Mental Health Inequalities in Europe - Government Action to Tackle Mental Health Inequalities

An Associated Event of the UK Presidency of the EU Health Programme

Radisson SAS Hotel, London Stansted Airport, UK

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The second day of a two-day seminar on Mental Health Inequalities in Europe, held at the Radisson SAS Hotel, London Stansted Airport, UK, on 7-8 November 2005, was dedicated to Government Action to Tackle Mental Health Inequalities. Delegates from 30 European countries were welcomed to the seminar by the opening speakers.

Addresses by Lewis Macdonald, Deputy Minister for Health & Community Care, Scotland; Dr Matt Muijen, WHO European Office, Copenhagen, Denmark; Mr Jurgen Scheftlein, European Commission, Luxembourg

Lewis Macdonald noted that this year had seen an unprecedented interest in and commitment to mental health across Europe. This was marked by the signing of the mental health declaration and action plan for Europe at the WHO Ministerial conference on Mental Health in Helsinki and at the launch of the European Commission's Green Paper on mental health in October.

It is the Scottish Parliament's firm belief, he said, that addressing social inequalities is the key to tackling inequalities in health and that this is a vital area for European collaboration, sharing, learning and action.

Picking up on the link between social inequalities and health inequalities, Dr Muijen agreed that typically people with mental health problems could be found at the bottom end of society.

The well-being of the whole of society needs to be addressed, he said, but there are groups within it which are particularly vulnerable and need different levels of help. "Equality means that everyone has the right to support but we have to recognise that some people need more than others," he said.

The key area of activity for tackling inequalities lies with governments and the way forward is to continue to build close partnerships between inter-government organisations, like the EC and WHO, and between countries.

Jurgen Scheftlein highlighted the cost to society of mental ill-health. This includes lost productivity, the financial cost of social systems and loss of social cohesion.

"The recent Green Paper stresses the need to adopt a public health approach to mental health with co-operation across all relevant sectors which have an influence on the mental health of the population," he said. "It's not only a task for the health sector. Mental health is everybody's business."

Mental Health Inequalities and their Consequences

Dr Eva Jané-Llopis, WHO European Office and IMPHA Network

A huge difference in suicide rates is evident across different countries, but incidence rises as one goes east, said Dr Eva Jané-Llopis in an introduction to mental health inequalities and their consequences, based on an overview of recent literature and European Studies.

Suicide is also more frequent in lower economic groups, in those poorly educated and among people who rent, rather than own, a house. Differences in psychological distress and other mental disorders are also evident – lower in the Netherlands and Sweden and highest in countries such as Portugal and Italy.

Gender inequalities include higher depression rates in women than men, in particular married women and mothers of small children.

Inequalities start to impact before birth, with poor nutrition in mothers, along with smoking and drinking in pregnancy, related to decreased birth weight, cognitive impairment in the baby, and mental ill-health and substance abuse in adulthood.

Parental separation, poor quality of parenting, and poor education are other indicators for mental ill-health. Poor education, for instance, increases the risk of suicide.

"Those having poor health are also at increased risk of mental disorders," said Dr Jané-Llopis. "For example, people with hypertension, or with diabetes, are up to 30% more likely to suffer depression than those in the general population."

Stress at work is another major determinant for mental ill-health. In a study, more than half of the 160 million workers in the EU reported working under tight deadlines, having to do monotonous tasks and having no control or influence over the work they were doing. This led to high rates of stress and doubled the likelihood of someone suffering from depression. Insecure employment increases the risk for poor mental health more than unemployment itself.

In people who smoke, diagnosis of mental health problems is higher than among non-smokers. This applies not only to current smokers but to people who have smoked in the past. Smoking prevalence is highest in people in lower social classes who live in crowded accommodation or rented apartments, and who are unemployed and under heavy stress - for example, lone parents.

