Rethinking mental health: a European WHO perspective

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In spite of recent clinical and research advances, an increased burden of mortality and morbidity related to stress and mental ill health can be noted, especially in European societies and populations undergoing stressful transitions and dramatic changes. A societal syndrome, consisting of depression, suicide, abuse, risk-taking and violent behaviour as well as vascular morbidity and mortality, can be observed, reflecting individual psychopathology related to disturbances of the serotonin metabolism as one of the oldest, most basic cerebral instruments of mankind to survive, to socialize, to cope with stress and danger. In a time where mental health professionals look for new and challenging identities, they have a tendency to abdicate from social psychiatric and public health activities in favour of more prestigious positions in brain research, genetics or advanced psychotherapy. A redefinition, reconceptualization and renaissance of social psychiatry seems timely and necessary, responding to the burden, advances and possibilities related to mental health we find today. It should proceed from the reductionism which often has characterized earlier psychosocial and social psychiatric approaches, utilize modern knowledge about neuroplasticity, psychoimmunology, neuropsychology and neurophilosophy, reflect the interaction between environment and structure, nature and nurture, and integrate different areas of knowledge in a holistic public mental health approach. Political decisions and societal solutions can be more or less in line with basic human preconditions. Consequences of failure to respect this already can be seen. A new awareness and responsibility-taking with regard to basic human ethological, physiological, psychological and existential conditions is needed and has to be concretized in innovative public mental health approaches.

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The mental health field in Europe is today in an exciting situation. We are experiencing scientific breakthroughs and developing more comprehensive treatment strategies in psychiatric disorders like psychoses, depressions and dementias. We are starting to understand the psychobiology of depression, aggression and self-destructive behaviour. We are learning about the amazing neuroplasticity of the brain, finding out how physiological wellbeing creates cerebral strength. But we are learning also how adverse psychological, social and existential environments can create structural weakness and long-lasting vulnerability in the brain.

Outgoing from this knowledge, we are experiencing today that curative, protecting and mental health promoting strategies have become feasible, realistic and necessary, utilising possibilities of interdisciplinary co-operation and teamwork, and engaging all sectors of society. We are also starting to learn how to integrate 'humanistic', psychosocial and existential knowledge into 'biological' medical science and vice versa, thus reflecting the inevitable human condition of being body and mind, recognising that there neither is a brainless mind nor a mindless brain, and avoiding biological as well as 'humanistic' reductionism. Recent developments in the field of neuropsychiatry, psychosomatics, stress research, psychoimmunology, and neurophilosophy as well as sociology and anthropology are here in the frontline of scientific progress by overcoming the split between humanism and biology and over-bridging the antagonism between qualitative and quantitative approaches, which for a long time has paralysed scientific progress and the development of comprehensive strategies.

SOCIETIES IN STRESS

But we are also living in a time of great and increasing burden and distress, caused by the helplessness and loss of control experienced by many, and influenced by social exclusion, identity loss, lack of coherence and meaning, existential emptiness and stress. Mental ill-being, especially depression and suicide, and the consequences of risk-taking behaviour and destructive life styles, have become one of the greatest - maybe already the greatest - health care burden in countries of societal transition and in populations at risk (adolescents, elderly, males, females, unrelated singles and rural populations).

A closer look at these societies and populations at risk, involved in dramatic societal change leading to helplessness, identity loss and lack of coherence, reveals a kind of 'community syndrome'. This consists of morbidity and mortality patterns related to depression, suicide, aggression, violence and destructive as well as self-destructive behaviour, which show an almost seismographic parallelism and time relatedness to stressful changes in the society. Knowing what we know today from research on serotonin metabolism as one of the most basic and phylogenetically important systems related to abilities of coping, socializing, fighting, flying and adapting, but also to aggression, violence, personality disturbances as well as cardiovascular diseases, we cannot avoid to identify a 'societal serotonin syndrome'.

In the World Health Report 2001 (1) and in the World Health Organization (WHO) Regional Office for Europe's 'Health 21- Health for All in the 21st Century' policy document (2), ratified by the European member states, the WHO, taking its role as a 'health conscience' to governments and decision makers, stresses mental health as a human right. It underlines the need for multidisciplinary and intersectoral partnership and co-operation, for evidence-based strategies and for community-based approaches, close to the individual and its social and psychological environment.

To facilitate this, the WHO mental health programme of the Regional Office for Europe has chosen three directions: firstly, a focus on the need for assessments and national mental health audits, with respect to the diversity throughout Europe regarding services, lifestyles and physical, psychosocial and existential prerequisites for mental health (we see in these audits an inevitable presupposition for sustainable and realistic national mental health planning); secondly, a focus on stress and helplessness-related morbidity and mortality resulting from depression, suicide and self-destructive lifestyles, with special regard to societies of transition; and thirdly, a focus on the need for destigmatisation and counteracting discrimination.

STIGMA

Nothing creates fear so much and easily as the lack of knowledge. This is why stigma, taboo and subsequent social exclusion in the countries of Europe today is laid on already disadvantaged mentally vulnerable persons. In this stigmatisation we find the greatest obstacle for early intervention and easy, open community-based monitoring and treatment of mental vulnerability, an obstacle which can only be tackled by less ignorance and more awareness, in order to overcome the treatment gap between what is doable and what is done in European mental health services today, counteracting exclusion and discrimination.

