

Editorial

Mental health reform: Europe at the cross-roads

DAVID MCDAID*

The London School of Economics and Political Science, UK

In June 2008, the European Commission (EC) will host a High Level Conference, under the auspices of Commission President José Manuel Barroso, to discuss the establishment of a new European Pact for Mental Health. This is the latest of several high profile initiatives on mental health to have taken place in Europe. Most notably, in 2005, the World Health Organization was instrumental in bringing together all of Europe's health ministries to endorse an ambitious plan for the Region (World Health Organization, 2005). The EC added its weight to this trend with publication of a widely discussed Green Paper on a potential strategy for mental health later that same year (Commission of the European Communities, 2005).

The subsequent failure of the EC to implement a strategy for mental health following consultation on the Green Paper and instead to focus its efforts on building consensus for action alongside Member States and other stakeholders through a non-binding Pact, has been viewed in some quarters as a major setback. Yet, for all its limitations, this Pact potentially is a very significant development. The new approach recognizes that the primary responsibility for action still rests with Member States and other stakeholders, but envisages an active role for the Commission to inform, complement, and encourage actions by these players. In this respect, it may be seen as being akin to the Open Method of Co-ordination (OMC), an approach that is used at EC level to help facilitate Member States to come together voluntarily to co-operate on health issues that are outside the competence of the European Union. However, what makes this initiative stand out from both the OMC process and past mental health initiatives, is the recognition that much of the action to both promote general population mental well-being and to address the needs of those living with mental health problems needs to be funded and implemented *outside* the health care system.

Hence, the High Level conference is being organized jointly by DG Health and Consumer Protection and DG Employment, Social Affairs and Equal Opportunities. Moreover, there is a strong emphasis in the Pact process on

*Correspondence: David McDaid, PSSRU and European Observatory on Health Systems and Policies, The London School of Economics and Political Science, Houghton Street, London WC2A 2AE, UK. Email: D.McDaid@lse.ac.uk

building coalitions for action across different sectors, with a focus on five key themes: prevention of suicide and depression, youth and education, workplace settings, the mental health of older people, and combating stigma/social exclusion. Follow up events will focus on each of these specific themes in more detail. If successful, this Pact process, with its emphasis on facilitating multi-sector dialogue and co-operation between stakeholders in both the public and private sectors, may provide a useful blueprint for those seeking to collaborate to reform mental health systems elsewhere.

Far-ranging impacts

The need for a multi-sector, multi-stakeholder approach to the promotion of mental health, as envisaged by the European Pact for Mental Health, is well documented. The personal, social, and economic impacts of poor mental health can be profound. As many as one in four individuals may experience a mental health problem during their lifetime, while for men and women in the WHO European region, neuro-psychiatric disorders account for 22% and 17% of the total disease burden, second only to cardiovascular disease (World Health Organization, 2004).

Conservatively, the economic costs of poor mental health have been estimated at €386 billion (2004 prices) in the EU 25, plus Norway, Iceland, and Switzerland (Andlin-Sobocki *et al.*, 2005). Although associated with higher rates of non-mental health-related co-morbidity and premature mortality, health system costs are typically dwarfed by the costs of lost productivity from employment, which can account for as much as 80% of all cost of poor mental health (Knapp, 2003). Other impacts outside the health system can include poor personal relationships and strain on families (Thorncroft *et al.*, 2004; van Wijngaarden *et al.*, 2004; Ostman and Hansson, 2004), a higher-than-average risk of homelessness (Anderson *et al.*, 2007), and increased contact with the criminal justice system (All Party Parliamentary Group on Prison Health, 2006).