"The consequences of mental ill-health are increased costs to governments, to society, to all of us," Dr Jané-Llopis concluded. However, many policy options to improve housing and education, support in parenting, etc, have shown very striking outcomes on how much we can reduce these inequalities in mental health."

Resource and Service Inequalities across Europe

Dr Shekhar Saxena, World Health Organization, Geneva, Switzerland

The varying levels of resources for meeting common objectives for mental health systems was the starting point of a presentation by Dr Saxena. "The goals are the same but the starting points for countries are very different," he said.

Using data based on WHO's most recent Mental Health Atlas, he pointed out that the number of people who do not receive any help for mental disorders is as much as 80% in some eastern and central European countries.

Mental health law is present in all EU countries except one, with supporting mental health policy at a national level evident in most. Spending on mental health by individual countries varies considerably, ranging from two per cent to 10 per cent of health budgets.

A mental health reporting system operates in most countries and mental health training in primary health care for general health personnel exists in almost all countries.

"It is gratifying to see that European countries have some of the largest numbers of human psychiatrists, psychologists and nurses compared to other countries," said Dr Saxena.

Overall, mental health and social services in Europe are better than in most regions of the world, but they are still insufficient to meet the growing need for them. It should also be noted that inequalities within countries are often almost as large as across countries.

The data highlights three areas in need of special attention. One is increased financial resources, especially for those countries spending a smaller amount of budget on mental health out of the total health budget.

There is also a requirement for more community-based mental health services as opposed to institutional-based mental health services. Europe is proving slow in integrating mental health services into primary care.

"Lastly, we need more systematic information collection across the countries," concluded Dr Saxena. "We need to use uniform indicators so that in coming years we can be much better prepared for monitoring progress and seeing where further inequalities are emerging or lasting."

Cross Government Commitment to Reducing Social Exclusion

Dr David Morris, National Institute for Mental Health in England, UK

Government intervention to tackle inequality needs to be cross-sectoral, connecting to other organisations and their work and engaging communities, said Dr Morris.

Social exclusion has multiple impacts and can result from a combination of linked problems which could include unemployment, low incomes, poor housing, high crime and family breakdown. More importantly, these problems are mutually reinforcing and could create a cycle from which it is difficult for people to escape.

Mental health is a challenge to equal citizenship because it limits integration in several dimensions. Aside from employment difficulties, mental ill-health can lead to harassment and low levels of participation in further education, leisure activities, arts etc. Accessing financial services, such as insurance, is difficult, as is becoming a juror or school governor.

Preventing social exclusion is a key strategy for government action in the UK. Formal policies addressing problems experienced by people with mental ill-health include the National Service Framework for mental health published in 1999. "The first standard in that policy speaks about social inclusion; it speaks about mental health promotion and the need to challenge discrimination," Dr Morris pointed out.

Choosing Health, a recent public health White Paper, talks about many of the issues of contextual importance to any strategy to implement social inclusion, such as consumer choice and the engagement of local communities.

In June last year, the Mental Health and Social Exclusion report was produced after a year's intensive work and evidence-gathering by the Social Exclusion Unit at the Office of the Deputy Prime Minister. "This is a unit that has the role of bringing together government

departments to support 'joined-up' work across government," said Dr Morris.

The report sets out action in six key areas: stigma and discrimination; the role of health and social care; employment; supporting families and community participation; getting the basics right (access to decent homes etc); and making it happen (clear arrangements for leading the programme and maintaining its momentum). A range of projects is now under way in all of these areas.

"Although social inclusion is a simple value, we are trying to implement it in a complex system," said Dr Morris. "And when you try and implement simple values in complex systems, you need to be able to impact on the system at many different points at the same time. So the programme that we developed is an architecture intended to deliver that."

That architecture includes a central cross-government team, non-Government organisations, user groups, professional organisations and many other bodies.

"We have a lot to learn from each other about the cultural norms, the approaches we take as mental health policy-makers and providers, the way we think about community and the way we think about the people we help," Dr Morris concluded.

