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# The European Mental Health Integration Index: reflections and conclusions

## Abstract

*This paper is by one of the expert advisors to the development of the Mental Health Integration Index (MHII) (2014) a recent Europe-wide survey on mental health and integration and the policy and provision for supporting people with mental illness. The MHII serves to provide facts on integration in order to inform policy development.*

**Method:** *Data gathering and interviews with key policy makers in 30 countries in Europe (the EU28 plus Switzerland and Norway). Data gathered enabled the production of an 18 indicator benchmarking index ranking the 30 countries based on their commitment to integrating those with mental illness.*

**Results:** *The main findings were: mental illness exacts a substantial human and economic toll on Europe, and has a substantial treatment gap. Germany's strong healthcare system and generous social provision put it at the top of the index. The UK and Scandinavian states are not far behind. The lowest-scoring countries in the index are from Europe's south-east, where there is a long history of neglecting mental illness. It has to be said though that the leading countries are not the only sources of best practice in integrating those with mental illness. Employment is the field of greatest concern for those with mental illness, but also the area with the most inconsistent policies across Europe. Real investment separates those addressing the issue from those setting only aspirational policies. Europe as a whole is only in the early stages of the journey from institution- to community-based care. Lack of data makes greater understanding of this field difficult.*

**Discussion and conclusions:** *The author reflects on a selection of the findings and considers areas for future concerted actions across Europe.*

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## Social inclusion and mental health

The concepts of social exclusion/inclusion emerged in the 1970s and 1980s in Europe, where social exclusion figured prominently in policy discourse, developing on from the concept of poverty. Social inclusion was popularised in 1997 in the UK by the Labour Government of the day, which established a coordinating policy body called the Social Exclusion Unit (SEU 1998) [1]. In recent years social inclusion has gained considerable currency internationally: being a focus of social policy in diverse countries such as Australia, Brazil, Canada, Indonesia, Macedonia and Nepal. The concept relates to all societal groups including children, ethnic minorities and migrants, older people, people with mental health problems or physical

disability, and unemployed people. It also encompasses diverse societal systems such as public health, social care, education and criminal justice.

While the concept of social inclusion is a contested one, for the purposes of the present paper we accept the World Bank definition. "Social Inclusion (SI) refers to promoting equal access to opportunities, enabling everyone to contribute to social and economic program and share in its rewards" [2]. Social inclusion is widely agreed to be:

- relative to a given society (place and time);
- multi-dimensional (whether those dimensions are conceived in terms of rights or key activities);
- dynamic (because inclusion is a process rather than a state); and
- multi-layered (in the sense that its causes operate at individual, familial, communal, societal and even global levels).

Social inclusion has been defined in the European Union (EU)7 as 'a process, which ensures that those at risk of

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poverty and social exclusion gain the opportunities and resources necessary to participate fully in economic, social and cultural life and to enjoy a standard of living and wellbeing that is considered normal in the society in which they live. It ensures that they have greater participation in decision-making, which affects their lives and access to their fundamental rights (as defined in the Charter of Fundamental Rights of the European Union) [3].

### **Why the topic and the MHII are important**

Psychiatric patients are defined by contact with psychiatric services, but most mental disorder never reaches the psychiatrist. Mental ill-health is a major worldwide public health problem. The WHO (2010) [4] reported that mental illnesses are the leading causes of disability adjusted life years (DALYs) worldwide, accounting for 37% of healthy years lost from non-communicable diseases (NCDs). Depression alone accounts for one third of this disability. The WHO report estimates the global cost of mental illness at nearly \$2.5T (two-thirds in indirect costs) in 2010, with a projected increase to over \$6T by 2030.

Every organisation in the EU is affected by mental distress and ill health in the workforce. The total cost to employers of mental health problems among their staff in the UK alone is estimated at nearly £26 billion each year; the business costs of mental ill health consist of: £8.4 billion a year in sickness absence. This adds up to 70 million lost working days a year, including one in seven directly caused by a person's work or working conditions; £15.1 billion a year in reduced productivity at work; and £2.4 billion a year in replacing staff who leave their jobs because of mental ill health.

Again in the UK almost one in five days of certificated work incapacity are due to mental illness alone, and 40 per cent of reports of adverse health effects at work are attributed to emotional problems. Mental illnesses are common, disabling and expensive. An estimated 38% of residents of the EU, or around 165m people, are affected by a mental illness at some point in any given year; however, only about 25% of those affected get any treatment at all. A mere 10% receive "notionally adequate" care.

A UK government report on mental health and social exclusion identified adults with mental health problems as one of the most excluded groups in society. It acknowledged the causal and consequential relationship between social exclusion and mental ill health and recognised the role of health and social care services and others such as employment, education, leisure and housing services, and the wider community, in promoting social inclusion and enabling people with mental health problems to regain the things in life that they value.

Others have pointed out that the alleviation of symptoms alone will not necessarily lead to reinstatement of former valued roles, relationships and lifestyles [5], and have called for mental health professionals to embrace recovery and social inclusion as treatment goals.

