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ONE OF MANY LESSONS FROM THE EUROPEAN MENTAL HEALTH INTEGRATION INDEX

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SUMMARY

The Mental Health Integration Index developed by the Economist Intelligence Unit describes and explores the challenges of European countries of integrating people with mental illness into society and employment, within the European Union's 28 Member States, plus Norway and Switzerland. Countries have been ranked according to estimation based on indicators of their degree of commitment to support those living with mental illness into society and employment. The Index is based on a list of indicators including the environment for those with mental illness, their access to medical help and services, their opportunities – specifically job-related - and the governance of the system, including human rights issues and efforts to combat stigma. The indicators were developed in consultation with a panel of independent experts on mental health. Key findings of the research are that Germany's strong healthcare system and generous social provision put it at the top of the Index, with the UK and Scandinavian states not far behind. However, examples of best practice "islands of excellence" in integration are not limited to the leading countries and exists in all European Countries.

The Index reveals also the discrepancy between perfect legislation and poor implementation of it in practice in many European countries. It proposes that the investment figure is a proxy for seriousness in establishing good policy and practice. According to the Index some reform plans including entire national mental health programmes are largely aspirational and are grossly under-funded. Moreover various levels of government responsible for the implementation of its component parts are largely ignoring its implementation. When we consider the legislation as an promise to professionals and people with mental health problems, this promise is largely unfulfilled. The is a need for strong leadership in mental health changes process, policy capacity and real financial investments in the way of The European countries to develop community based mental health services and system of care.

Key words: *psychiatry - Public Health - Integration - communication skills*

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According to Forest et al. (2015) "Health reform is not a one-time event but rather an ongoing process in which long-term policy goals are achieved despite conflicted political environments and frequent changes in public authorities, staff, and consultants. The process cannot succeed without an effective distribution of information about health issues among multiple players and stakeholders." One of such important source of information on the European level is The European Mental Health Integration Index (Economist Intelligence Unit 2014), which was published on 8th October 2014, followed by many other activities like publication of country reports for MHII for Belgium, France, Germany, Greece, Hungary, Ireland, Netherlands, Poland (Economist Intelligence Unit 2015, Huxley 2015), Romania and United Kingdom. The meeting in the European Parliament European (Marking 2014, Murawiec 2015) (Parliament Interest Group on Mental Health, Well-being and Brain Disorders on 19th November 2014) was mostly devoted to the presentation of this report by its principal author dr Paul Kielstra. The Mental Health Integration Index was commissioned by the Janssen Pharmaceutical Companies, part of Johnson & Johnson and undertaken by the Economist Intelligence Unit. The Economist Intelligence Unit is the world leader in global business intelligence. It is the business-to-business arm of The Economist Group, which publishes The Economist newspaper.

The European Mental Health Integration Index (Economist Intelligence Unit 2014) explores the challenges of integrating Europeans with mental illness into society and employment, within the European Union's 28 Member States, plus Norway and Switzerland. The risk of exclusion of people with mental illnesses from the job market is high (Cybula-Fujiwara 2015). Anyway work integration of people with mental illnesses is a very important challenge for modern societies (Pachoud 2014, Rymaszewska 2014), however it still faces many psychological barriers (Laberon 2014). The goal of the psychosocial rehabilitation is also reintegration of the affected person into society (Tavormina 2014, Bouvet 2014, Podogrodzka-Niell 2014).

In the evaluation of the European Mental Integration Index countries have been ranked according to their degree of commitment to support those living with mental illness in social and occupational integration. The Index is a source of much important information about the mental health systems in Europe, the situation of people with mental disorder in the context of their integration into society and many other topics. A complete discussion of this body of work is beyond the scope of this paper, as original sources may provide more comprehensive data (Economist Intelligence Unit 2014, Economist Intelligence Unit 2015, Wittchen 2011) and the situation of the polish health system was also reviewed by Sagan et al. (2011). The aim of this

paper is to focus on one of key aspects of the Index findings, expressed by the chapter entitled: "Real investment sets apart those seriously addressing the issue and those creating "Potemkin policies" which are more façade than substance" (Economist Intelligence Unit 2014), suggesting that that the investment figure is a proxy for seriousness in establishing good policy and practice in wide sense of mental health domain.

The comparison of countries in the index was achieved by compiling a score for each country based on a set of indicators applied uniformly across all 30 countries. The index has a total of 18 unique indicators which focus on the degree of governments' commitment to integrating people with mental illness, and seven additional background indicators on each country. Some of the 18 unique indicators are composites consisting of several sub-indicators.

