Mental health policy and practice across Europe: an overview

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Morbidity, need and consequences

Recent years have seen mental health rise significantly up global and European health policy agendas. *The World Health Report 2001* was devoted entirely to mental health (World Health Organization 2001). The World Bank has emphasized better mental health as part of its strategy to improve disadvantaged economies (World Bank 2002). All 52 member states of the WHO European Region, as well as the European Union (EU) and Council of Europe, endorsed a *Declaration and Action Plan* on mental health in 2005 (World Health Organization 2005a, 2005b). The EU published its Green Paper on mental health later that same year, following on from other reports related to the state of mental health in Europe and EU actions related to mental health promotion and depression (Commission of the European Communities 2004; G. Henderson *et al.* 2004; Jané-Llopis and Anderson 2005).

International interest of this intensity is long overdue. One in four people experience a significant episode of mental illness during their lifetime, but the ‘treatment gap’ between the need for, and receipt of, appropriate services remains wide (Kohn *et al.* 2003). Suicide is one of the top ten leading causes of premature death in Europe, contributing an additional 2 per cent to the overall burden of illness (World Health Organization 2005c). The rate of suicide is much higher for men than women and, after traffic accidents, is the principal cause of mortality among 15–35-year-old males in the region. Mental health problems account for approximately 20 per cent of the total disability burden of ill health across Europe (World Health Organization 2004), but receive much
lower proportions of total health expenditure (see Chapter 4), often below 5 per cent. Indeed, disability burden calculations of this kind could be under-estimates as they overlook the broad impact that mental health problems can have on many aspects of life including physical health, family relationships, social networks, employment status, earnings and broader economic status. Moreover, they do not pick up the impacts on other family members, which are sometimes substantial (see Chapter 16). The stigma still very commonly associated with mental health problems can lead to discrimination, and may help to explain an apparent reluctance by some policy-makers to invest in mental health (see Chapter 13).

Despite growing policy attention, as well as advances in recognition and treatment, there are concerns that the situation in some parts of Europe could get worse before it gets better. Rapid economic and social change in central and eastern Europe has been accompanied by a decline in population mental health, with increasing rates of alcohol problems, violence and suicide (see Chapters 11 and 17). The mental health needs of people displaced through conflict, persecution or economic migration pose further challenges (see Chapter 15). The changing demography of Europe will clearly generate growth in age-related needs over the next few decades. Generally speaking, although the age-specific prevalence of most mental disorders would not be expected to rise (see Kessler et al. 2005), economic and social instability in some countries may bring their own inexorable pressures.

There is a strong relationship between poor mental health and social deprivation, with the causal influences working in both directions (Social Exclusion Unit 2004; see Chapter 3). For example, individuals living in areas of high unemployment are at increased risk of developing mental health problems, while deep-rooted stigma, profound ignorance and widely practised discrimination greatly limit education and employment opportunities for mental health service users, often dragging them down into poverty (Thornicroft 2006a). People with chronic mental health problems are at greater risk than the general population of becoming homeless. Contacts with the criminal justice system tend to be quite high for people with psychoses (whether as perpetrators or – all too often – as victims). The long-term impacts on children of people with mental health problems can also be significant: they may suffer from neglect and their schooling may be disrupted, curtailing their own long-term prospects.

Not surprisingly, the economic costs of mental health problems are very high: a few years ago they were conservatively estimated as amounting to between 3 and 4 per cent of gross national product (GNP) for the former EU–15 (Gabriel and Liimatainen 2000). The costs are also widely spread, and indeed the largest economic impacts usually arise outside the health sector (Knapp et al. 2004). Productivity losses can be especially large, stemming from short- and long-term absenteeism, reduced performance at the workplace (so-called ‘presenteeism’), early retirement, other work cutbacks, reduced opportunities for career development, days ‘out of role’ for people not in paid work, and reduced lifetime productivity due to premature mortality. Productivity-related costs appear to be on the increase in many European countries (McDaid et al. 2005). Other potentially large, non-health costs may fall to social care, housing and criminal justice
agencies (see Chapter 4), and of course, to families and service users themselves (see Chapters 14 and 16). Many of those economic impacts persist long into adulthood (Scott et al. 2001; Healey et al. 2004).