The extent of social inclusion is, therefore, one of the key indicators of the success of mental health policy and services. The measurement of social inclusion at the individual and societal level is essential in this context. Our most recent measure, The Social and Communities Opportunities Profile (SCOPE) is being used in services in the UK and Australia, and is currently being assessed in mental health NGOS in Hong Kong (SCOPE-C). In all of our QOL and inclusion instruments we recognise that the material environment is very important for individual quality of life and well-being, but also that people's subjective appreciation of their position in their societies and communities is as important and an essential source of data. The indicators in the MHII follow this principle. The following sections comment on the major dimensions of the MHII report.

### **Opportunities**

Although employment ranks highly for those people on the road to recovery, policies across Europe are highly variable. The author has been involved in systematic reviews of the value of different methods of improving people's participation in employment, working with Gary Bond and others in the USA. In this connection, the author spent nearly 25 years on research in Boulder Colorado with friend and colleague Richard Warner, the results of which revealed the importance of gainful and meaningful activity for people with the most severe illnesses and how this feeds into their recovery process (as the GAMIAN survey shows) giving people access to financial and social capital leading to inclusion. Work is, of course, important in its own right for the development of self-esteem, a sense of purpose and feeling valued. We need to be aware, however, of the stresses caused by the workplace, and the economic costs of days lost to production. Employers' awareness of mental health issues is another important factor on the road to social inclusion.

### **Access**

Accessing care and treatment is the second of the Index's four major dimensions. As the MHII also shows, and as we found in our own nationally representative survey in the UK, the people who have most inclusion difficulties are actually those people with common mental disorders, the anxieties and depressions, who are often untreated and excluded from community activities and participation more generally because of the debilitating nature of their symptoms. The index confirms that many people with common disorders remain untreated.

## Environment

Environment is the third of the index's major dimensions. Of course, societies differ in their environment for people with mental illnesses, and the range of attitudes and practices are culturally very different. As the MHII [6] White Paper points out, the move towards de-institutionalisation is variable across Europe. The author was struck by one of these cultural differences when working for DFID (the UK Department for International Development) in Russia, in a project designed to support the development of community based services in the Sverdlovsk Oblast. Families, professionals, and the patients themselves believed that institutional care was not only justified but it was 'right' that the Russian state should offer this total care. Early research into hospital closures showed that individuals were far more capable and had resilient strengths when they moved into community settings and that a total institution environment denied them these opportunities. Breaking this belief system is a hard won enterprise, and it is not surprising that in Europe and other parts of the world, it remains resistant to change.

## Governance

Governance is the fourth of the index's major dimensions. The index shows many countries now have rights-based policies that include social inclusion as a goal for people with mental health problems, and the right not to be subject to personal or structural discrimination. This is in line with the fifth of the WHO rights charter approach on social inclusions.

Hopefully, the repeat of the index will show progress over time, eventually, in this area.

One of the most interesting findings is that only 7 of the 38 countries are actively embracing the use of what are called in the general health field PROMS, patient recorded outcome measures. I expect that the use of instruments developed by or with services users and which focus on user and carer concerns rather than those of the professional service providers will increase beyond the seven and eventually become the norm. Recently, in a visit to Australia, researchers and practitioners expressed the view that within 1 few years, peer-delivered services would be the norm in the community setting. Again the index can reveal the extent to which this is happening in Europe, provided the data are robust and regularly collected.

## References

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## What to do next

We need to improve data quality, and ensure that the same data is collected in the same way in each country. It would be extremely helpful for policy makers and others, to repeat the index — probably every 2 or 3 years should be sufficient to identify progress

It would be a significant development if we could make use of the index for research to understand first, knowledge transfer — how and why good practices arise and are adopted (the diffusion of innovations) and second how the policies and policy changes directly affect quality of life of individuals in different countries. We need to assign more resources to these tasks.

There is a lack of research data on the inclusion issues faced by people affected by mild to moderate mental illness and this needs to be remedied, by the research community but especially research funding bodies. Policy development should include measures to ensure better integration of people affected by mild to moderate mental illness.

An appropriate level of resources needs to be directed to the factors that will improve social inclusion. A key finding of the MHII is that aspirational policies are inadequate and the best performing countries have dedicated large resources to mental health care. For example, the Polish policy regulations in the field of mental health integration are very good; the problem is that there is no money to implement them. This is why the finding that investment is a proxy for policy and practice is so important. The gap between funding and policy needs to be addressed. Murawiec has suggested that if perfect regulations have been agreed but are not being implemented, policy makers are seriously lagging behind [7].

Combating the stigma associated with mental health problems still needs to be high on the future agenda. The stigma of mental illness not only affects patients; it also affects psychiatrists and other mental health professionals. Efforts are being made in Poland to raise awareness of mental health and combat stigma and seeing a psychiatrist now seems easier than it used to be.

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