The 18 indicators dealing with mental health integration fall into four categories, as follows:

Environment

This category considers the presence or absence of policies and conditions enabling people with mental illness to enjoy a stable home and family life. This includes indicators such as availability of secure housing and of financial support.

Access

This category considers the presence or absence of policies and conditions enabling access by people with mental illness to healthcare and social services. This includes indicators such as outreach programmes to ensure awareness of such services.

Opportunities

This category considers the presence or absence of policy measures that help people with mental illness to find work, stay in work, and work free of discrimination.

Goavernnce

This category considers the presence or absence of policy measures to combat stigma against people with mental illness. It includes such indicators as awareness campaigns and policies encouraging people with mental illness to influence decisions.

Each country's score can be viewed at the aggregate level - i.e., as the sum of its scores on all the indicators - as well as at the category level, i.e., as the sum of its scores on the indicators within a given category. In this way, countries can be compared both overall and at the category level.

As an example the access category indicators were:

Assertive outreach

Presence or absence of community-based outreach services and other specialist community mental health services

Mental health workforce

A composite score reflecting the number of psychiatrists, psychologists, mental health nurses and social workers per 100,000 population

Advocacy within the healthcare system

Score reflects whether the country provides funding for advocacy schemes for mental health service users

Access to therapy and medication

A composite score reflecting the degree of access of people with mental illness to various therapies, mood stabilisers and/or antipsychotic medication

Support in prison

Score reflects the prevalence of mental health support measures for incarcerated people who have a mental illness, and for such individuals post-release

The Mental Health Integration Index Expert Panel members were: Professor Peter Huxley (UK), Kevin Jones, (Ireland) Secretary General of the European Federation of Associations of Families of People with Mental Illness (EUFAMI), Pedro Montellano, (Portugal) President, Global Alliance of Mental Illness Advocacy Networks-Europe (GAMIAN Europe), Dr Sławomir Murawiec, (Poland) and Stephanie Saenger, (Netherlands) President, Council of Occupational Therapists for the European Countries.

The findings demonstrate that while there are many examples of good practice across Europe, so called "island of excellence" the whole region has a long way to go before people with mental illness are adequately supported and truly integrated into their communities.

For example data in the index's above mentioned "access" category indicate that availability of therapy and medication is inadequate and that medical services for those with mental illness are poorly integrated: The type of clinicians available for people with mental problems vary notably within countries. For example Germany scores full points for its number of specialist social workers per capita, but surprisingly only 25.4 out of 100 for its number of psychologists. The particular type of services available in country on highest levelis unpredictable as Latvia comes 25th in the access category but is one of only four index states to provide a full range of mental health support in prisons.

The winners in overall score were Germany (85,6 points), United Kingdom (84,1 points) and Denmark (82 points). Poland's results were as follows:

- Overall score: 15th place - 64.1 points;
- Environment: 13th place - 80.0 points;
- Access: 21st place - 45.5 points;
- Opportunities: 9th place - 72.2 points;
- Governance 10th place - 62,1 points.

What can be obviously seen from this ranking by first sight is that there is a discrepancy between ranks

that are very good (9-13 position in the ranking with the scores above 50% of potentially available points) and the access category which is below 50%.

According to Country Report Poland (Economist Intelligence Unit 2015) entitled "a mismatch between policy and reality": "Poland's ranking in 15th place in The Economist Intelligence Unit's Mental Health Integration Index reflects the country's strengths in its official policies. A closer look, however, shows that its result is much less indicative of reality on the ground. Probably more accurate overall is the country's 21st place in the "Access" category, a part of the Index wherenon-policy elements have greater weight than elsewhere. Worse still, despite all the positive ideas in Poland'scurrent National Mental Health Protection Programme (Also commonly translated as the National Mental Health Programme) its implementation is very far behind schedule,and officials are often not bothering to put it into practice at all. The policy's fate reflects a deeper barrier to progress on mental health issues: a large degree of official indifference" – says authors of the report (Economist Intelligence Unit 2015).

The Index highlights strengths and up-to date reforms of the Polish National Mental Health Protection Programme intended to shift the locus of care away froml arge hospitals into the local community care. At the same time it states that the problem, made clear in a damning report published by Poland's public Ombudsman, is that the programe is grossly under-funded and that the various levels of government responsible for the implementation of its component parts are largely ignoring it and most planned indicators of its implementation are far behind.