Cross Government Action on Mental Health in Albania

Dr Santino Severoni, WHO Country Office, Albania

Sharing the experience of working to implement health reforms "in a difficult country with seriously undermining infrastructures" was the aim of Dr Santino Severoni.

Albania, he said, is a small country with a small population of about 3.2m. The economy has been growing fast in the last 10 years, but started from a very low baseline. A quarter of the population is considered poor and 5% extremely poor. About 40% of the population is aged under 18, so it is "a country with hope, with a future, but still with quite major public health problems".

The past 10 years has seen three major crises which have "disconnected" the government infrastructure. One of these is the impact of the Kosovo conflict when half a million refugees arrived into Albania "almost overnight".

Migration brought the government and ministry of health new problems to address, such as HIV, sexually transmitted diseases, psychological trauma, and drug abuse.

Lack of infrastructures, institutions, human resources, funds and corruption all presented

problems. "In a country that has to face so many difficulties, one has to understand that the health sector is going to be marginalised," said Dr Severoni.

However, with recent restoration of stability, reform programmes are back on track. Co-ordinated structures, vital for strengthening partnerships, for better monitoring, and for better implementation of the global commitment to better mental health services, are beginning to be put in place.

Placing patients at the centre of the health system, refining the roles of the public and private health sector, reforming the system of paying hospitals and paying doctors and other professionals, and improving the quality of services are all part of the government's agenda.

The urgent need to address mental ill-health is recognised. The aim is to establish a modern mental health care system in Albania by improving and consolidating the quality and efficiency of mental health services. This is being tackled at legislative, policy and service provision level.

Dr Severoni described his country's ongoing

revision of its mental health act as a road map for the reorganisation of mental health provision and a way of affirming the principle of better services, fighting segregation, social exclusion and full respect for human rights.

Meanwhile, lack of human resources continues to pose a challenge. The number of doctors and nurses in Albania is still far lower than the European average.

Tackling Exclusion and Discrimination – action on European, national and local level

Promoting Social Inclusion: Moving beyond the Health Sector

David McDaid, London School of Economics, London, UK

"Think broad and think beyond health," was the key message from David McDaid. "We know that the consequences, costs and risk factors for poor mental health are broad, therefore it is only logical to assume that the policy responses need to be equally broad."

While people with mental health problems can be vulnerable to social exclusion, it is equally important to emphasise that those individuals in the community who are marginalised are themselves vulnerable and exposed to stresses that can increase the risk of mental health problems.

The personal costs of mental health problems include lost opportunity to work, poor health, stigma and discrimination, but there are also significant costs to health social care systems and other sectors.

The London School of Economics, supported by the Gatsby Charity Foundation in England, has reviewed literature on the links between social exclusion and mental health between 1948 and 2003.

"One of the key things that comes out of this is the importance of an individual social network, whether it be family, community or work colleagues," said David McDaid.

There is also steadily increasing evidence of a link between investing in good quality housing/urban regeneration and improved mental health. Several countries have taken action in this area. In Malta, for example, independent housing for three to four people is provided with the rent paid directly by the government. Individuals are encouraged to empower and support each other.

"The important thing is to be moving beyond simply trying to improve housing," said David McDaid. "There is clearly also a need to be working with other sectors to try and deal with issues around promoting community development and reducing social exclusion within communities themselves."

There are many initiatives to tackle social isolation in communities and the key to their success is working across sectors.

"We need to think not just about those people who already have a mental health problem; we need to think about trying to reduce the risk of people developing mental health problems by dealing with social exclusion factors that can lead to poor mental health," David McDaid concluded.

Legislation for Social Inclusion & Promotion of Well-being

Mr Gregor Henderson, Scottish Executive, Scotland, UK

The Scottish Government's vision to improve the mental health and well-being of everyone living in Scotland is supported by a policy framework designed to update modern mental health policy.

