

Policy brief

Mental health I
**Key issues in the development of
policy and practice across Europe**

by

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Policy brief

Key issues in the development of mental health policy and practice across Europe¹

Introduction

Mental health problems account for approximately 20% of the total burden of ill health in Europe (WHO, 2004a). This estimate of burden is just the tip of the iceberg; what makes mental health almost unique is the broad impact it can have on all aspects of life, including physical health, family relationships and social networks, employment status and contact with the criminal-justice system. A high level of stigma associated with mental health problems can also lead to discrimination and reduced self-esteem. The economic costs of poor mental health are very high because of these multiple adverse consequences.

Promoting good mental well-being and intervening to tackle the consequences of poor mental health should logically be a major priority for health policy-makers across Europe. However, both the development of national policies and the level of funding for mental health are limited. Mental health promotion continues to be a low priority in most countries; instead, the emphasis is placed on treating the clinical aspects of mental health problems with much less attention paid to the broader environmental and social consequences. The development of community care-led systems of mental health care is patchy, and fundamental abuses of human rights continue to occur, most visibly, but not exclusively, within institutions in central and eastern Europe. The concept of empowering service users to be involved in making informed decisions about which services best meet their needs is still not widely implemented.

New challenges to face include the consequences of rapid economic and societal change, which, as observed in central and eastern Europe, have been accompanied by a decline in population mental health, with increasing rates of alcohol-use disorders, violence and suicide. The mental health needs of those

1. This policy brief is one of a series on health care issues by the European Observatory on Health Systems and Policies. This series is available online at: www.observatory.dk



displaced through conflict, persecution or economic migration represents another of the new challenges that must be faced. Dementia in older people will also become more common as the population across Europe continues to age.

Perhaps more than any other health issue, therefore, mental health requires an effective coordinated multisectoral approach to both the development of policies and the delivery of services. More effective preventative interventions as well as pharmaceutical and psychosocial treatments are now available, but evidence on what works, in what circumstances and at what cost, still needs to be facilitated into the policy-making process. This policy brief describes the health and socioeconomic burden of mental health in Europe and provides an overview of some of the key areas that need to be considered in developing and implementing policy, providing examples of different approaches taken to meet some of these challenges.

What are the consequences of poor mental health?

Mental health problems affect all; one in four people experience a significant episode of mental illness during their lifetime. Four of the six leading causes of years lived with disability are due to mental health problems: depression, schizophrenia, bi-polar disorders and alcohol-use disorders. Depressive disorders are most common, making up nearly one-third of all mental health problems. Only cardiovascular disease contributes more to the burden of illness in Europe, but mental health problems can have many more consequences for all domains of life.

People with mental health problems are more likely to have physical health problems, and family relationships can suffer. There is a strong relationship between poor mental health and social deprivation. Individuals who live in areas with a high rate of unemployment are at an increased risk of developing mental health problems, while the profound levels of stigma, ignorance and subsequent discrimination associated with mental health problems can limit education and employment opportunities, leading to a descent into poverty. There is also a greater risk of becoming homeless or of coming into contact with the criminal-justice system. The long-term impacts on the children of people with mental health problems can also be significant: they may suffer from neglect and their schooling may be disrupted, curtailing their long-term opportunities.

Suicide is one of the top ten leading causes of premature death in Europe, contributing an additional 2% to the overall burden of illness (WHO, 2004d). The rate of suicide is much higher in men than in women and after traffic

accidents it is the principal cause of mortality among 15–35-year-old males in the region. The countries with the highest annual male suicide rates in the world are all found here: Lithuania (80.7 per 100 000), the Russian Federation (69.3) and Belarus (60.3). While there is much variance in rates across Europe, countries undergoing economic transition in central and eastern Europe typically have the highest rates, although comparatively high rates are also found elsewhere, such as in Austria and Finland. The lowest rates are found in southern Europe: there are just over 5 male suicides per 100 000 in Greece and Malta.

What are the economic costs?

The economic costs of mental health problems are high, very conservatively estimated across the fifteen countries that were members of the EU before 1 May 2004 alone to be at least 3–4% of GNP (Gabriel & Liimatainen, 2000). In fact, the majority of quantified costs occur *outside* the health sector, being due to lost employment, absenteeism, poor performance within the workplace and premature retirement. Typically these costs account for between 60% and 80% of the total economic impact of major mental health problems.