Two main conclusions from Mental Health Integration Index were summarized by the authors as follows:

- Unexpected in the leading position is Germany, the country with the highest overall score in the index as this country was rarely listed by experts as on the top in this area, but what is important is Germany's strong general healthcare system and generous social welfare provision have many attributes that are helpful to the effective integration of those with mental illness into society. More consistent with the expectations are the countries which follow Germany - the United Kingdom and several Scandinavian states, as they are frequently named as having examples of good practice in this area. The weakest countries in the index are largely from Europe's south-east. According to the authors of the Index this is not merely a result of the need to overcome the legacy of communist-era psychiatric care: Estonia is 8th in the index and Greece, also in the south-east but never in the Eastern Bloc, finishes 28th. It is rather a result of the long history of southeastern region of neglecting mental illness.
- Experts from Germany and the UK readily admit ongoing, substantial problems with their care and integration efforts. On the other hand, because mental healthcare is frequently organized by region rather than at the national level, important "islands of excellence" exist in countries that are in the middle of the index rankings, such as Trieste in Italy, Lille in France and Andalusia in Spain.

But in the context of the main problem we want to signalize in this paper we want to put special attention on three Authors' conclusions of the Index, which are of paramount importance:

- Consistency pays off. A regards countries from the top in the index, Germany, Norway and the UK have consistently been looking at ways to improve mental healthcare and integration since the 1970s and 1980s, and for Denmark and Sweden, this started in the 1990s. Moreover, generally those with the highest overall scores tend to do well (The Economist Intelligence Unit 2014).
- "Real investment sets apart those seriously addressing the issue and those creating" Potemkin policies" which are more façade than substance. Overall country scores in the index correlate strongly with the proportion of GDP spent on mental health. To some extent, this connection arises because certain index indicators - such as the number of clinicians - are directly related to such spending. The correlation also exists, however, for index categories where such a direct link does not exist. This suggests that the investment figure is a proxy for seriousness in establishing good policy and practice. Such sincerity of intent is not always present: the area of mental health has many examples of policies - including entire national mental health programmes - that are largely aspirational" (The Economist Intelligence Unit 2014).
- Effective care for those with mental illness includes integrated medical, socialand employment services, but government wide policy in these areas is the exception. It is known that unemployment, social exclusion and poor housing are statistically both risk factors for and consequences of mental illness. The lines between medical care, social care and employment support are therefore blurry in this field. The index, however, shows that just eight out of 30 countries have even collaborative programmes between the department responsible formental health and all of those tasked with education, employment, housing, welfare, child protection, older people and criminal justice (The Economist Intelligence Unit 2014).

LEADERSHIP, POLICY CAPACITY AND FINANCIAL INVESTMENT

There are some important factors that influence changes in mental health systems in Europe, that are crucial to the field of this paper:

- Leadership;
- Policy capacity;
- Financial investment (but not costs).

In case of every country there some questions that should be asked: what is the attitude to leadership in mental health reforms (what are the positions of potential or actual leaders), what about the policy capacity and are the expenses directed to mental health system regarded as investment rather than costs?

Contrary to Forest (2015) opinion that the importance of leadership for successful policy transformation is universally acknowledged, it is not always the case. In many cases potentials or actual leaders are out of the public health system or even expelled, sometimes they move to other countries. But "It is difficult to imagine innovation – significant and relevant innovation – without strong leadership to provide inspiration, guidance, and an overall sense of purpose. The area of health reform is no exception" (Forest 2015). The strong leadership is rather an exception, clearly visible on the "islands of excellence" than a rule. There are many examples of strong leadership and island of good practice in Poland.

The second element, policy capacity (Forest 2015) is concerned with the gathering of information and the formulation of options for public action in the initial phases of policy consultation and development. It touches on all stages of the policy process, from the strategic identification of a problem to the actual development of the policy. The stages are adoption, implementation, and evaluation and continuation or modification. According to Forest (2015) policy capacity is formulated as" the sum of competencies, resources, and experience that governments and public agencies use to identify, formulate, implement, and evaluate solutions to public problems. It is concerned with more than the gathering of information and the formulation of options for public action in the initial phases of policy consultation and development. It touches on all stages of the policy process, from the strategic identification of a problem to the actual development of the policy, its formal adoption, its implementation, and even further, its evaluation and continuation or modification".

