Mental Health is going mainstream - but will anyone be left out in the cold?

Report on the first consultation meeting on the EU Green Paper on Mental Health, 16-17 January, 2006. By Adam Duncan (adamishi@yahoo.co.uk)

The Rough Guide to Europe says that 'the spectacular setting alone justifies a visit', but I travelled to Luxembourg City on behalf of ENUSP for other reasons. The EU is holding three meetings early this year to find out what people think of their proposals for a strategy on "Improving the Mental Health of the Population". I was involved in a two-day consultation on how the EU could promote positive mental health in everyone and act to prevent particular mental health problems. In full plenary sessions, gathered before the EU Commission staff and translators, were representatives of the EU member countries; scientific researchers; and organisations with a particular stake in mental health. The three groups also went away as subgroups to debate their main issues, which were then summarised back to the full group.

In initial keynote speeches, we heard about the need to address both social and genetic determinants of mental health, and for collaboration with 'civil society' and the voluntary sector. We heard about the situation within EU member states (IMHPA country stories report) showing, for example, that: 86% of their policy documents refer to mental health but only 30% of countries had national policies or action plans on mental health; that many common challenges were reported, including the need for more cooperation between governmental and non-governmental organisations, and for a focus on health promotion and problem prevention (including the reoccurence of disorders) rather than just treatment after the fact; that there is 'an enormous wealth' of projects and activities in the EU but they must be more coordinated, sustained, and always designed so their effectiveness can be evaluated.

A speaker from the Ministry of Health in France said they have a low referral rate to mental health services, which are dominated by psychiatrists (apparently found to be clustered in the sunny South and by the coast!) and have lots of gaps disrupting full rehabilitation (as phrase was translated). She spoke of impressive national-level plans to address mental health through work, housing, the family, social groups/clubs, and clinically - including mobile mental health teams accessible to people at home.

An interesting point from the floor was that we need a mental health 'curriculum' that teaches people (incl. professionals in all lines of work) how to help ourselves and help others. Someone added that positive mental health laws and policies must in be place for this to really take off.

Now the subgroup to which ENUSP had been invited, involving on the day about 15 representatives of European stakeholder organisations. We discussed a lot in a stimulating and productive way. The following themes (in no particular order) emerged over the two days. I am grateful to the Chair and Rapporteur of our subgroup for their work to involve us all.

<u>Settings for action</u>

It was clear that the workplace and schools will be major settings for action. We heard of the need to include and integrate people in the workplace, to build personal coping resources, and to promote 'productive ageing'. In Germany now, if you off work for health reasons for a certain

period, the employer has a duty to meet with you and discuss how they could improve things. The importance of schools was also highlighted, given the potential for promotion and prevention at a young age. It was necessary to build networks across education and take a holistic approach, integrating into policies and involving families etc. I said it was great to see so much on these areas, including the anti-bullying work.

I suggested that the family setting didn't appear to be talked about much, mentioning the work on 'Expressed Emotion' showing that negative, hostile or over-controlling attitudes within the family (and health services in fact) can worsen mental health problems or cause re-occurence.

The need for social and legal inclusion for everyone was highlighted, including for service users or for migrants (including from outside the EU). As was the need to be sensitive to the terms and concepts with currency in different settings. In hindsight, perhaps more could be said about working within communities, reaching out collaboratively to different cultures, religions and lifestyles. The phrase "work-life balance" was never used. And perhaps need more on the vital importance of good suitable housing, especially for those with particular mental health problems.

The Continuum and The Conditions

The public health people naturally saw everybody on a continuum, whereby everyone's mental health can be more or less positive or problematic. I double-checked whether those seen as having a psychiatric condition were being viewed as on this same continuum, and the answer was a cautious but clear yes. I was worried that others seemed to be promoting a hardline concept of discrete mental illnesses, however, where 'quality of life' was the only hope. On the other hand, they also talked about not neglecting the people they were putting into those categories, which of course I supported. How to get the balance right?

I felt there was a need to challenge unqualified statements about clear-cut medicalised illnesses, and that the EU documents should acknowledge important alternative (scientific and experiential) viewpoints. It seemed that ENUSP could have an essential role to play in pulling psychiatry in from its extremes - perhaps most effectively by highlighting the common 'spectrum' approach to diagnoses (e.g. Depression from severe to moderate to mild, the Bipolar Spectrum, the Autistic Spectrum). And drawing in public health people by, for example, highlighting that psychiatric spectrums blend into each other and into the continuum of the general population (I gave the example of 'schizophrenia' and the 'schizotypal' trait, although there are better ones).

Individuality and Stigma

I argued that it is important not to over-pathologise people or force services on them. I gave the example of the work of voice hearers in the Netherlands showing that many see themselves as simply different and are successful in this context, and the example of people who are more stress-sensitive than average who can flourish in the right environments with personal control. I argued, along with others, for a need to respect difference and diversity in the EU.