The Pact process is also seeking to highlight the macro-economic rationale for investing in mental health through a number of background papers (see <http://www.ec-mental-health-process.net>). The adverse impacts of poor mental health on productivity and absenteeism are cited as an important obstacle to the achievement of the European Union's (EU) so-called 'Lisbon Agenda' on economic growth and full employment.¹ This focus on the cost to business

¹ The 'Lisbon Agenda' or 'Lisbon Strategy' is an action and development plan for the European Union. Its aim is to make the EU 'the most dynamic and competitive knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion, and respect for the environment by 2010' set against the background of productivity in the EU being below that of the USA. It was set out by the European Council in Lisbon in March 2000. See http://ec.europa.eu/growthandjobs/faqs/background/index_en.htm

can also be mirrored at a national level. For instance, a recent review of the health of the working age population in England, Scotland and Wales (Black, 2008) was just the latest of several documents and reports to highlight the business case for actions by enterprises to promote a mentally healthy workforce e.g. (Jarvisalo *et al.*, 2005; Berkels *et al.*, 2004).

Mental health reform: key challenges

Mental health reform raises a number of challenges to policy makers in the EU and beyond. Some of these, such as the issue of equitable funding, lie solely within the competence of Member States, but information can however be collected and exchanged at an EU level on comparative differences between Member States. Do services and initiatives that aim to meet mental health needs get their fair share of available health care system funding? This was a question recently addressed by the EC supported Mental Health Economics European Network (www.mheen.org), which sought to estimate the level of health care expenditure on mental health across 32 European countries. It came to the conclusion that available funds were modest at best, despite the ever-increasing evidence on cost effective interventions (e.g. Barrett *et al.*, 2005; Romeo *et al.*, 2005; Chisholm, 2005; Chisholm *et al.*, 2004; Chisholm *et al.*, 2005; Zechmeister *et al.*, 2008). Only four EEA (European Economic Area) countries spent at least 10% of their health care budget on mental health (range 2.5% to 14%). This perhaps is unsurprising given the pervading sense of stigma, taboo, and discrimination that can impact negatively on funding for mental health (Matschinger and Angermeyer, 2004).

The MHEEN group did, however, caveat their findings with a warning on their interpretation. In particular, the boundaries between what is a 'health service' and what may be funded through social care can be very different, meaning that just looking at funding within the health care sector alone is likely to underestimate the true level of expenditure on mental health in many countries. Certainly in the EU there has been a shift of services from the health to social care sectors, reflecting the changing mix of services away from institutions and towards systems that are more community-focused (McDaid *et al.*, 2007).

Moving this locus of care creates many new and welcome opportunities, but also raises challenges in coordinating activities across organizational and budgetary boundaries, including those for social care, housing, criminal justice, and employment. These may have equity implications as some services that may have been provided free of charge within the health care system, such as help with supported housing, may be means tested once they are shifted to another sector. In Austria, for instance, individuals and their families may pay out of pocket up to one-third of the costs of social care services provided by the regional authorities (Länder) (Zechmeister and Oesterle, 2006).

A second set of challenges are concerned with how to deliver a mix of services that best meet the needs of people with mental health problems. The Pact process potentially provides an opportunity to exchange information on how different Member States have sought to rebalance the provision of care, so as to give primacy to care delivered in the community with the aim of promoting rehabilitation and reintegration. This will involve actions in a number of sectors, such as the provision of help with housing or in obtaining employment, as well as moving towards more flexible financing mechanisms that allow funds to be used across sectors. Encouraging dialogue at Member State level across sectors through the Pact process may help facilitate the rebalancing of care.

Another issue for policy makers to consider is the extent to which the focus should be on those already living with mental health problems rather than taking a broader population mental health perspective, which puts greater emphasis on promotion and prevention, for instance through interventions to promote the mental wellbeing of children in the first years of life (Barlow *et al.*, 2005) or through activities to reduce the risk of social isolation in older people (Cattan *et al.*, 2005). Background documents prepared as part of the Pact process together with other EC funded activities are helping to disseminate the evidence base effect prevention and promotion activities. Many of these population level interventions will need to be implemented outside the health care sector, e.g. in the workplace or at school, which again is consistent with the focus on consensus building across sectors that is central to the Pact process.