This is a long catalogue of needs, consequences and challenges. Perhaps more than any other health issue, mental health requires a concerted, coordinated, multi-sectoral approach to policy framing and implementation. Of course, Europe comprises a highly heterogeneous collection of countries, and that variety is reflected in the needs of people with mental health problems, their material and social circumstances, their access to treatment and support, and their quality of life. Logically, it should also lead to heterogeneity in policy responses.

Throughout this book we will therefore be searching for commonalities of need, experience, response and outcome, as well as trying to understand the reasons for differences and what they imply for the design and implementation of policy. Of course, we cannot cover every issue affecting mental health policy or practice across a collection of more than 50 countries which demonstrate diversity along so many dimensions. We have, for example, given less attention to mental health problems in childhood, adolescence and older age (and the policy responses to them) than we have to what are sometimes called ‘working-age adults’ (although the term in itself makes a number of assumptions worthy of debate). We have given more attention to the organization and configuration of services than to the details of the precise treatments they deliver – writing a psychiatry, psychology or nursing textbook was not our aim. There is little in this book on the aetiology of illness, or on the rapidly developing field of enquiry that seeks to unravel the interplay of genes and environment. Doubtless, there are other omissions that will disappoint some readers, but what the book aims to do is to identify, analyse and discuss many of the core and most pressing policy challenges confronting Europe’s mental health system ‘architects’ today. In the remainder of this chapter we introduce those challenges.

Policy responses

Given the many and damaging consequences of poor mental health, one might have expected that promoting good mental well-being and intervening to tackle the consequences of illness would be major priorities for policy-makers. But both the development of national policies and the level of funding for mental health services or initiatives have been disappointing across almost the length and breadth of Europe. Consequently, mental health promotion continues to receive little attention in most countries (see Chapter 8), and treatment strategies are somewhat unevenly and inconsistently implemented (see Chapters 5, 6 and 9). Moreover, some therapeutic initiatives seem to overlook the broad functional and societal ramifications of a diverse group of disorders that includes chronic psychological malaise, destabilizing and disabling phobias and episodes of acute psychosis.

Institution-focused services continue to dominate much of the European mental health landscape and community-based support systems are patchy in
availability and quality. Fundamental abuses of human rights continue to occur, perhaps most visibly within the institutions of central and eastern Europe, but certainly not confined to those settings or those parts of the continent (see Chapters 3, 13 and 17). Empowering service users – involving them in decisions and generally broadening the range of choice – is still a long way off in most countries (Mental Disability Advocacy Center 2005a; see Chapter 14).

Having a national policy on mental health is widely seen as fundamental to the task of raising awareness and securing resources, which, in turn, are necessary to deliver effective, equitable and affordable treatments (World Health Organization 2005a, 2005b). A national policy can obviously provide the framework within which to coordinate actions across the multiple agencies and sectors that one would hope would be in place to respond to the multiple needs of people with mental health problems. Developing and strengthening policy for mental health across Europe, therefore, remains a key concern, and most countries now have national or regional mental health policies in place. Some have a long pedigree (see Chapter 2), some are revisited and revised quite regularly, while others are rather dated and clearly in need of reform. Quite a few look out of touch with today’s social norms, aspirations and mores. Some national policy frameworks fail to extend beyond the confines of the health system, failing to emphasize the need for concerted attention from the contiguous fields of housing, education, social care, criminal justice and employment (see Chapter 12). Clear statements on rights, enshrined in legislation, are still rare (see Chapter 13). Remarkably, in view of the high suicide rates in many countries, there also appear to be few national strategies for suicide prevention (Beautrais 2005). And even when policies are laid out, they may not actually be implemented (see Chapter 17).

