, data on prescribed antidepressants are not collected consistently.
- For the countries who were able to submit the requested information, the proportion of the population prescribed antidepressants varied from 12% in Moldova and 10% in Spain (Catalonia) to 3% in Lithuania and 1% in Bosnia and Herzegovina (Republika Srpska).
- Visits to mental health facilities show a wide range of differences in access, from 1% to 28% of the population.
- Rates of admission to inpatient units vary 13-fold. At the high end and, are such countries as Romania, Hungary and Estonia, together with such countries as Germany and Sweden. In some cases, the high admission rates could be due to perverse financial incentives within the health system such as payment per admission or payment for a limited period of admission

only, encouraging discharge and readmission. In other countries, a large supply of beds could be a factor.

- Intriguingly, there is an overrepresentation of women in outpatient services but almost equal sex distribution in inpatient services.
- Opportunities for the empowerment and representation of service users and carers: the report shows a strong association between trends in mental health expenditure, trends in the development of community mental health services and the involvement of users and carers. These are strongest among the 15 countries that were members of the European Union before 2004 (EU15).[1] In many countries in the eastern part of the WHO European Region, where the institutional model of care still dominates, user and carer movements are in a developmental stage.
- The expectations for general practitioners (GP's) vary widely and are not always correlated to the degree of education. For example, in Norway, psychological and psychiatric issues are not very prominent in the education of GPs, who are, nevertheless, expected to provide services for people with common mental health problems.
- Funds on research sometimes inefficiently spent: there is a major divide across the European Region between countries with well-developed information systems that also invest in research and dissemination, typically the EU15 countries, and the countries that do not. If these data were cross-tabulated with presence of community services and diversity of workforce, a clear association would be found. Considering the few countries that invest heavily in research, most countries probably have no access to original research. This suggests that many countries are analysing identical research, presumably to publish comparable treatment guidelines. Considerable gains in quality and efficiency could be made through a closer collaboration.

The burden of mental health in Europe – some key facts and figures

Most European countries have recognized mental health as a priority area in recent years. Neuropsychiatric disorders are the second leading cause of disability-adjusted life-years (DALYs) in the WHO European Region, accounting for 19.5% of all DALYs.

According to the most recent available data (2002), neuropsychiatric disorders are the first-ranked cause of years lived with disability (YLD) in Europe, accounting for 39.7% of those attributable to all causes. Unipolar depressive disorder alone is responsible for 13.7% of YLD, making it by far the leading cause of chronic conditions in Europe.[2] Alzheimer's disease and other forms of dementia are the seventh leading cause of chronic conditions in Europe and account for 3.8% of all YLD. Schizophrenia and bipolar disorders are each responsible for 2.3% of all YLD.

Suicide rates are high in the European Region. The average suicide prevalence rate in Europe is 15.1 per 100 000 population, with the highest rates in the countries of the CIS (22.7 per 100 000 population) followed by the countries that have joined the EU since 2004[3] (15.5 per 100 000 population).

[1] The EU15 countries comprise Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom.

[2] *Global burden of disease estimates.* Geneva, World Health Organization, 2004 (http://www.who.int/healthinfo/bodestimates/en/index.html, accessed 8 May 2008).

[3] The countries that have joined the EU since 2004 comprise Bulgaria, Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia.

Background to the study:

The health ministries of the participating countries were responsible for delivering the data for this report. Forty-two countries in the WHO European Region participated in this project:

- all 27 EU countries: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom;
- seven countries from south-eastern Europe: Albania, Bosnia and Herzegovina (Federation of Bosnia and Herzegovina and Republika Srpska), Croatia, Montenegro, Serbia, the former Yugoslav Republic of Macedonia and Turkey;
- five CIS countries: Azerbaijan, Georgia, Moldova, Russian Federation and Uzbekistan; and
- Israel, Norway and Switzerland.

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