There are a growing number of national cost estimates available. However, as methods of calculation used vary markedly, making direct comparisons between countries remains difficult. The estimates below provide some indication of these costs; for instance, official estimates of total health care costs alone of all mental and behavioural disorders in Germany in 2002 were estimated to be €22.44 billion, 62% of which were incurred by women because of their higher susceptibility to depressive disorders. This included specific costs for depression (€4.025 billion), schizophrenia and associated disorders (€2.756 billion), and neurotic disorders including stress (€2.825 billion). The average cost per head of population was €270 in 2002.

Depression is associated with the highest level of economic cost, because it is a common disorder often impacting on people in employment. One recent study from England estimated the total costs of adult depression alone in 2002 to be €15.46 billion or €309.2 per head of population; treatment costs accounted for only €636 million, the vast majority of additional costs being due to lost employment because of absenteeism and premature mortality (Thomas & Morris, 2003). This is a common finding: millions of working days are lost each year throughout Europe because of mental health problems. For example, 31.9 million lost working days in France in 2000 were attributed to depression (Béjean & Sultan-Taieb, 2004).



Although a much smaller number of people have schizophrenia, costs remain substantial. The economic impact in several studies in the Netherlands and Belgium, for instance, has been estimated to be equivalent to around 2% of all health care costs, even without including lost productivity costs or other adverse economic consequences. Studies in Hungary and England have both reported that health and social care costs account for around one-third of all costs, with the other two-thirds due to lost employment (Knapp et al., 2004).

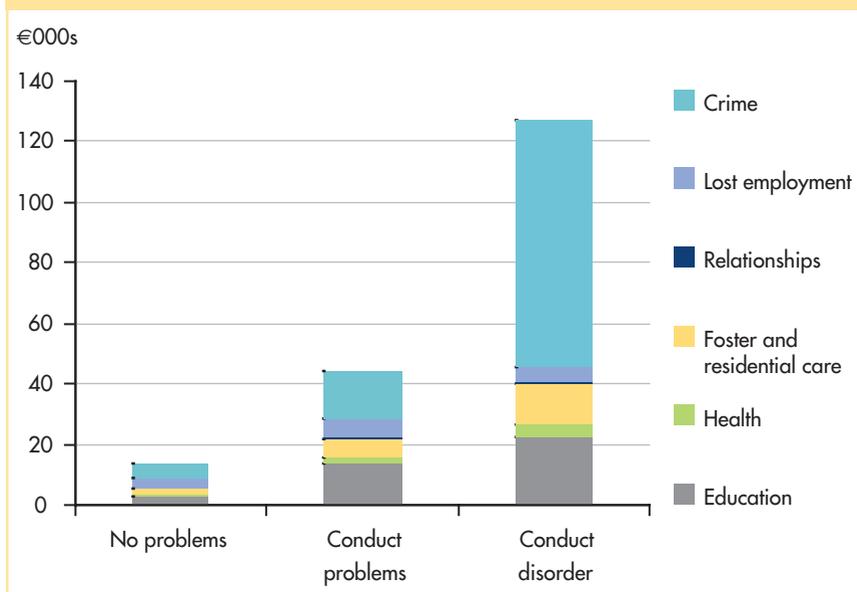
Many costs and consequences arising from poor mental health are less well reported. The costs of *reduced performance* at work by people with untreated mental health problems may be five times as great as those for absenteeism, but only limited research has examined this issue (Kessler & Frank, 1997). There are also long-term fiscal impacts, as mental health problems are a leading cause of early retirement or receipt of a disability pension. Substantial costs for family carers may be overlooked: for schizophrenia alone, families may provide between 6 and 9 hours per day of support, while for dementia and related disorders the contributions of caregivers can make up more than 70% of total costs, with carers often providing support 24 hours a day.