There is a continuing need to take action to address human rights violations, stigma, discrimination and social exclusion more broadly. Few other health problems are characterized by such disadvantages. Violations of rights have been reported across Europe, but are most visible in the psychiatric institutions, dispensaries and social care homes that remain the mainstay of mental health systems in parts of central and eastern Europe. In some countries, individuals admitted to institutional settings still have a very low probability of returning to the community. There have also been well documented accounts by human rights groups and the Council of Europe of individuals being kept in ‘caged beds’ or being subjected to electro-convulsive therapy without anaesthesia or muscle relaxants in contravention of international guidelines (see Chapter 13).

Legislative instruments have obvious roles to play. There are already human rights instruments drawn up by the United Nations, the Council of Europe and the EU which are intended to protect people with mental health problems, the principles of which should underpin the development of national legislation. However, any such legislation can only be effective if implemented and monitored, with adequate sanctions to effect change. Legislation can ensure, for example, that compulsory treatment or detention is used as a last resort, and can build in safeguards such as access to an independent periodic review for people involuntarily treated or admitted to services.
Funding

In broad terms, there is a simple link between funding, the employment of staff and other resources, their combination to deliver services, treatments and support, and the achievement of individual, familial and societal mental health goals. In reality, of course, the links themselves are far from simple, but getting the right funding base established must accompany the development of a robust policy framework.

The levels and routes of mental health service financing vary somewhat from country to country, and indeed within countries, in response to a plethora of political, economic, cultural and other influences. Some funding routes can create incentives to better practice, while others erect barriers to the achievement of better individual-level and other outcomes (see Chapter 4). What is abundantly clear is that as the countries of Europe move away from mental health systems dominated by ‘asylum management’ to systems focused on ‘community management’, so too must the balance of funding shift from almost exclusive reliance on health systems to a more mixed economy of resources. As community models develop, services and supports from outside the health system will be called upon to help people to access appropriate housing, leisure facilities, associations, employment and all of those ‘ordinary’ ingredients that together greatly influence quality of life. Bureaucracy, immutable budgetary boundaries, official indifference, professional ignorance, pervasive stigma and sometimes simply the desperate scarcity of resources can stack up to deny people with mental health problems the liberties, opportunities and achievements enjoyed by others.

One of the major challenges across Europe, therefore, and unfortunately a challenge that has still to be taken up by many governments, is to create the incentives for the appropriate resources to be mobilized and, where necessary, moved between agencies and services so that people can access the support they need across relevant life domains. In countries such as the United Kingdom, where access to social care services is selective and means-tested, while access to health care is universal and free at the point of delivery, there are clearly ideological as well as practical difficulties to be overcome. In countries such as Austria, which has moved to a financing system based upon diagnostic-related groups, the problems are of a different kind, relating to the under-funding of mental health services. In countries where service users are expected to make substantial out-of-pocket contributions to the costs of their treatment, a major barrier will be affordability, particularly given that so many service users have to survive on very low incomes. In parts of eastern Europe the resource challenge is that governments do not, or cannot, prioritize mental health services, leaving the systems of support mired in outmoded practices dominated by institutions.

Institutions and communities

We emphasized earlier the heterogeneity of mental health policies and practices in Europe. Nowhere is this more evident than in the respect of institutional care: consigned to history in a few west European countries – where the gaze of
policy attention is now more likely to be turning (albeit gradually) to social inclusion, destigmatization and empowerment – elsewhere it is still the primary focus of official action and still eating up the lion’s share of total dedicated mental health expenditure.

The old asylums were promoted on a number of grounds. It was widely assumed that grouping people together in large numbers, with (hopefully) benign if (largely) unqualified staff, was the most effective way to contain and perhaps even to ‘cure’ people with mental health problems. Economies of scale were attractive. The preference of family members was often to have their ‘disturbed’ relatives accommodated in secluded settings, away from social embarrassment and harm (but also often then forgotten). Those asylums were undoubtedly also used as instruments of social control, not generally in the appalling way that psychiatric services were abused in the former Soviet system (see Chapter 17), but simply as an expedient, cheap and unobtrusive way of managing ‘imbeciles’, ‘lunatics’, promiscuous young women and other social ‘deviants’.