Rebalancing care

So what direction has reform taken in the EU and what might this mean for those engaged in reform elsewhere? Certainly, there has been a decline in the use of psychiatric beds in much of the EU over the last 30 years; moreover, where long-stay care is provided this is now much more likely to be in general hospitals rather than specialist psychiatric institutions. Much remains to be done: there has been little change in the balance of care in some of the new Member States, e.g. Bulgaria, Latvia, and Romania (Mossialos *et al.*, 2003). Moreover, serious concerns persist about the human rights and dignity of those residing in institutional care facilities in several of the new EU Member States: large-scale isolated institutions, some with 1,000 beds or more, may be of very poor quality, sometimes barely providing little more than the most basic food, warmth and shelter, and giving no thought or concern to individual privacy or to investment in activities to help individuals reintegrate into the community. Moving away from a reliance on such institutions is consistent with the EC objective of promoting the social inclusion of people with mental health problems and an EC funded mapping exercise on the state of institutional care has recently been completed (Mansell *et al.*, 2007).

Barriers to rebalancing care can include perverse finance mechanisms. Particularly in central and Eastern Europe, funding may be 'locked' in long-stay institutions, so service providers may actually have incentives to maintain a high rate of occupancy in order to ensure that their budgets are not ratcheted down. This concentration of limited funds in institutions can be compounded when aid and loans from non-governmental organizations and international agencies are sometimes used to refurbish these institutions rather than to develop alternative services (Knapp *et al.*, 2006). Large and often isolated institutions can also be a major source of jobs in a locality, meaning that resistance to closure may be substantial. One way of overcoming local resistance to institutional closure could be through the implementation of economic regeneration packages, but as yet there has been little evaluation of the effectiveness of such measures in Europe (Mansell *et al.*, 2007)

Rebalancing care also implies investing in the development of alternative community based care services, whilst maintaining existing (excess) long-stay services during a period of transition. Unfortunately, the historically low priority given to mental health has meant that funds have not always been transferred to community-based services, even after hospitals have closed. Without sufficient community-based support, there is a greater risk of reduced quality of life for those discharged from institutions. They may become homeless or have more contact with the criminal justice system. The onus may also fall on families to fill the gap and provide support, as has for example been seen in Italy and Denmark (de Girolamo *et al.*, 2007, Munk-Jorgensen, 1999). Poorly planned and inadequately resourced hospital to community 'transfer' can thus serve to undermine public confidence in future investment in community-based care.

Flexible funding mechanisms

Flexible funding and organizational arrangements have been used to help rebalance the provision of care, by allowing funds to be tied to individuals rather than be linked to specific institutional infrastructures. For instance, in Flanders money notionally intended for the provision of beds can actually be used to foster independent living, while the pooling of budgets through mergers between institutions and ambulatory services in the Netherlands was an important step in rebalancing care. The latter made it much easier to substitute the use of clinical facilities with greater use of day care treatments and home care as well as improved access to supported housing. Total institutional places were halved over a ten-year period (Ravelli, 2006).

Flexible funding can also be used as a way of promoting empowerment and choice in mental health service users. Consumer directed payments are the subject of ongoing analyses in several European countries, including England, Scotland, and the Netherlands. This mechanism allows various population groups who have multiple service needs, including older people, those with

disabilities, and people with mental health problems, to receive a budget to spend on services both within and external to the health system. They can allow those with enduring mental health problems to go on training courses to help increase their chances of entering and/or returning to the labour market. Preliminary evaluation in England suggests that uptake of such schemes has been very limited; a major factor for this appears to be a reluctance on the part of local authorities to raise awareness of the right that individuals have to take direct control of budgets (Spandler and Vick, 2006).

A similar mechanism, now being evaluated in England, is the use of individual budgets – (see <http://php.york.ac.uk/inst/spru/research/summs/ibsen.php>). Historically, the expansion of the social welfare system helped to provide individuals with a safety net that has enabled some of the most vulnerable individuals to live independently in the community. Over time, these benefit systems have become increasingly complex and fragmented. Individual budgets bring together in one place all welfare benefits that an individual is entitled to receive. Again, the aim is to increase flexibility in how monies can be used to best meet needs.

