The European WHO mental health programme and the *World Health Report 2001*: input and implications

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When the mental health programme of the World Health Organization (WHO) Regional Office for Europe was 'resurrected' in 1999, a review of the situation in the European Region of the WHO provided a surprisingly diverse picture. In this Region, which stretches from Greenland to Malta, from Ireland to Kamchatka, dramatic differences were noted in life expectancy and suicidality, income, housing, employment and social cohesion, as well as services, social support, human rights and the accessibility of basic care. In many societies, stigma and discrimination effectively excluded the mentally vulnerable from society and its basic services. Stigmatisation also hindered early intervention, rehabilitation and reintegration into society (WHO Regional Office for Europe, 1999, 2001).

What was especially striking was a panorama of increasing stress- and mental illness-related morbidity and mortality, resulting from a cluster of disorders and behaviours such as depression, suicide, accidents, addiction, violence and destructive lifestyles, as well as psychosomatically caused vascular diseases, forming a 'community syndrome' characterising societies in distress and undergoing dramatic change (Rutz, 2001). This pattern of high mortality and morbidity could be found especially in eastern European countries in transition, where the different pathologies described above increased in prevalence during the years of societal transformation. As a result, male life expectancy decreased by up to 10 years within one decade in some of the eastern European countries. Males appeared particularly vulnerable to societal stress and this vulnerability seemed related to factors such as sense of coherence and meaning in life, social connectedness, significance and family cohesion as well as factors related to helplessness and inner control (Wilkinson & Marmot, 1998).

This 'community syndrome', striking societies in transition, could also be identified in certain at-risk populations (undergoing psychosocial changes) in western European countries: farmers, elderly people and adolescents.

WORK PERFORMED AND ONGOING

As a result of these observations, the mental health programme of the WHO Regional Office for Europe established a number of task forces and networks:

(a) the WHO European Task Force on Premature Mortality, focusing on stress- and helplessness-related conditions;

(b) the WHO European Task Force on Destigmatisation, focusing on the need for humanisation, integration and the facilitation of early intervention;

(c) the WHO European Task Force on Assessment and National Mental Health Policies, individually assisting the Region's member states on their establishment, implementation and monitoring of national mental health strategies;

(d) the WHO European Network on Suicide Prevention and Research, monitoring the suicide situation in member states and developing, implementing and evaluating national strategies.

To create a basis for this work a European network of ministerially mandated national counterparts for mental health was established, including today 48 of the member states, who meet twice a year. The main areas of engagement became the eastern European countries and south-eastern Europe. Some specific needs for action were clear.

Gender issues

There had been negligence and lack of awareness about male morbidity and mortality, owing to an excessive historical preoccupation with female morbidity. This situation was worsened by men's seemingly alexithymic incapacity to seek help in time. Two paradoxes of public health, evident from the overarching perspective of the WHO, were related to this issue. The first was that males seem much less frequently to be depressed than females, but show on the other hand a much higher mortality from suicide. The other paradox is that males have less evident morbidity and lower health care consumption, but their life expectancy is much less than that of females – up to 14 years less in some eastern European countries and 6 years in the European Union as a whole.

Reorganisation of mental health services

Mental health services need to be accessible and usable for all parts of the population. Financial resources and professional mental health competence should respond to needs and 'follow the patient' from institution to community. Primary health care must be engaged in the fight against stress-related morbidity. This could be achieved by increased awareness, empowerment, education and curriculum development (WHO Regional Office for Europe, 1998), using as examples successful educational programmes for general practitioners in Scandinavia, the UK, Ireland, Hungary and Germany, where an improvement in ability to recognise and monitor depression has led to decreased morbidity, lower costs and suicide reduction (Dawson & Tylee, 2001).

Other task force activities

Other task force activities were to review successful European national or regional campaigns against stigma, to research the epidemiology of suicidal behaviour and its psychosocial background variables and to gather experience from successful suicide prevention programmes. A number of comprehensive national assessments on mental health were carried out, giving a basis for national policy development, national planning on mental health, its implementation and follow-up (Rutz, 2001).