The impetus to close the asylums came from equivalent, if diametrically opposite, arguments (see Chapter 10). It gradually came to be recognized that community-based services were more effective in promoting quality of life for the majority of people (Thornicroft and Tansella 2004), and also that they were not necessarily more expensive (Knapp et al. 1997). The views of individual service users were now sought, listened to and (increasingly, if slowly) acted upon, while the views of families and of wider society were mellowing – moving away from the need to hide ‘peculiar’ people away. Communities may be less hostile today, although one should be careful not to exaggerate the extent of any change. Similarly, the social control rationalization for asylums has been somewhat eroded, if not exactly swept away, by a slowly rising tide of support for human rights.

There is now quite wide acknowledgement that a ‘balanced care’ approach is required, where front-line services are based in the community but hospitals and other congregate care settings play important roles as specialist providers (Thornicroft and Tansella 2004). Where they are required, hospital stays should be as brief as possible, and should be offered in ‘normalized’ integrated facilities rather than in specialized, isolated locations. All but a few countries of the EU-25, for example, have seen the steady rundown of psychiatric hospital bed numbers over the last 30 or more years, although the decline generally has been slower in the newer member states (McDaid and Thornicroft 2005). Outside the EU, this shift away from institutional care generally has been slower, and there is often the added complication of a long tradition of using long-stay social care homes (internats). Perverse financial incentives sometimes link funding directly to bed occupancy, giving little encouragement or flexibility to local decision-makers to develop community-based alternatives.

New challenges may be looming. Some countries which have successfully closed most of their psychiatric hospitals may be moving into a phase of what some commentators have termed ‘reinstitutionalization’, where the kinds of individuals once accommodated in the old hospitals are now quite likely to find themselves in prisons, secure forensic units or care homes (Priebe et al. 2005).
Social inclusion and empowerment

Accompanying the move away from hospital-centred services across much of the European continent, particularly in higher-income countries, has been a gradual ‘reconceptualization’ of need, with more emphasis on human rights and social inclusion. As we have already stressed, a huge challenge for many people with mental health problems is stigma, which can lead to social marginalization, neglect and disadvantage. Even mental health professionals who themselves have used mental health services may experience discrimination from employers, colleagues and educators (Rooke-Matthews and Lindow 1998). A well received report from the Social Exclusion Unit (2004: 4) in England argued that there are:

Five main reasons why mental health problems too often lead to and reinforce social exclusion: stigma and discrimination . . . low expectations of what people with mental health problems can achieve . . . lack of clear responsibility for promoting vocational and social outcomes . . . lack [of] ongoing support to enable them to work . . . [and] barriers to engaging in the community.

These reasons were identified in the English context, but would have their equivalents elsewhere (see Chapter 3).

One illustrative domain can be considered. Because paid work is so central to an individual’s economic well-being, as well as to their social status and integration, attention is today being paid by some governments to the employment opportunities and needs of people with mental health problems. The detailed Action Plan endorsed by health ministers in Helsinki in 2005 called specifically for efforts to ‘create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles’, and also to ‘include mental health in programmes dealing with occupational health and safety’ (World Health Organization 2005b: 2). Whether these positive words get turned into widely implemented deeds remains to be seen, but there are some encouraging signs in a few countries (Berkels et al. 2004; Henderson et al. 2005). Initiatives have been taken in some states to reform social welfare benefit structures in order to encourage people to return to work (Teague 1999). Such initiatives will have an impact on people claiming disability benefits, among whom are an increasing number of people with mental health problems (Jarvisalo et al. 2005).

While such reforms may act as an incentive for individuals to seek employment, changes to the social welfare system alone will not be sufficient to promote long-term job acquisition and retention by people with mental health problems. Welfare reform needs to be part of a broader package of measures that includes enforcement of anti-discrimination legislation, participation in vocational rehabilitation or supported employment schemes, improvements to workplace support, flexible working arrangements and better access to effective treatments. Health professionals may hold low expectations of what mental health service users can achieve, and may do little to encourage their employment aspirations. The previously mentioned report on social exclusion in England found a lack of clear responsibility for promoting social and vocational
outcomes, a lack of ongoing support to enable people to work, and structural barriers to engagement in the community (Social Exclusion Unit 2004). It called for more choice and empowerment of service users, as well as help to retain jobs, to return to employment after an episode of illness, and to achieve career progression. Helping individuals to obtain and retain employment in the open job market could help reduce stigma and discrimination by employers, although breaking into this vicious cycle is not straightforward (Bond 1998).