There can be economic impacts over very long time periods, especially for childhood mental health problems. One study found that children with a diagnosis of “conduct problems” at age 10 were likely to incur an additional €29 000 in costs between the ages of 10 and 27 years, while children with a diagnosis of “conduct disorder” (more severe than conduct problems) incurred over €109 000 in additional costs (Scott et al., 2001). For both the conduct problem and conduct disorder groups, the largest proportions of additional costs were for criminal-justice services, followed by extra educational provision, foster and residential care and state benefits; health care costs were much smaller (see Figure 1).

Developing and strengthening mental health policy

Having a national policy on mental health can help raise awareness, secure resources for services, and coordinate actions across many different sectors. Developing and strengthening policy for mental health across Europe remains a key concern, with a number of countries continuing to have no policy or action plan in place. A recommended prerequisite to policy development is to undertake a systematic appraisal of a country’s status, looking at local epidemiology and suicide rates, the availability of existing mental health-related structures (for example, the balance between institutional and community care), funding mechanisms, entitlements and access to services.

Figure 1: Long term economic costs of mental health problems – long-term follow-up of anti-social children



Costs at 2002 prices.

Source: Scott et al., 2001.

Consultation with all stakeholders should be an integral part of this process, with final recommendations and plans tailored to take account of culture, resources and local structures. This is vital to the development of approaches and solutions that can actually be implemented within a local context (Jenkins et al., 2002). Policy development needs to be accompanied by an implementation strategy and there should be engagement with other relevant government sectors such as education, housing and environmental affairs. It is also important to recognize that policy cannot develop in a vacuum; having concrete examples of effective services can help facilitate system development. NGOs can play a role in helping to build local examples of such services.

What role can legislation play in protecting human rights and in developing mental health policy?

There is a continuing need to take action to address human rights violations, stigma, discrimination and the consequent social exclusion that set mental health apart from most other health concerns. In some parts of central and eastern Europe fundamental human rights abuses continue to be seen in the



psychiatric institutions and social care homes (*internats*) that remain the mainstay of mental health systems. Once in an *internat* individuals rarely return to the community. There have been reports of people kept in “caged beds” or subjected to electroconvulsive therapy without anaesthesia or muscle relaxants in contravention of international guidelines.

Legislative instruments clearly have a crucial role (Parker, 2005). There are already human rights instruments from the UN, the Council of Europe, and the EU intended to protect people with mental health problems, the principles of which ideally need to underpin the development of national legislation. Such legislation, however, can only be effective if monitored, with adequate sanctions to effect change. Legislation can ensure that compulsory treatment or detention is seen as a last resort, and can build in a safeguard of access to an independent periodic review for all people admitted or treated involuntarily.

Legislation can also be a key tool in implementing mental health policy and addressing service reform issues, setting the framework for the assessment and provision of mental health services, and their integration with general health and community services. It can also be used to encourage the development of new approaches to involving users, for instance promoting the use of consumer-directed payments where feasible, empowering individuals to purchase appropriate services of their own choice. Legislation can also move beyond health and social care, and protect against discrimination and encourage implementation of mental health-promoting interventions in other sectors.

What can be done to promote positive mental well-being?

Positive mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2001a). The absence of mental well-being can have severe consequences; evidence from Finland over a 20-year period suggests that high levels of self-reported unhappiness are associated with higher levels of suicide (Koivumaa-Honkanen et al., 2003). The World Health Organization has published evidence that mental health promotion and mental disorder prevention can help in maintaining or improving health, have a positive impact on quality of life and be economically worthwhile (WHO, 2004b, 2004c).

In practice there have only been limited efforts thus far to introduce evidence-based approaches to mental health promotion across Europe (Jané-Llopis & Anderson, 2005). One challenge is that in developing and implementing a

strategy for public mental health promotion, actions should be taken across many different sectors. Effective actions can be taken across the life-cycle, for instance, through 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. There is a need to work with a range of stakeholders, such as teachers, social workers, employers' associations, trade unions and local community groups, including faith-based organizations.

One example of a multisectoral approach to mental health promotion is The National Programme for Improving the Mental Health and Well-Being of Scotland's Population (see Box 1). There are also initiatives at European level that recognize that different approaches to implementation of health-promoting strategies may be required in different countries and contexts. The 28-country EC-supported Implementing Mental Health Promotion Action network (www.imhpa.net) has developed a European Action Plan for Mental Health Promotion and Mental Disorder Prevention, a policy framework identifying high-priority policy initiatives to improve mental health, based on their proven efficacy and practicality of implementation.