The European input to the World Health Report

The activities of the WHO Regional Office provided input to the *World Health Report 2001* (WHO, 2001). The European contribution was especially directed towards depression, suicide, primary health

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care involvement, national mental health audits and national mental health planning, as well as decentralisation and dehospitalisation efforts. The involvement of all sectors of society in mental health development and a multi-disciplinary team approach reflecting the complex nature of human and mental conditions was advocated, following the 'Health 21' policy, ratified by the governments of Europe in 1998 (WHO Regional Office for Europe, 1998). Depopulation phenomena, in some countries perceived to be a national crisis due to mental ill health and stress-related premature mortality, were also addressed. The differences between the cost of mental ill health and effective resource allocation ('the awareness gap') in various countries were underlined, as was the 'treatment gap' between what European services and expertise are able to do to relieve suffering, to promote and protect mental health, and to prevent disease and disorder, and what really is done. Developments in research and also the need for a realistic perception of the burden of mental ill health were analysed and introduced into the common global focus of the WHO and United Nations Year of Mental Health in 2001 (WHO Regional Office for Europe, 2001).

The *World Health Report 2001* (WHO, 2001), subtitled *Mental Health: New Understanding, New Hope*, has so far been presented in many member states at meetings with governmental participation and it continues to play a crucial role. It focuses on decentralisation and the need to establish community-based mental health services, giving the mentally vulnerable access to treatment at home, and utilising their social networks, existential identity and psychological environment. It focuses on the need for individual and societal empowerment, and public education about mental health, as well as the education of mental health professionals, family doctors, families and the social sector. It underlines the extreme and still increasing burden of depression and suicide and the need for inter-disciplinary teamwork. It advocates national mental health development, evidence-oriented research and awareness-raising activities (WHO, 2001).

NEW INITIATIVES AND CHALLENGES FOR THE FUTURE

There is a need to focus on the mental health of both males and females, supporting gender-specific activities, in particular studying the problem of male premature mortality, as well as identifying the factors apparently protecting women in times of crisis and change.

Primary health care plays a crucial role in the fight against depressive conditions, helplessness and suicide. A decrease in suicide rates can be found already in several European countries, despite the persistence of social problems and an increased prevalence of depression. This is thought to be related to improvements in recognition, comprehensive treatment and monitoring.

There is increasing evidence for a relationship between vascular mortality and depression, as well as the connection of depression, stress and helplessness to addictive, risk-taking, sensation-seeking and destructive behaviours.

A professional mental health body is needed to take responsibility not only for clinical work and research, but also for public mental health, particularly in an advisory and expert capacity to decision-makers and politicians (WHO Regional Office for Europe, 2002).

There is a need to prepare European societies for the threat of unpredictable terrorism, not only in order to protect people, but also to avoid societal split or regressive societal phenomena such as scapegoating, racism, paranoid isolationism and suspicion, regressive striving for authoritative structures, leaders, saviours and salvation, religious or ideological orthodoxy and fundamentalism.

Problems of classification and diagnoses, as well the issues of how to monitor mental vulnerability, psychiatric morbidity and mortality, are becoming increasingly important. Evidence is not proved solely by randomised controlled trials and there is a need to integrate this with qualitative types of evidence to provide a holistic *Gestalt* of evidence and knowledge.

CONCLUSIONS

A transfer of knowledge and support to less advantaged member states is crucial. This should be a two-way process as these countries can in turn provide clinical experience and scientific expertise and a holistic approach to treatment. We need to develop a framework of ethical clinical standards and guidelines that are both acceptable and affordable for all member states of the European Region.

The activities of the WHO Year of Mental Health and the *World Health Report 2001* have created a momentum and a recognition that, without mental health, there is no health (and no peace) (WHO, 2001). Mental health is the responsibility of everybody and every sector in society. An awareness of the impact of politics on mental health and a willingness to analyse this in the same way as we analyse environmental impact will be crucial. Investment in mental health is an investment that no country, however rich, however poor, can afford not to make. This will be the focus of a WHO ministerial conference in 2005.

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