Potential limitations of any consumer directed payment approach include complexity in administration; ideally, as is the case in many of the English and Scottish schemes, support and information mechanisms are in place to provide support to those individuals who might find themselves overwhelmed by the different choices when deciding on how to use their budgets. Questions may also arise as to the speed at which existing service providers will be able to adapt to the demands of potential service users, while assuring the quality of services provided can also be challenging; in the case of the later, some direct payment schemes only permit individuals to buy services from an approved list of suppliers.

Actions in the workplace

Initiatives in the workplace are a major focus of the proposed European Pact. As the share of social welfare benefits linked to premature withdrawal from the labour market increases, European policy makers have begun to turn their attention to the employment difficulties experienced by people with common mental health problems, including stress and depression, often working in partnership with employers (Jarvisalo *et al.*, 2005). Examples of pan European actions include the ‘Framework Agreement on Stress in the Workplace’, signed by the major European umbrella organizations representing private and public sector employers and the European Trade Unions Congress in 2004 (Anonymous, 2004), and the ‘Commission Strategy on Health and Safety at Work 2007–2012’, which places an emphasis on promoting mental well-being as a way of promoting productivity at work (Commission of the European Communities, 2007).

Companies are also increasingly taking advantage of the business case for investment in workplace mental health promotion. Organizational interventions, including flexible working arrangements, job and or task redesign, better dialogue and collaboration between managers and employees, enhanced use of teamwork, and opportunities for career progression, are thought to promote mental wellbeing (Cooper, 2006). Stress awareness and management programmes can also help. Evaluation of one scheme at the UK insurer Royal and Sun Alliance indicated that the costs of absenteeism avoided were three times greater than the cost of investment in the programme, while there were statistically significant reductions in levels of anxiety and depression in participating employees (Tehrani, 2004). In France, *Electricite de France* has implemented a screening programme for employees on sick leave. Those identified with depressive disorders were placed on a programme involving the provision of information and a recommendation to consult with their general practitioner, occupational physician, or psychiatrist. Overall this group had a significantly higher rate of remission and recovery compared with individuals in a control group (Godard *et al.*, 2006).

Most of this workplace activity has occurred in large-scale companies, i.e. those with more than 500 employees. One challenge is to find a way to expand the availability of cost-effective workplace mental health promotion schemes to small and medium size enterprises (SMEs). The Pact process could potentially encourage Member States, who stand to benefit economically from a healthier workforce, to consider ways of providing financial incentives and other supports to SME's, so as to increase the access of their employees to mental health promotion programmes.

Where next?

Mental health problems are a major contributor to the burden of disease across the globe. They are associated with premature mortality and have profound socio-economic impacts, both for individuals and for the wider economy. Within Europe, increased awareness of these impacts can be seen in a number of major policy documents on mental health, including the WHO Declaration and Action Plan for Europe, endorsed by all Ministries of Health in 2005.

Despite welcome policy statements and an increasing evidence base supporting the economic case for action, investment in mental health in Europe still appears modest. However, analysis of funding has tended to focus on actions taken within the health care system, overlooking both the current and future contribution of external sectors. Careful consideration needs to be given to looking at ways in which to break down funding silos between sectors. In the same way, policy initiatives at both EU and national level have often been targeted solely at the health sector, even when their impacts are much more widespread.

Mental health policy in the EU has reached a crossroads. Some may view the proposed non-binding European Pact for Mental Health as a disappointing policy outcome, given that mental health issues have been so much more visible since the publication of the WHO World Health Report on Mental Health in 2001 (World Health Organization, 2001). The Pact may yet, however, represent a golden opportunity to promote mental health reform. This will be dependent on whether it can help facilitate a commitment by Member States to provide sufficient resources for sustained actions that will promote and protect mental health across sectors, whilst also encouraging activity by other stakeholders such as the business community. Only time will tell whether the Pact will indeed be a catalyst for a greater consensus on evidence informed action across sectors. Failure may however see the issue of mental health further marginalized on the health policy agenda.