Stigma and social exclusion: how might they be tackled?

Lack of knowledge, and ignorance, contribute to the stigma associated with mental illness. The fear of stigmatization also reduces the likelihood of individuals with mental health problems coming into contact with formal services. It also contributes to the low priority of mental health in policy-making. Stigma distinguishes mental health disorders from many other conditions and ultimately leads to discrimination and social exclusion. Such social exclusion occurs if an individual is unable to fully participate in society, or if their fundamental rights as citizens are denied. Social exclusion manifests itself in many ways, for example, through the low rate of employment for people with mental health problems generally, or the very low rate of marriage or cohabitation for people with psychoses (Thornicoft et al., 2004).

One recent major review of the links between social exclusion and mental health in England (ODPM, 2004a) found that in addition to widespread stigma and discrimination, health professionals also have a low expectation of what individuals with mental health problems can achieve, and that employment in particular is not seen as a key objective. It found that there was a lack of clear responsibility for promoting social and vocational outcomes, a lack of ongoing



Box 1: The National Programme for Improving the Mental Health and Well-Being of Scotland's Population (<http://www.wellontheweb.net>)

Key aims 2003–2006:

- Raising awareness and promoting mental health and well-being
- Eliminating stigma and discrimination
- Preventing suicide
- Promoting and supporting recovery.

The National Programme aims to work with and through others to achieve these key aims in the following priority areas:

- Improving infant mental health (the early years)
- Improving the mental health of children and young people
- Improving mental health and well-being in employment and working life
- Improving mental health and well-being in later life
- Improving community mental health and well-being
- Improving the ability of public services to act in support of the promotion of mental health and the prevention of mental illness.

support to enable people to work, and structural barriers to engagement in the community. The report called for more choice and empowerment of service users, and help to retain jobs, return to employment and develop careers. The fundamental importance of family and social participation for health was stressed, and the need for a multisectoral partnership between health, social care, employment and other community services was recognized. An action plan has now been developed (see Box 2) which includes long-term actions such as intervention in schools to raise awareness of mental health, and constructive engagement with the media, who have socially reinforced stigma and social exclusion by sensationalist and inaccurate portrayals of mental health.

What should the balance be between institutional and community-based care?

The last century was characterized initially by the rise and then, by the gradual reduction in the use of asylums as the mainstay of service provision for people with mental health problems in many parts of Europe. There has been a broad

Box 2: Actions to tackle social exclusion in England (ODPM, 2004b)

- 27-point action plan on mental health and social exclusion published October 2004.
- Sustained anti-stigma campaign including teaching in schools/work with broadcasters; action in the public sector; improved training for Job Centre staff implementing evidence-based practice in vocational services and community reintegration.
- Working for greater employment opportunities (proactive in public sector).
- Providing support for families and community participation.
- Providing help with basic rights – gaining access to benefits, decent housing, financial advice.
- A clear implementation strategy – actions incorporated into departmental delivery plans – linked to public service targets.

consensus to move towards deinstitutionalization in most of western Europe for more than 30 years. This change is now also under way in some parts of central and eastern Europe. The rate of change has varied markedly, as has the availability of alternative community-based support (Ammadeo et al., 2005). Evidence on the cost-effectiveness of community versus institutional care suggests that community-based services do not reduce health-system costs, but that the perceived quality of care and satisfaction with services by service users is improved.

The extent to which services can be shifted from institutions to the community, and the shape that models of service provision take, continues to be a key question for policy-makers. A report prepared for the WHO Regional Office for Europe's Health Evidence Network concluded that there are no persuasive arguments or data to support a hospital-only approach, nor is there any scientific evidence that community services alone can provide satisfactory comprehensive care (Thorncroft & Tansella, 2003). Instead, it argued that a "balanced care" approach is required where front-line services are based in the community, but that hospitals and other institutions can play an important role in providing services. Where required, hospital stays should be as brief as possible, with these services being provided in normal community settings rather than in remote isolated locations.



