Mental health in the enlarged European Union: need for relevant public mental health action

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On 1 May 2004 ten new countries will join the European Union (EU), which as a result will comprise 25 culturally quite different countries. Each enlargement of the EU so far has been a difficult experience for both the existing member states and the new entrants, since each membership change has altered the structure and the sharing of costs and benefits of membership. Furthermore, each new member brings its own traditions, preferences, strengths and weaknesses, including the mental health of its population and its psychiatric services. Are we ready for the changes to come?

MENTAL HEALTH IN THE EUROPEAN UNION

The European Commission has already recognised that mental health problems are of major importance to all societies and to all age groups in the EU. It has been agreed that mental health problems are a significant contributor to the burden of disease, and that related loss of quality of life can not only cause human suffering and disability, but also increase social exclusion and mortality. It has also been pointed out that stigma in relation to mental health contributes negatively to equality and social inclusion. Accordingly, the needs to collect good-quality data on mental health (valid and reliable across time and across Europe), to support action based on evidence, to promote prevention and appropriate treatment of mental disorders, to aid access to treatment and the integration of people with mental disorders into society, and to raise awareness of the real burden of mental disorders, are all priorities.

Is the European Community action programme for public mental health effective enough to achieve these objectives, especially after the enlargement has taken place? Most probably not. In terms of health informatics, the reporting and analysis of mental health statistics and the quality of public mental health reports leave much to be desired. Access to and transfer of data at EU level will need to be improved. Although the health determinants objectives do cover some aspects of mental health, the health threats programme ignores mental illness almost entirely. Mental health threats that should be covered include surveillance development and integration (the rights of people with mental disorders continue to be violated in the EU, as exemplified by cases exposed by associations such as the Geneva Initiative on psychiatry).

MENTAL HEALTH IN THE NEW ENTRANT COUNTRIES

Why is it so important to anticipate a public mental health initiative following the enlargement? Of the ten new member states, eight are located in central and eastern Europe – Hungary, Estonia, Poland, the Czech Republic, Slovenia, Latvia, Lithuania and Slovakia – and two in the Mediterranean – Cyprus and Malta. Most of these countries are small in both size and population (with the exception of Poland) and also in terms of their economic capacity. The latter factor will undoubtedly have restricted mental health research, which is reflected in these countries' lower number of internationally recognised publications (Table 1). Clearly, psychiatrists from the new member states do not publish

Table 1 Research publications in psychiatry in European member states (new entrant countries in bold type)

Country	Population[1]	Number of publications[2]	Rate $n/10^6$ inhabitants
Ireland	3 786 900	84	22.18
Finland	5 176 220	53	10.24
Denmark	5 293 000	38	7.18
Sweden	8 872 294	54	6.09
Luxembourg	438 500	2	4.56
Austria	8 110 200	31	3.82
Malta	**385 809**	**1**	**2.59**
Estonia	**1 369 515**	**3**	**2.19**
Germany	82 187 616	179	2.18
Netherlands	15 925 513	32	2.01
France	59 079 000	92	1.56
UK	59 755 660	80	1.34
Lithuania	**3 499 536**	**4**	**1.14**
Greece	10 645 000	12	1.13
Slovenia	**1 977 229**	**2**	**1.01**
Belgium	10 161 000	10	0.98
Czech Republic	**10 272 503**	**9**	**0.88**
Spain	40 173 504	35	0.87
Latvia	**2 372 984**	**2**	**0.84**
Hungary	**10 210 971**	**8**	**0.78**
Italy	57 761 956	39	0.68
Poland	**38 646 200**	**14**	**0.36**
Portugal	10 210 553	3	0.29
Slovakia	**5 400 679**	**1**	**0.19**
Cyprus	**693 789**	**0**	**0.00**

1. Population in July 2000.
2. Publications found using query [NAME OF EU COUNTRY] and PSYCHIATRY in the Science Citation Index and the Social Sciences Citation Index for the years 1994–2004.

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as frequently as their EU colleagues, and the size of the population cannot be the only reason.

If we look at the content of these publications, it is clear that they concern different mental health problems. The best way to explain this difference is by looking at official mental health indicators: for example, looking at deaths from suicide, five of the new member states rank among the top nine countries in Europe in terms of suicide rates, which are well above those in the rest of Europe (26–44 per 100 000 per year *v*. well below 20 per 100 000 per year in the rest of the EU, with the exception of Finland, which has a rate of 22 per 100 000 per year; World Health Organization, 2003). The figures for alcoholic cirrhosis are equally bleak. Alcohol misuse and suicide represent important aspects of public mental health that will require greater attention as a consequence of EU enlargement.

Prevention of suicide and alcohol misuse will not be the only relevant aspects of public mental health. Better understanding of the differences and similarities between mental health indicators in the current and newly joined member states will also be needed. As Kleinman & Becker (1988) pointed out when presenting the concept of sociosomatics:

> 'Social context gets integrated into mind and body understandings. Mind and body interactions are reframed as mind and body in social context. The direct impact of social context upon bodily or illness experience is expected: psychophysiologic processes are shaped by social forces and patterns of symptoms are identified as local idioms of distress and cultural syndromes'.

EUROPEAN PSYCHIATRY AS CROSS-CULTURAL PSYCHIATRY

This concept is becoming increasingly important for the cross-cultural understanding of mental health in the EU following its enlargement.

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A great degree of support and coordination will be needed if diverse and worrying mental health problems are to be tackled appropriately. The EU could start thinking about creating new agencies to tackle public mental health issues. We have already seen the effectiveness of the European Monitoring Centre for Drugs and Drug Addiction in Lisbon. Similar agencies could cover other relevant public mental health concerns, such as suicidal behaviour or premature mortality related to mental illness. For example, about 70% of deaths from suicide occur in people aged 25–64 years, which are from the socio-economic point of view the most productive years. Such deaths impose great economic burdens on society through lost future productivity. Suicide claims substantially more life years and more future personal income during the age interval 20–64 years than either of the two 'major killers', cardiovascular disease and cancer. The average number of years of productivity lost through suicide is twice the number lost through cerebrovascular disease and ischaemic heart disease. In Slovenia – which is only fifth in the new table of national suicide rates in the EU – death from suicide accounts for the greatest loss of future income (Šešok *et al*, 2004); suicide in Slovenia is:

(a) the leading cause of future lifetime income lost;

(b) the leading cause of valued years of potential life lost;

(c) the second leading cause of working years of potential life lost, with an average number of 21.7 years per person who died prematurely;

(d) the second leading cause of premature years of potential life lost (29.7 years per person who died prematurely);

(e) the third leading cause of premature death (rate 15.9 per 100 000 inhabitants aged 0–64 years).

Bearing this in mind, would it be too daring to plan to set up a European Monitoring Centre for Suicide and Attempted Suicide?

The accession of ten more countries to the EU will expand its borders from Sweden to Greece and from Ireland to Lithuania. Many of the central European countries have former political and economic ties that extend as far as Asia, and will bring a new slant to traditional European thinking. At such a moment there should be a journal to play a 'bridging role' between these merging parts of the world. One way forward for the *British Journal of Psychiatry* would be to commission research reports from more familiar and less known parts of the world at the same time and in equal measure. This would in turn help research coordinators in Britain and elsewhere to involve as many reliable research teams from around the world as possible. Contemporary scientific funding (e.g. the Sixth Framework Programme) continues to promote multicentre research activities across Europe, and the more new member countries are involved, the better.

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