Linked to the promotion of social inclusion is empowerment. There is, for example, evidence that many service-user organizations (as well as other stakeholders) in the United Kingdom support the use of ‘advanced directives’, where an individual, when well, specifies how they wish to be treated if they become unwell (Atkinson et al. 2004; C. Henderson et al. 2004). Such advance directives were thought to be empowering and potentially destigmatizing, although it was recognized that many problems need to be overcome in their implementation. Support for advance directives has also been reported among Dutch patient groups (Varekamp 2004). Crisis cards can be empowering (Sutherby et al. 1999). Consumer-directed services, such as arrangements that allow individuals to hold the budgets with which they can purchase some of the services they need, take service user control onto another plane. However, most such arrangements currently tend to exclude health care, and there are also numerous potential complications to be ironed out concerning the roles of family members, how the funding can be used and the extent to which individuals are empowered to take risks (Ungerson 2004). In fact, uptake of such arrangements in England has been disappointingly slow (Fernandez et al. 2006).

**Conclusion: continuing challenges**

What then, are the key questions for policy-makers in Europe and what are the toughest challenges they face as they seek to develop strategies and service systems that are fit for purpose in the new millennium, rather than stuck in a bygone age of narrow views, stigmatizing attitudes and bottom-of-the-pile priorities?

**Fighting discrimination**

Stigma distinguishes mental health disorders from most other health problems and is the major reason for discrimination and social exclusion. Tackling this discrimination remains a key policy challenge (Thornicroft 2006b). In some parts of central and eastern Europe fundamental human rights abuses continue to be seen in the psychiatric institutions and social care homes that are the mainstay of mental health systems (Mental Disability Advocacy Center 2005b). But abuse manifests itself in many ways; even where community-based care is the dominant mode of delivery, neglect and isolation can be widespread. Fear of stigmatization reduces an individual’s willingness to seek treatment (Corrigan and Calabrese 2005). There are no easy solutions for policy-makers, but long-term
actions such as intervention in schools to raise awareness of mental health (Pinfold et al. 2003, 2005), and constructive engagement with the media (which can reinforce negative social attitudes by sensationalist and inaccurate portrayals of mental illness) appear to be effective if concerted and prolonged (Hickie 2004; Jorm et al. 2005).

**Closing the institutions**

Clearly one of the biggest challenges in a number of European countries is to move the balance of care away from the old institutions. The large, closed asylums may have had their uses, but they embody and indeed reinforce wholly negative attitudes – including stigmatizing attitudes – about mental illness. As discussed in Chapters 4 and 10, it is relatively easy to close an institution but far harder to replace it with community-based arrangements that offer better support and greater opportunity by delivering high quality services of the kind that people actually want to use. Entrenched views held by the general public and by many mental health professionals need to be countered, and real efforts made to get people out of these institutions.

**Developing caring communities**

A related set of questions for policy-makers, therefore, is how to foster better community-based systems of support and treatment. This has to mean more than just replacing asylum provision with the occasional outpatient appointment. Policy-makers must assess the needs that people have, and identify appropriate configurations of community services to meet them. Are specialist services required to address specialist needs such as those associated with prodromal signs of serious illness, or the eruption of crises, or the need to keep people in contact with services? Has the development and rapid growth in uptake of new pharmacotherapies helped, or is too much reliance placed on them (see Chapter 7; Knapp et al. 2005)?