Box 3: Mental health service mix – policy considerations

- *Low-resource countries* should focus on establishing and improving mental health services within primary care settings, using specialist services as a backup.
- *Medium-resource countries* should also seek to provide related components such as outpatient clinics, community mental health care teams, acute inpatient care, long-term community-based residential care and occupational care.
- In addition to such measures, *high-resource countries* should provide forms of more differentiated care such as specialized ambulatory clinics and community mental health care teams, assertive community treatment, and alternatives to acute inpatient care, long-term community residential care and vocational rehabilitation.

Source: Thornicroft & Tansella, 2003

There are many potential elements to a balanced care approach, and not all are applicable or appropriate in each country. Each needs to be considered for its local relevance and will be dependent on the flexibility, coordination and ready availability of resources. Box 3 provides recommendations on service mix depending on whether countries have a low, medium or high level of resources.

Many implementation challenges exist. In some countries the primary care sector may be very underdeveloped and have had little to do with the recognition and management of mental health problems. There may also be little experience, and indeed distrust of intersectoral working. Effective coordination between all agencies involved in both funding and delivering services is needed. One approach to improve coordination across sectors may be the use of a “one-stop shop” model where one agency is responsible for working with service users to help them to purchase services or gain access to entitlements not just in the health and social care sectors, but elsewhere, for example, by providing help with housing and obtaining social security benefits. Another option may be consumer-directed payments to service users, allowing individuals to purchase services directly that best meet their perceived needs. This, however, still requires careful evaluation.

The needs of the mental health workforce should also not be overlooked when considering the balance of services. A well-trained workforce is a prerequisite for quality services. This should not be restricted to training in mental health-related skills alone; there is also a need for training in organizational and managerial skills, which in particular are lacking in some countries, hampering reform and the coordination of multiagency, multisectoral services.

In former totalitarian countries governance structures may be poor and there may be little culture of using evidence to support the decision-making process (Tomov et al., 2005). Administrators may be extremely reluctant to countenance change; they may also be worried about losing their status and authority if, for instance, institutions are shut down and replaced by community services. Employees in mental health systems will also be understandably concerned about their own job prospects as the balance in service provision changes.

Should more resources be invested in mental health?

While no recommendation could or should be made on the specific level of funding, given that mental health problems account for at least 20% of all ill health in Europe, mental health services appear to be grossly underfunded in many European countries.

The 2001 WHO *Atlas* on mental health was the first attempt to systematically collect information on expenditure on mental health across Europe, indeed across the world. Combining data from the *Atlas* with more recent work undertaken by the Mental Health Economics European Network (MHEEN) – an initiative funded by the EC and coordinated by Mental Health Europe and the London School of Economics – data on mental health expenditure in 28 countries are now available (McDaid et al., 2004). Only four countries in Europe report spending more than 10% of their health budget on mental health, with the lowest reported levels of under 2% in many newly independent states in the east of the region.

This appears to be both inefficient, because of the substantial benefits that would be offered by prevention, treatments and rehabilitation strategies that are known to be effective and cost-effective, and inequitable given that mental health problems account for at least one in five of all health problems in Europe. The returns from investment in mental health can be very high compared to many other health issues because of the many negative external impacts of mental health that could be avoided.



While money is not everything, major reforms are likely to need protected funding. It is important that, as the balance of services shifts from institutions towards the community, safeguards are put in place to ensure that funds are also fully transferred. Otherwise there is a temptation to use system reform as a vehicle for cost reduction, especially when the economic climate is tough. During such a transitional period, funding will be required *both* for the new community services as well as for the institutions being phased out. One option may be to “ring-fence” funding for mental health, while other possible approaches (depending on local context) may include using resource allocation mechanisms that take account of mental health needs when distributing funding both geographically and across sectors in health (and other) systems.

What contribution can economics make?

Economics can play an important role in helping to strengthen the case for funding. Decision-makers face two key questions when considering whether to use or recommend a particular form of intervention for a specified mental health problem. The first is the clinical question, which asks whether a treatment or promotion strategy is effective in improving patient health, or – when considering two or more treatment options – which of them has the better or best outcomes. Once the decision-maker knows about effectiveness, s/he wants an answer to the second question: Is it cost-effective? That is, does the treatment achieve the improved individual outcomes or quality of life at a cost that is worth paying? These two questions (Is the intervention effective? Is it worth it?) sit at the heart of cost-effectiveness analysis, and well-conducted cost-effectiveness studies can be a powerful tool for strengthening the case for investment in mental health.