References

- All Party Parliamentary Group on Prison Health (2006), 'The mental health problem in UK HM Prisons', London, House of Commons.
- Anderson, R., R. Wynne, and D. McDaid (2007), 'Housing and Employment', in M. Knapp, D. McDaid, E. Mossialos, and G. Thornicroft, (eds), *Mental Health Policy and Practice Across Europe*, Buckingham: Open University Press.
- Andlin-Sobocki, P., B. Jonsson, H.U. Wittchen, and J. Olesen (2005), 'Cost of Disorders of the Brain in Europe', *European Journal of Neurology*, **12**(1): 1–27.
- Anonymous (2004), 'Framework Agreement on Work Related Stress', European Trade Union Conference, Brussels.
- Barlow, J., J. Parsons, and S. Stewart-brown (2005), 'Preventing Emotional and Behavioural Problems: The Effectiveness of Parenting Programmes with Children Less than Three Years of Age', *Child Care Health and Development*, **31**: 33–42.
- Barrett, B., S. Byford, and M. Knapp (2005), 'Evidence of Cost-Effective Treatments for Depression: A Systematic Review', *Journal of Affective Disorders*, **84**: 1–13.
- Berkels, H., J. Henderson, N. Henke, K. Kuhn, J. Lavikainen, V. Lehtinen, A. Ozamiz, P. Van Den Heede, and K. Zenzinger (2004), *Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress Related Disorders in Europe (2001–2003)*, Bremerhaven: Wirtschaftsverlag NW Verlag für neue Wissenschaft GmbH.
- Black, C. (2008), *Working for a Healthier Tomorrow: Dame Carol Black's Review of the Health of Britain's Working Age Population*, London: The Stationery Office.
- Cattan, M., M. White, J. Bond, and A. Learmouth (2005), 'Preventing Social Isolation and Loneliness among Older People: A Systematic Review of Health Promotion Interventions', *Ageing and Society*, **25**: 41–67.
- Chisholm, D. (2005), 'Choosing Cost-Effective Interventions in Psychiatry: Results from the CHOICE Programme of the World Health Organization', *World Psychiatry*, **4**: 37–44.
- Chisholm, D., K. Sanderson, J.L. Ayuso-Mateos, and S. Saxena (2004), 'Reducing the Global Burden of Depression: Population-Level Analysis of Intervention Cost-Effectiveness in 14 World Regions', *British Journal of Psychiatry*, **184**: 393–403.