"For too long mental health policies in many countries have started from the premise of mental illness treatment services and not extended beyond that," said Gregor Henderson.

"In Scotland we have tried to adopt a comprehensive approach to mental health policy. This covers legislation and the need for a high-quality care and treatment service, but also extends to looking at ways of improving the quality of life and social inclusion of people with illness. Beyond that we have a population approach to promoting positive mental health and well-being."

Local authorities now have a duty to promote social development and well-being of those who have experienced, or who are currently experiencing, mental illnesses. This is an important legislative force because it has implications about access to arts, culture, recreation, education and training, and gaining and sustaining employment.

Support action on discrimination includes a national anti-stigma campaign. This is about creating public demand for changes in the way in which the lives of people with mental illness are thwarted by having fewer opportunities and being socially excluded.

A "very poor sense of mental health literacy in Scotland" is being addressed by training and informing people about common mental health problems. By 2008, 40,000 people in Scotland will have been trained in mental health first aid – a simple, easy-to-deliver, quality-assured, 12-hour programme.

Support for social inclusion includes funding for the Scottish Arts Council to take forward an inclusion programme promoting awareness of mental health, mental illness and recovery of people from mental health problems.

Other initiatives include Pathway to Work pilots, which are about getting people off incapacity benefit by health and employment support staff working together to manage conditions.

One lesson learned to date is that legislation helps, but that it needs to be part of a much broader policy approach. It is part of the social justice legislation and not separate from it. Creating separate strands of legislation is not the answer. They all have to be pushing in the right direction.

"We need to be working in partnership, engaging others and never giving up, because this is an incredibly long term agenda," said Mr Henderson.

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MENTAL HEALTH INEQUALITIES IN EUROPE - DAY TWO
ASSOCIATED EVENT OF THE UK PRESIDENCY OF THE EU HEALTH PROGRAMME 7-8 NOVEMBER 2005

Mental Health Images & Realities: Theory into Practice

Dr Jean Luc Roelandt, WHO Collaborating Centre, EPSM Lille Métropole, France

Results of an international study to assess psychiatric stigma, called *Mental Health and General Population Images and Realities*, was the starting point for Dr Roelandt's presentation.

The study confirms that psychiatric hospitals are still perceived as a place where mentally ill people should be locked up – the only place they can be cared for. "In the public's eyes, the image of a psychiatric hospital image overlaps that of prison," said Dr Roelandt. "For the general population, the lunatic and mentally ill is always 'somebody else' but me. The only illness they can imagine is depression and they believe that people suffering from this can be cared for at home with the help of a GP."

One way to tackle stigmatisation is to change psychiatric services organisation and place them close to the population. Prison and hospitals should not overlap their practices any longer. Family and users should be involved in care because they are the first available support for clients.

"Above all, fighting stigma means to accept that human and civic rights are inalienable and that psychiatric disorders can never invalidate them," said Dr Roelandt.

In Lille, these beliefs are put into practice. Mental health is everybody's business and specialists and non-specialists in psychiatry and social exclusion work together. Users, families, local people, social and health workers are involved in how the service works and have access to information on illness and treatment. Therapeutic workshops are open to the public and municipal, artistic and cultural service are open to people with mental health problems, where they mix with the general population.

The great majority of people are not hospitalised but cared for at home by General Practitioners and chemists. Host families are used as an alternative to admission instead of full time beds. Each year 2000 people are cared for by the service. Only 13% are admitted - for a very short stay - within an open ward. Sometimes nobody is admitted. All services are integrated into community facilities. This is so-called 'citizen psychiatry'.

"This de-stigmatisation work is just the beginning; a lot is still to be done," said Dr Roelandt. "Twenty years of fighting something is a very short time when it comes to 200 years of psychiatry hospital habits.

"The image of mental health changes when the practices change. The most difficult task is to convince the psychiatric professionals to dare to open their practices and start networking in the community with all partners. Raising population awareness is the place to open the real debate about madness and mental illnesses."