There are a number of different approaches available. Some, such as cost-utility analysis and cost-benefit analysis, can allow comparisons to be made not only between interventions for improvement of mental health but also with other potential uses of resources both within and outside the health care sector.

While the evidence base on cost-effectiveness of interventions for mental health is growing, most studies have taken place in North America, western Europe or Australasia, and their results may not be generalizable to other settings. A continuing challenge is to further improve our understanding of cost-effectiveness across country settings, taking account of local circumstances, available resources and system structures. There are significant gaps in our knowledge, for instance on the cost-effectiveness of mental health promotion strategies and interventions targeted at children.

The MHEEN network is currently looking at some of these issues in 31 countries while the World Health Organization's ongoing CHOICE (CHOosing Interventions that are Cost-Effective) programme has put together a database on the cost-effectiveness of many interventions for mental health in Europe. This information, while not at a country-specific level, is provided for three European subregions in a transparent manner so that data can potentially be adapted to take account of local costs and the availability of resources. This database confirms that cost-effective treatments are available for *all* of Europe, even where resources for health are very limited.

What can be done at international level?

In countries where internal funding for mental health is limited, the role of international donors is of particular importance. Much can be done at international level to build on existing cooperation between international agencies, overseas donors and local civil-society groups, and focus more on how to ensure the long-term sustainability of initiatives that promote positive mental well-being and social inclusion. Past experience suggests that without thinking about the long term, successful initiatives, especially in those countries where civil-society structures may be minimal, may fail to be maintained on a permanent basis. Projects should be helped to develop a long-term strategy for sustainability early on in the implementation process.

International cooperation also needs to be promoted not just across organizational structures but also within agencies, including the different directorates of the Commission (such as employment and social affairs) and programmes of the United Nations, so that impacts on mental health are considered in many different areas. More can also be done to share information and move towards the standardization of different sources of data on mental health status and effective interventions so that more meaningful comparisons can be made across countries. Sharing experiences on the process of implementing reform and innovation in mental health can help identify barriers, and opportunities that countries just a short way down the path of reform may be able to benefit from.

Conclusion

Poor mental health is a major public health issue in Europe; it has many health and socioeconomic consequences for individuals and their families, as well as society generally.



The last five years have seen a significant increase in the attention given to mental health in Europe, culminating in the intergovernmental conference on mental health in Helsinki in January 2005, under the auspices of the WHO, the EU, the Council of Europe and the Government of Finland.

There is now substantial evidence that greater investment in many areas of mental health is not only justified on grounds of tackling the high degree of social exclusion and adverse health consequences, but also that it represents a more efficient use of health (and other sector) resources, allowing many individuals to maintain or regain their normal role, making an active contribution to society either through paid work or through other activities. Despite this, levels of funding for mental health still appear to be low in many countries, reflecting the challenge of overcoming long-standing negative perceptions of mental health.

It is clearly not enough to generate an evidence base on the effectiveness or cost-effectiveness of different strategies or mixes of services; more effort needs to be focused on the way in which this information is conveyed to policy-makers. Too often information is presented in an unsuitable dense and highly technical format, limiting its usefulness. More can be done to create effective channels of communication between policy-makers, researchers and other stakeholders, perhaps investing resources in training so-called “knowledge brokers”: individuals with knowledge both of scientific methods and of their interpretation, who are also familiar and comfortable in the policy arena. This can also help identify gaps in knowledge of relevance to policy-makers that are feasible for researchers to address.

International initiatives aimed at improving awareness of, and looking at the transferability of, the results of interventions such as mental health promotion strategies, such as the work of IMPHA and cost-effectiveness studies through the WHO CHOICE programme and the MHEEN network in Europe, can help build capacity and fill some of these gaps, and may strengthen the case further for investment in mental health.²

2. The author of this text is David McDaid, of the Personal Social Service Research Unit, LSE Health and Social Care, and the European Observatory on Health Systems and Policies, London School of Economics and Political Science.