Policy capacity in the health domain should combine proved aptitudes for economic and social data analysis and operational research with understanding of medical and health realities – including the sociology of illness and health – and communication skills (Forest 2015). For example there are reports from the literature that the frequency of depressive symptoms increases with the deterioration of income and education and subjective perceived position in a social class (Kim 2014). A similar phenomenon refers to suicidal ideations (Kim 2015). According to the National Longitudinal Survey of Youth 1979 (Quesnel-Vallee 2012) the level of education of the Young people and their parents has an impact on their income an status of their mental health. Life course socioeconomic position and racial discrimination are highly associated with depression (Hudson 2013). The importance of communication skills was found to be important in training programs (Gabay 2015). In the diabetes study of Northern California (DISTANCE) it was confirmed how crucial the communications skills are in the adherence to anti-depressive treatment in diabetes patients (Bauer 2014).

The third element is the investment- cost issue. In the ROAMER projects (Forsman 2014) it was found that public mental health research in Europe is increasing, however it is much better developed in the northwestern Europe countries with a higher GDP. An interesting study showing the relationship between the GDP and the duration of untreated psychosis (DUP) was done by Large et al. (2008). Similar conclusions come from the study by Farooq et al. (Farooq 2009). They found that in the low and middle income countries DUP was negatively correlated with the economic condition of the country (Large 2008). Addressing the burden of mental illness requires costs which are incurred up-front (Economist Intelligence Unit 2014). The interpretation of the actual financial investment are important as they pay-off in the future and indirectly. According to the Index although data covering all aspects of integration were impossible to find, country scores in the index correlate strongly with the proportion of GDP spent on mental health. The Index's access category is based largely on the size of the healthcare workforce and the extent of healthcare services available to people with mental problems and this is closely tied to governments'budgets. It is clear connection in this case and this category sees the greatest correlation between its scores and mental health spending as a proportion of GDP. But the scores for the environment and occupational categories, are also significantly linked to mental health spending per GDP, especially as the latter two focus largely on the existence or absence of policy (The Economist Intelligence Unit 2014). The most likely reason for indirect correlations is "that the amount which countries are willing to spend on mental health is a proxy for how seriously governments take the issues surrounding integration and the extent to which their policies are true political priorities - as opposed to "Potemkin policies", which are more façade than reality." Authors of the Index call this phenomenon 'aspirational policy" by pointing out that in some European countries a field exists where policies are too often aspirational rather than intended for timely implementation. The two examples are Polish National Mental Health Programme 2010 and Hungary's 2009 National Programme of Mental Health. Both of this programmes represented shifts towards better community-centred care, but both lacked adequate budgets. These, however, are only two of more examples and Kevin Jones of the EUFAMI (European Federation of Associations of Families of People with Mental Illness)cited in the report explains that "we look across Europe and see lots of plans at the strategic national levels, but people become frustrated at the lack of implementation." (Economist Intelligence Unit 2014).

CONCLUSIONS

The latter statement brings the notion of psychological aspects of the situation described in the Index. Establishing a good program of reforms can be seen as both declaration and promise. It is the declaration that authorities on different levels (both government, professionals in mental health field and other stakeholders) are aware of the direction for future efforts and promises to both professionals and people with mental health problems to implement strategies to achieve established goals. In Europe the idea of transforming mental health-care from an institution-based, medically focused, clinician directed system to integrated community based system of care and social support is largely based of general consensus. But consensus about that goals does not mean implementation of its rules into practice, as it is estimated that only 10% of affected by mental problems in Europe receive care that could be described as "nationally adequate" (Economist Intelligence Unit 2014). So the legislation is good but implementation is far from being perfect. The promise is not followed by realization of this promise, and that is called "aspirational policy" in the Index. In 2005 the European Commission estimated that roughly three-quarters of legislation relating to mental health provision on the continent was enacted after 1990 (Economist Intelligence Unit 2014). But those promises need financial investment, established leadership and policy capacity. According to authors of the Index one of the Index's most surprising findings show little has been done. Considering Europeas a whole, even the relocation of care away from psychiatric institutions remains a work in progress. Moreover, as Ms Stephanie Saenger of Council of Occupational Therapist for the European Countries (COTEC) points out: "Closing hospitals has consequences", as it requires the creation of alternative structures to provide care and accessible services to care for those with a mental illness. Progress in this area in Europe has been even slower than deinstitutionalisation, leaving service users to fall between the cracks in some areas (Economist Intelligence Unit 2014).

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Sławomir Murawiec served as advisory panel member for the indicator and scoring system for the The Intelligence Unit.

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