The pharmaceutical representatives argued that we should "emphasise the burden' and that "health is wealth". I agreed that it is essential to highlight the need and the collective benefit of providing resources, but that loaded terms like this can also stereotype and stigmatise individuals. I pointed

out that people make great contributions despite mental health problems or because of associated qualities. They didn't seem to care about this, so I was so heartened when the public policy people made it clear that they did. They also spoke of the potential stigma caused by labelling particular groups of people as 'vulnerable', and that this can distract from the fact that it is their situation, or the acts of others, that are the real problem. Fantastic. It was suggested to talk instead about a gap (between current and potential) and about inclusion.

Pharmaceuticals present, but where is the psychosocial?

I felt a heavy presence of those representing or trained in pharmaceutical approaches - and hardly any apparent presence of those representing or trained in the equivalent psychosocial approaches. On the first day there were two representatives in our small subgroup from the European Federation of Pharmaceutical Industries and Associations (EFPIA), but no equivalent psychosocial organisation (thankfully the public health representatives were there).

The representative of older people reported a lack of psychotherapy options, and the need for user-friendly 'tool kits' on mental health was proposed. I suggested that cognitive-behavioural, interpersonal and other approaches seemed to be relatively neglected in the plans and that the dissemination of self-help/self-management techniques to a wider audience seems a major way to promote mental health and prevent the (re)occurence of problems. I pointed out that evidence-based self-help resources are increasingly available and the EU could support them (including, for example, through public libraries or the internet). This level of action seemed to be falling through the gap between psychiatry and public health. I felt that ENUSP could be vital in making sure this area isn't neglected.

It was argued in the plenary session that more work was needed on the (36) indicators proposed to monitor mental health in each country. I mentioned in the subgroup the current proposal to count the number of mental health staff in the three categories of "psychiatrists, child psychiatrists; other professionals" and had wondered if it might be a joke. This must be a complicated area and I assume it will be addressed in the third consultation in May on information, data and knowledge in mental health.

EU Mechanisms for Action

There was clear agreement that the EU needed a single coherent mental health policy. Important themes were the need to connect up different policy areas and departments and to use existing laws (e.g. on disability, discrimination). This is all part of 'mainstreaming' mental health. A process to screen other policies for links to mental health is now underway, with suggestions called for. "Don't underestimate the latitude of other [EU sectors] to act when they are on board". The resource and staffing limitations of the commission were also pointed out, however. I believe the suggestion (I couldn't say for sure!) was for 'recommendations' or 'communications' on mental health at this stage, rather than new directives or regulations.

Involving people with particular mental health problems

The pharmaceutical representatives talked about the need to 'scale up' research. I cautioned about the need to involve service users, and that ENUSP had made an offer to help the EU achieve this. I also later argued that, just as policy can be ethnocentric or gender-biased, so it can be biased if it is made only by those at the higher end of the mental health continuum, for which there was agreement. The next two consultation meetings seems most relevant to this issue.

The task ahead

Back in the main hall, the discussions of the subgroups were summarised. It seemed difficult for some points to come through clearly when out of context. The research subgroup seemed to report some positive things - addressing social as well as genetic factors and the interactions between them; the problems with public trust if policy is seen to just involve researchers and politicians (sadly, they did not mention the influence of the pharmaceutical industry); and the need to work with different media. The member state subgroup appeared positive, mentioning a need for policies to take into account differences between countries. The presentations and full reports will be circulated in due course. The EU organisers seemed keen to hear from more organisations and to disseminate information as widely as possible.

Personally I felt too intimidated to add anything in the plenary sessions. This seemed unavoidable, although it didn't help when my table was shaking as the psychiatrist next to me aggressively made his points to the assembled representatives. Perhaps I could have asked someone to say something on my behalf.

Mental health issues are far from just abstract topics for those whose lives have been most affected by them. On my flight back to London, looking down at the blanket of cloud, I couldn't quite believe what I'd just been able to do, thanks to ENUSP. I felt relieved, stressed and a bit overwhelmed, but happy about the good things I had heard - especially from the public health people (it felt like the cavalry had arrived). I thought about things I wished I could have said. The aspirational words of the WHO observer stuck in my mind - "The sky is the limit". But we must make sure that the grassroots are not forgotten.

Website for EU Commission Mental Health Green Paper:
http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm

Related documents handed out at the meeting (and see website):

Green Paper :Improving the Mental Health of the population: Towards a strategy on mental health for the European Union (2005)

The State of Mental Health in the European Union (2004)

Action for Mental Health: Activities co-funded from European Community Public Health Programmes, 1997-2004 [Apparently it is not too late to influence the 2003-2008 Action Plan]

Actions against depression (2004)

Background briefings on mental health topics