Related publications

Ammadeo F et al. (2005). Reforms in community care: the balance between hospital and community-based mental health care. In: Knapp M et al., eds. *Mental Health Policy and Practice Across Europe*. Buckingham, Open University Press.

Béjean S, Sultan-Taïeb H (2004). Modelling the economic burden of diseases imputable to stress at work. *European Journal of Health Economics* [forthcoming].

Gabriel P, Liimatainen MR (2000). *Mental Health in the Workplace*. Geneva, International Labour Organization.

Jané-Llopis E, Anderson P (2005). A policy framework for the promotion of mental health and the prevention of mental disorders. In: Knapp M et al., eds. *Mental Health Policy and Practice Across Europe*. Buckingham, Open University Press.

Jenkins R et al. (2002). *Developing a National Mental Health Policy*. Hove, Psychology Press.

Kessler R, Frank R (1997). The impact of psychiatric disorders on work loss days. *Psychological Medicine*, 27(4):861–872.

Knapp M, Mangalore R, Simon J (2004). The global costs of schizophrenia. *Schizophrenia Bulletin*, 2:293–297.

Koivumaa-Honkanen H et al. (2003). Self-reported happiness in life and suicide in ensuing 20 years. *Social Psychiatry and Psychiatric Epidemiology*, 38:244–248.

McDaid D et al. (2004). *Financing Arrangements for Mental Health in Western Europe*. Report to the European Commission. London, London School of Economics.

ODPM Social Exclusion Unit (2004a). *Mental Health and Social Exclusion*. London, Office of the Deputy Prime Minister.

ODPM Social Exclusion Unit (2004b). *Action on Mental Health. A Guide to Promoting Social Inclusion*. London, Office of the Deputy Prime Minister.

Parker C (2005). Developing mental health policy: a human rights perspective. In: Knapp M et al., eds. *Mental Health Policy and Practice Across Europe*. Buckingham, Open University Press.

Scott S et al. (2001). Financial cost of social exclusion: follow-up study of antisocial children into adulthood. *British Medical Journal*, 323:191–196.

Thomas CM, Morris S (2003). Cost of depression among adults in England in 2000. *British Journal of Psychiatry*, 183:514–519.



Thorncroft G, Tansella M (2003). *What are the Arguments for Community-based Mental Health Care?* Copenhagen, World Health Organization, Health Evidence Network.

Thorncroft G et al. (2004). The personal impact of schizophrenia in Europe. *Schizophrenia Research*, 69:125–132.

Tomov T et al. (2005). Mental health policy in former Eastern bloc countries. In: Knapp M et al., eds. *Mental Health Policy and Practice Across Europe*. Buckingham, Open University Press.

World Health Organization (2001a). *Mental Health: New Understanding, New Hope*. Geneva, World Health Organization.
<http://www.who.int/whr/2001/en>

World Health Organization (2001b). *Project Atlas. Mental Health Resources Around the World*. Geneva, World Health Organization.
http://www.who.int/mental_health/evidence/atlas

World Health Organization (2004a). *The World Health Report 2004. Changing History*. Geneva, World Health Organization.
<http://www.who.int/whr/2004/en>

World Health Organization (2004b) in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. Geneva, World Health Organization.
http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

World Health Organization (2004c) in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. *Prevention of Mental Disorders: Effective Interventions and Policy Options*. Geneva, World Health Organization.
http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

World Health Organization (2004d). Suicide prevention web sites.
http://www.who.int/mental_health/prevention/suicide/suicideprevent/en

Useful web sites

Implementing Mental Health Promotion Action Network: <http://www.imhpa.net>

Mental Health Economics European Network:
<http://www.mentalhealth-econ.org>

World Health Organization Choice Programme:
<http://www.who.int/evidence/cea>

More information on mental health in Europe can be found in:

Mental health policy and practice across Europe

Edited by Martin Knapp, David McDaid, Elias Mossialos and Graham Thornicroft

Open University Press/McGraw Hill, August 2005

Paperback ISBN 0 335 21467 3

Hardback ISBN 0 335 21468 1

(Advance) orders for this publication can be made from:

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This policy brief is intended for policy-makers and those addressing the issues of mental health and health care systems.