The Potential for Social Firms to Provide Employment Opportunities

Dr Roberto Mezzina, Trieste Mental Health Services, Italy

The enormous effort it takes for people with mental health problems to come back from a situation where they lack freedom, have lost rights and been denied resources was highlighted by Dr Mezzina. "Recovery, therefore, has to do with the restoration or reconstruction of citizenship rights," he said.

The concept of rehabilitation in Trieste is conceived alongside a programme of restoration of full rights and citizenship. The town has 250,000 inhabitants and four community mental health centres which are open 24 hours a day. They have beds and are designed for easy access. One small unit in Genoa hospital deals with emergencies at night.

Running a mental hospital in 1971 cost more than twice as much as the current services, said Dr Mezzina.

"It is possible to live in a town without a psychiatric hospital and to shift from institutionalising people to offering them fully community-based services," he said. "These services are without barriers - they are immersed and integrated in a community and they offer easy access.

"This practice in mental health care ensures a high level of freedom and follows the principle of respecting the power of users. Care has shifted towards the idea of the individual being in the centre of the system."

Dr Mezzina also described the strong movement to set up social co-operatives in Italy. At least 30% of the people co-operatives employ have to be so-called disadvantaged members of society. This concept is so wide that it includes young people at risk of social exclusion as well as prisoners and people with mental health problems.

A 'social enterprise' strategy reconverted the human and economic resources of the mental hospital in community services; fostered the local administration in delivering resources directly to users (benefits, jobs, housing); promoted the identification of other resources (institutional, NGOs) and laymen available for a creative involvement; and created productive, social co-operatives that offer diversified job opportunities and educational and vocational training with user involvement in the economic and decisional structure of the various enterprises, thereby bridging the gap between labour market and welfare system.

Legislation is helping social co-operatives to be successful. Tax exemptions are allowed to anyone employing disadvantaged members of society and there is a tax reduction for co-operatives renting or buying houses. The co-operative has a democratic and participative structure, so every member has a vote in an assembly that makes all decisions relating to it.

A welfare encouraging, protecting and valorising personal autonomies, as well as social cohesion and inclusion, represents an evolutionary challenge highlighted by the Regional Government.

"The idea is to move towards a welfare community which puts the citizen at the centre of the system of care," said Dr Mezzina. "We think that recovery is, in a way, citizenship and citizenship is a process; it is not a status, it is a practice that we have to ensure day to day through our actions."

Tackling Suicide – action at European, national and local level

Suicide Prevention as part of the Action Plan for the Helsinki Declaration
Dr Ellenor Mittendorfer-Rutz, National Centre for Suicide Research and Prevention of Mental Ill-health, Sweden

In 21 countries during the 80s to the mid-90s, suicide rates in male adolescents increased, making youth suicide a particular public health concern, said Dr Mittendorfer-Rutz.

Strategies in suicide prevention within health services include identification of people with mental problems, improved diagnostics, improved treatment, follow-up of suicide attempts and improved access to health services.

Public health polices target vulnerable groups, increasing knowledge about mental disorder and suicidal behaviour, and changing attitudes towards mental disorder. Several examples of controlling access of means to suicide have proved successful.

"Ideally of course these measures from health care services and public health are combined and integrated to create a successful suicide preventive programme," said Dr Mittendorfer-Rutz.

The first line of suicide prevention is to train GPs to increase their knowledge about diagnostics of depression and treatment. Projects in several different countries have demonstrated the benefits of this approach by showing a decrease in suicides.

An example of a public health strategy that has decreased suicide rates and hospital admissions for mental ill-health comes from Italy where a particularly vulnerable group – the elderly – are supplied with alarm systems to request help. In another project good

results are achieved by simple correspondence (24 contacts within 5 years) with another vulnerable group - suicide attempters.

Examples from former USSR also show that an alcohol restriction programme can decrease not only suicide, but also death from undetermined causes, homicide, violent deaths, accidental alcohol poisoning, cardiovascular diseases and respiratory diseases.