**Promoting broad quality of life**

The central concern of any mental health care system should be how best to promote the quality of life of individuals and families affected by, or at risk of developing, mental illness. Quality of life is a nebulous concept, inherently subjective, culture-bound and notoriously hard to measure well. What is clear, however, is the frequency and regularity with which service users emphasize certain dimensions of quality of life such as access to employment and other valued social roles, removal of discriminatory barriers and better social integration. This implies a pressing need for mental health systems to look beyond ‘merely’ alleviating symptoms or reducing the probability of relapse, and instead to encourage services and therapies that are more holistic and more ambitious in their aims.
Developing an evidence-based decision-making approach

What therapies, services and support arrangements achieve the outcome improvements wanted by service users and their families? If there is more than one option, which is the most cost-effective? There exist validated tools for measuring well-being and adjudging outcomes (Thornicroft et al. 2006), and an evidence base on effectiveness and cost-effectiveness is certainly developing (see Chapters 4–9, for example). But the volume and quality of evaluative evidence could certainly be improved. Steps need to be taken to ensure that available information is what policy-makers actually want, that it reaches them in a form that they can understand and employ, and of course, that they take into consideration. More can also be done to improve channels of communication between policy-makers, ‘front-line’ workers, researchers and other stakeholders. It must be asked whether the evidence is robust enough to allow mental health services to compete with other claims on a country’s scarce health or wider resources. And if the evidence base is there for better treatments and interventions, are the right skills available within the workforce, and can the people with those skills be recruited to deliver what is needed?

Choice and control

A lot of attention has been focused recently on the promotion of self-determination through the empowerment of service users (see Chapters 3 and 14), linked to the protection of their human rights (Chapter 13). Do mental health service users have the same rights and opportunities to exercise choice and assume control as are available to other members of society? For policy-makers, one major challenge is to balance the need to keep vulnerable people in touch with services against the danger of interfering too assertively in their lives. Another is to design policy and practice measures that balance the need to protect individuals and communities from harm (including self-harm) against the risk of denying people their right to freedom and self-determination.

Understanding the money

We have already alluded to the funding challenge. By their very nature, many mental health problems are multiple, complex and (mostly) chronic. For people with more severe problems the consequence is therefore often a need for support from a range of different services and agencies. Policy-makers need to understand the widely ranging costs associated with mental health problems and look to create the right funding environment and the right structure of incentives to ensure that resources from across different agencies are combined in the best ways to enhance quality of life. The case for investment in mental health is surely very strong. There is now substantial evidence that greater expenditure in many areas of mental health is not only justified on the grounds
of symptom alleviation and quality of life promotion, but also because it represents a more efficient use of health (and other sector) resources, allowing individuals to achieve, maintain or regain valued social roles.

**Joining up decision-making**

Even if there is sufficient political commitment to invest in effective interventions to promote better mental health, implementation remains problematic. Multiple responsibilities and multiple costs can raise a number of barriers (Knapp *et al.* 2006). One danger is that well-meaning initiatives or reforms are seriously under-funded and under-coordinated. Some of these problems may be addressed by creating joint health, social care and housing budgets for mental health, or by reaching agreements that facilitate the movement of money between different national or local government budgets in order to help overcome some of the disincentive (or perverse incentive) problems that can distort or inhibit appropriate action.

**Promoting promotion**

It is obvious from many chapters in this book that much more could be done to support mental health promotion. Few governments have given much attention to policies that can promote population well-being and individual mental health. Are the promotion possibilities recognized and responded to? Are governments setting up the right public mental health initiatives? One obvious challenge is that the development and implementation of strategies for public mental health promotion require action across many different agencies and sectors, as well across the life course. Examples include parent training programmes and interventions for the early identification of mental health problems in schools, flexible practices and access to counselling and support in the workplace, and bereavement counselling and social activities to reduce isolation and the risk of depression in older age. In turn, these efforts need mental health decision-makers to engage with a range of stakeholders including teachers, social workers, employers associations, trade unions and local community groups, including faith-based organizations.

**From containment to opportunity**

The most general over-arching challenge is to continue to move Europe’s mental health systems out of the age of containment and confinement and into an era of opportunity and choice. The Helsinki Declaration of 2005 was most certainly a welcome development, setting out a whole range of actions to which signatory countries gave their commitment. The supra-national signatories to the Declaration (the EU, the World Health Organization and the Council of Europe) will want to work with national governments to support implementation of the *Action Plan*. The opening is there to create new opportunities for
people affected by mental health problems to be socially included, to move from structures seemingly obsessed with containment to policies focused on lifestyle opportunities.

References


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