However, destigmatisation approaches, necessary in any development towards community-based mental health care, have to be realistic and must not deny the dysfunction and the emotional as well as intellectual distortion more or less temporarily linked to mental disorder. They should neither increase the burden of others, as some of the stigma campaigns considering neurological diseases do, by stressing the 'non-mentality' of 'neurological' brain diseases.

Destigmatisation programs, however, are only long-lasting and sustainable if they are integrated in a comprehensive development towards community-based services and if they focus on the need for pluralism, tolerance and respect for the individual in a democratic society, even if she or he behaves differently.

MENTAL HEALTH POLICIES

Some principles of mental health development appear today as important:

- Experience shows that positive mental health policy development presupposes a self-critical professional but also an ethical analysis of the situation of the mentally ill in the past - in a way, a reconciliation process.
- Mental health service development should be carried out without placing the clients 'out in the cold' - as it has happened in some European countries.
- There should be a constructive amount of consensus, in spite of ideological quarrels and the conflicting interests of the different professions.
- A civil dialog has to be created between professionals, users, families and significant others as well as administrators.
- Ways have to be found to increase awareness about mental health as an important capital in a society and about the costs of 'doing nothing'.

Developing, humanizing and decentralizing mental health services, however, is a tricky task: it is a human right to demand respect for one's integrity, autonomy, and freedom to live one's own life according to the ideals and wishes one could have, even if they are deviant and different. It is our first task to respond to this right. But it is also a human right to have access to professional treatment and assistance, to regain the autonomy, which only can be experienced in a condition free from anxiety, psychosis and fragmentation. To be psychotic is not to be free and everyone has a human right to treatment, help and health. Mental disorder can be as limiting and life threatening as a somatic disease and needs the same careful treatment and monitoring.

It is also a fact that professionalism without humanism is not enough. Neither is humanism without professionalism. Humanism is the prerequisite and the conditio sine qua non for any kind of professionalism in treatment and support to human beings, but can never replace it.

MENTAL HEALTH IMPACT

2001 was declared the year of mental health all over the world. The World Health Day of April 7 has been celebrated in every nation. The World Health Assembly in May has gathered the decision-makers of the entire world, and the World Health Report in October has given evidence to all this and called for action.

Some of the main messages were:

- that mental health can be promoted by intelligent political action based on scientific evidence, that the impact on mental health caused by political and societal interventions must be considered and that no country can afford not to invest in mental health;
- that mental disorder is underestimated, underrecognized, and undertreated, due to stigma, taboo and lack of knowledge;
- that it is a heavy, but avoidable burden, which can afflict anybody, but is preventable and treatable;
- that it can be tackled by community-based services integrated into societies.

Today we also begin to feel that no country can afford not to be aware of the impact of political decisions and policy changes on reconciliation, tolerance and democracy, in due consideration that mental health and peace in a society are strongly linked to each other and that community-based services are the most important instruments to take this into account.

Considering the burden of mental disorders and the morbidity and mortality related to stress and mental ill health, and considering the fact that the vast majority of governments and decision makers allocate less than three percent of their health care budgets to mental health issues, we clearly find that the awareness about the burden of mental ill health and the importance of considering mental health as one of the most valuable capitals of society has to be improved. The impact of any political decision on the mental health of a population should be considered and carefully assessed. No country, even the poorest one, can today afford to do nothing, not to do all possible to invest in mental health and to promote, protect and regain it in its population. However, in order to achieve this, political and public awareness and education, and overcoming of taboos and stigma mechanisms individually, publicly and politically is not sufficient. We also need a renewed responsibility taking of mental health and psychiatric professionals with regard to public mental health issues.

PUBLIC MENTAL HEALTH - A CHALLENGE TO PSYCHIATRY

Today, in Europe's professional societies, there is a continuous struggle for identification and a tendency to strive for clinical and scientific identities in psychotherapy or brain research, genetics or neuropsychiatry, considering them to be the most fashionable ones. The interest for and status of social medicine, social psychiatry and social mental health approaches focussed on promotion of salutogenic factors has decreased and young professionals are seldom encouraged to take interest in public mental health. Psychiatry seems to abdicate from public mental health responsibility. This process is facilitated by the fact that the mechanisms being in place for scientific publication and academic career hardly honour the type of comprehensive research we should need, integrating and connecting the already existing pieces of scientific knowledge and creating holistic and socially relevant synopses.

Modern psychiatry, with its new psycho- as well as biodynamical insights in causalities, complexities and interactions, can ethically not abdicate from interest and responsibility taking about promotional and prevention aspects of mental health. We may need the birth of a new type of social psychiatry, not as formerly reductionistically focusing on solely sociological and psychodynamic theories, but integrating what we begin to know today about the plasticity of the brain, about basic organic and genetically defined mechanisms influencing social behaviour and environments as well as the interaction of nurture and nature.

Mental health impact assessments and consequent analysis of political decisions should become a routine, just as environmental impact assessments today. The social psychiatric question of how a society could be developed, governed and monitored to be kind to human beings' serotonin system may become our future challenge.

References

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