Other examples of strategies that have worked include training hospital staff to modify their negative attitudes towards suicidal people and helping young people through schools to develop coping strategies.

Targeting the access of means to suicide, such as reducing availability of toxic medications and guns, and securing bridges and subways, has been proved to be effective in decreasing suicide rates.

Surveys scrutinising national suicide preventive programmes and strategies in Europe reveal that 13 countries have national suicide preventive strategies. Obstacles for implementing suicide prevention activities include lack of governmental support, financial constraints, lack of co-ordination, lack of specialised staff and under-developed mental health services.

Lessons Learned from a National Suicide Prevention Strategy for England
Mr Keith Foster, National Institute for Mental Health in England

The suicide prevention strategy for England was launched in September 2002 with a target to reduce suicides from 9.2 deaths per 100,000 population to 7.3 deaths in 2009, 2010 and 2011.

The decision on how to develop the strategy was based on statistical evidence of a high risk of suicide amongst groups such as mental health in-patients, young men, prisoners and some occupational groups.

Some of the initiatives being taken forward are based on recommendations from a national confidential inquiry into suicide and homicide by people with mental illness. For example, hanging is reported to be the main means of suicide in in-patient units. These units were asked to remove and replace all non-collapsible bed and shower fittings with collapsible fittings.

The inquiry also outlines the fact that people discharged from an in-patient unit are most at risk of suicide in the following seven days. This highlights the importance of in-patient care plans and working with the community and primary care services to ensure good quality follow-up and continuity of care.

Work to reduce suicides among

young men centres on mental health promotion pilots in three areas in England. These look at ways to encourage young men to seek help earlier and to access support. They include developing websites to signpost young men to services in their local area and improving the emotional literacy of vulnerable groups of young men, such as those passing through the criminal justice system.

"One of the challenges for health and for other services is to address the fact that young men have said they don't use primary care services because they don't have confidence in the confidentiality of the service," said Mr Foster. "So we may be looking at outreach services in places where young men go, such as job centres, high streets and leisure centres, rather than expecting them to come to us."

Other parts of the Suicide Prevention Strategy include a five-year plan to tackle stigma and discrimination and improving search engine facilities on the Internet to make sure people trying to access suicide websites and chat rooms are directed to a supportive site first. The government is also talking to Internet service providers about how it could work with them to restrict access to insensitive and dangerous Internet sites by vulnerable young people.

Tackling High Suicide Rates in the Baltic Region

Dainus Puras, Associate Professor, Vilnius University, Lithuania

Although Lithuania has the highest rates of suicide in the world, especially among men, Prof Puras said it is important not to focus too much on one country because nine of the countries with the highest suicide rates in the world are in Eastern Central Europe.

Lithuania faces many problems. These include how to integrate mental health and public health when major stakeholders are still not particularly motivated to do so, and how to facilitate social inclusion policies and practices in the region when most of the population still prefer social exclusion of vulnerable groups as a remedy for solving problems. How to reduce access to means of suicide in the country, where the most popular method of suicide is hanging, is another problem.

Understanding countries' different backgrounds is important. Fifty to seventy years of totalitarianism in the region means that in Lithuania institutionalisation and stigmatisation of marginal groups are the norm. Public health approaches to mental ill-health and psycho-social interventions are usually still neglected, along with community-based approaches and primary care involvement.
In the last 10-15 years, some efforts towards

change have taken place nationally, but the direction of investments remain based on historical principles, psychiatric institutions and biomedical technologies.

"Finally, due to the new political environment, the WHO conference in Helsinki and the Green Paper, we see a clear need for an evidence-based national mental health policy with

suicide prevention a very important and integrated component of a general policy," said Prof Puras.

The new mental health policy draft proposes a structure of community-based services and psycho-social interventions. One of the greatest challenges will be promoting and implementing the principle of autonomy and participation in users who have lived for many years with very different values "in users who have lived for many years in the environment of very different values, based on dependence and neglect of human rights".