- Chisholm, D., M. Van Ommeren, J.L. Ayuso-Mateos, and S. Saxena (2005), 'Cost-Effectiveness of Clinical Interventions for Reducing the Global Burden of Bipolar Disorder', *British Journal of Psychiatry*, **187**: 559–567.
- Commission of the European Communities (2005), 'Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union', Green Paper, Brussels, Health and Consumer Protection Directorate, European Commission.
- Commission of the European Communities (2007), 'Improving Quality and Productivity at Work: Commission Strategy 2007–2012 on Health and Safety at Work', Brussels, Commission of the European Communities, available at http://ec.europa.eu/employment_social/news/2007/feb/commstrat_en.pdf.
- Cooper, C. (2006), 'The Challenges of Managing the Changing Nature of Workplace Stress', *Journal of Public Mental Health*, **5**: 6–9.
- De Girolamo, G., M. Bassi, G. Neri, M. Ruggeri, G. Santone, and A. Picardi (2007), 'The Current State of Mental Health Care in Italy: Problems, Perspectives, and Lessons to Learn', *European Archives of Psychiatry and Clinical Neuroscience*, **257**: 83–91.
- Godard, C., A. Chevalier, L. Lecrubier, and G. Lahon (2006), 'APRAND Programme: An Intervention to Prevent Relapses of Anxiety and Depressive Disorders – First Results of a Medical Health Promotion Intervention in a Population of employees', *European Psychiatry*, **21**: 451–459.
- Jarvisalo, J., B. Andersson, W. Boedeker, and I. Houtman (2005), 'Mental Disorders as a Major Challenge in the Prevention of Work Disability: Experiences in Finland, Germany, the Netherlands and Sweden. Helsinki', The Social Insurance Institution.
- Knapp, M. (2003), 'Hidden Costs of Mental Illness', *British Journal Psychiatry*, **183**: 477–478.
- Knapp, M., M. Funk, C. Curran, M. Prince, M. Grigg, and D. McDaid (2006), 'Economic Barriers to Better Mental Health Practice and Policy', *Health Policy Plan*, **21**: 157–170.
- Mansell, J., M. Knapp, J. Beadle-Brown, and J. Beecham (2007), *Deinstitutionalisation and Community Living – Outcomes and Costs: Report of a European Study, Volume 1: Executive Summary*, Canterbury: Tizard Centre, University of Kent.
- Matschinger, H., and M.C. Angermeyer (2004), 'The Public's Preferences Concerning the Allocation of Financial Resources to Health Care: Results from a Representative Population Survey in Germany', *European Psychiatry*, **19**: 478–482.
- McDaid, D., M. Oliveira, K. Jurczak, M. Knapp, and The MHEEN Group (2007), 'Moving Beyond the Mental Health Care System: An Exploration of the Interfaces between Health and Non-Health Sectors', *Journal of Mental Health*, **16**: 181–194.
- Mossialos, E., A. Murthy, and D. McDaid (2003), 'European Union Enlargement: Will Mental Health be Forgotten Again?', *European Journal of Public Health*, **13**: 2–3.
- Munk-Jorgensen, P. (1999), 'Has Deinstitutionalization Gone Too Far?', *European Archives of Psychiatry and Clinical Neuroscience*, **249**: 136–143.
- Ostman, M., and L. Hansson (2004), 'Appraisal of Caregiving, Burden and Psychological Distress in Relatives of Psychiatric Inpatients', *European Psychiatry*, **19**: 402–407.
- Ravelli, D.P. (2006), 'Deinstitutionalisation of Mental Health Care in the Netherlands: Towards an Integrative Approach', *International Journal of Integrated Care*, **6**: 1–11.
- Romeo, R., S. Byford, and M. Knapp (2005), 'Annotation: Economic Evaluations of Child and Adolescent Mental Health Interventions – a Systematic Review', *Journal of Child Psychology and Psychiatry*, **46**: 919–930.

- Spandler, H. and N. Vick (2006), 'Opportunities for Independent Living Using Direct Payments in Mental Health', *Health and Social Care in the Community*, **14**: 107–115.
- Tehrani, N. (2004), *Recovery, Rehabilitation and Retention: Maintaining a Productive Workforce*, London: Chartered Institute of Personnel and Development.
- Thornicroft, G., M. Tansella, T. Becker, M. Knapp, M. Leese, A.H. Schene, and J. L. Vazquez-Barquero, (2004), 'The Personal Impact of Schizophrenia in Europe', *Schizophrenia Research*, **69**: 125–132.
- Van Wijngaarden, B., A.H. Schene, and M.W. Koeter (2004), 'Family Caregiving in Depression: Impact on Caregivers' Daily Life, Distress, and Help Seeking', *Journal of Affective Disorders*, **81**: 211–222.
- World Health Organization (2001), *Mental Health: New Understanding, New Hope*, Geneva: World Health Organization.
- World Health Organization (2004), *Global Burden of Disease Estimates*, Geneva: World Health Organization.
- World Health Organization (2005), *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions*, Copenhagen: World Health Organization.
- Zechmeister, I., R. Kilian, and D. McDaid (2008), 'Is It Worth Investing in Mental Health Promotion and Prevention of Mental Illness? A Systematic Review of the Evidence from Economic Evaluations', *BMC Public Health*, **8**: 20.
- Zechmeister, I. and A. Oesterle (2006), 'Distributional Impacts of Mental Health Care Financing Arrangements: A Comparison of the UK, Germany and Austria', *Journal of Mental Health Policy and Economics*, **9**: 35–44.