Also featuring among planned developments is a new system of funding for mental health services and a system of surveillance and monitoring of public health and mental health indicators.

"We very much want to contribute to the debate on relations between individuals, civil society and the state," said Prof Puras. "However, the concepts of citizenship and trust in our region were destroyed by a totalitarian system and we have to restore them. If we change the context, we shall be much more effective in our policies and practices and then we will be more successful in implementing them."

"We are now co-operating with regions in 16 European countries," said Prof Hegerl. "These regions are establishing local alliances. They are adapting our material, putting together best practice material from all the other partner countries, and they are learning how to apply it to their own country."
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European Alliance Against Depression

Professor Ulrich Hegerl, University of Munich, Germany

Improving the care of depressed patients to reduce suicide was the theme of Prof Hegerl's presentation. He pointed out that depression is a prevalent, recurring and life-threatening disorder. Between 40 and 70 per cent of all suicides are the result of depressive disorders.

An initiative in Nuremberg has been launched to improve the care of depressed patients and to reduce suicide through a two-year, multi-faceted, community-based intervention. Würzburg is being used as the 'control' region against which all results will be compared.

In a four-level intervention programme, the first intervention is in primary care. GPs are supplied with videos on depression to give to patients, so that they can learn about the disorder, how it could be treated and the benefits and side-effects of anti-depressants.

The second intervention is a public relations exercise presenting the key messages that depression has many faces and that it can be treated. Activities in this area include poster displays and press conferences.

Training community facilitators to help people with depression is the third intervention. Local media have been given a 10-point guide on how to report suicides.

The final intervention is support of self-help activities and to give a 24-hour telephone helpline number to patients and families of patients who have attempted suicide.

Results show a 24 per cent reduction in both male and female suicidal acts in Nuremberg. The most drastic methods of suicide with the highest fatalities – hanging, shooting and jumping – show the highest reduction – 53 per cent. "I think the Nuremberg Alliance against depression provides strong evidence that the four-level intervention has been effective in improving the care of depressed patients and in reducing suicidality," said Prof Hegerl.

Interest in the initiative across Germany has led to the founding of the German Alliance Against Depression and many supporting regional alliances. In April 2005, following interest from several other countries, the European Alliance Against Depression was set up.

Next Steps & Action Planning

At the end of the event, delegates agreed on the following conclusions based on the outcomes of the General Health Inequalities Summit held in London in October 2005:

★ Inequalities in health exist in all Member States, with lower life expectancy and health status among those who are poorer, less well-educated and of lower professional status.

★ The causes of the health gap within countries include social and economic factors, such as poverty, education and social welfare, as well as lifestyle determinants.

★ Strategies are needed which address social and economic determinants as well as health determinants.

★ Member States vary significantly in their actions to reduce health inequalities.

★ Efforts should be intensified to collect evidence of effective actions and strategies to tackle health inequalities. These should be shared and disseminated.

★ Member States should do more to develop cross-government and cross-sector policies to reduce health inequalities in a systematic and sustainable manner.

★ Political engagement and action at all levels - EU, national, regional and local - is essential in reducing health inequalities with the engagement of departments across governments.

★ Information on health inequalities and their determinants across the EU is of variable availability and quality. Good quality health information will assist Member States to identify health inequalities, develop and implement appropriate policies and monitor progress.

★ Activity within society should be strengthened and capacity and responsibility should be developed.

★ Service User Groups, NGOs and Public Health Agencies need to be assertive, confident and vocal in challenging governments and in taking a leadership role in collaborative working towards reducing mental health inequalities.

This event was organised by the Department of Health as part of the health inequalities programme for the UK Presidency of the EU in 2005. For further information contact Susannah Rix, UK National Counterpart for Mental Health to WHO at susannah.rix@dh.gsi.gov.uk