Interest group on mental health 4 December

Report

Antonyia Parvanova MEP welcomed participants and provided some background information on the aims and activities of the Interest Group. She underlined the specific aims of the meeting, i.e.

- To raise awareness of the strong link between physical and mental health;
- To advocate the importance for policymakers to take account of this link in all policies that impact on health, more specifically in view of the upcoming Joint Action on mental health;
- To support the development and implementation of good policy and practice in relation to a holistic approach which incorporates both mental as well as physical health.

She added that the Interest Group has already made its presence felt on many occasions, for instance by ensuring a mental health dimension in the Health for Growth programme. Keeping up this advocacy is important against the background of austerity; while health budgets are being cut generally, this is even more the case for mental health. The Interest Group needs to remain vigilant and act wherever possible to prevent this.

The first speaker was **Pedro Montellano (President of GAMIAN Europe)** who presented the outcome of a GAMIAN-Europe patient survey on the impact of physical problems on mental health patients, building on the work of the Mental and Physical Health Platform. Some 1150 people suffering from mental health problems across 30 countries responded to the survey. Rather than a scientific analysis, the survey provided patients' perspectives on the links between mental and physical health. Main findings:

- 85% of respondents suffer from physical problems.
- 63% of the physical problems were diagnosed after the mental health problems, indicating that the physical problems could be a consequence of the mental disorder.
- Nearly 50% of respondents think that their physical health conditions are linked to their mental health condition or treatment.
- Mental health patients are 2 to 3 times more likely to develop a chronic condition such as diabetes and other cardiovascular risk factors. Only 1/3 has normal weight.
- 41% of respondents have experienced barriers to receiving care for their physical problems.
- The main barriers to receiving care for patients' physical problems is user charges (financial reasons), stigma (fear of disclosing the mental health problems), and lack of referral.
- 39% respondents indicated that their mental health doctor had failed to ask about the medications they may have been prescribed for any physical condition.
- 25 % said that their psychiatrists provided no or insufficient information regarding the potential impact of how mental problems could affect physical health.

The survey was reviewed by a steering committee of patient representatives, and has led to the formulation of a number of recommendations, such as:

- better communication is needed between mental health and physical health professionals,
- mental health and physical health should be integrated ,
- specialist care should focus more on the potential risks of co-morbidity,

- mental health professionals should pay particular attention to the physical consequences and side effects of mental health conditions or treatments,
- There is a need to remove barriers (stigma, finances) to receiving support for physical problems.

The second speaker, **Davy Vancampfort (Leuven)** started his presentation by stating that interactions between physical health and mental health only have emerged as a major issue in the last 5 to 10 years. Until today, the basic needs for patients with mental health problems are still largely neglected, despite the existence of screening guidelines in a number of areas. A recent survey found that the quality of existing guidelines is insufficient to actually guide clinicians. The shared responsibility of screening patients at risk is an important issue. It is clear that high quality guidelines for a closer integration of primary care and mental health are urgently needed.
Davy underlined the importance of the 2009 Mental and Physical Health Platform Charter which calls for better communication and co-operation between medical disciplines, carers, families, service users and policy makers.
The increased risk of death from natural causes for people living with depression, anxiety-related disorders, psychoses, substance misuse and eating disorders can be witnessed by health professionals every day. For instance, studies indicate that in the case of schizophrenia, individuals may die up to 30 years earlier than the general population. Another example: while the risk of dying from cardiovascular diseases in the general population is decreasing -mainly due to rigorous clinical practice guidelines, clear policy changes and effective health campaigns -in patients with severe mental illness the premature mortality due to cardiovascular diseases is still increasing.
Other major concerns, such as the strong link between poor mental and physical health and poverty should also not be forgotten. Individuals with severe mental illness without financial means are less likely to lead healthy lives. Another issue relates to the fact that some mental health problems reduce the willingness or impact on the capacity of individuals in communicating their physical health needs. Next to this, social isolation reduces the likelihood even more that these individuals will seek help for their physical health problems.
In addition, the impact of stigma on the daily care of patients plays a major role. And lastly, pharmacological treatment on its own should be considered a risk factor, as there are the – often severe – side effects (such as weight gain) to these treatments.
Any successful approach to integrate physical and mental health care should target lifestyle risk factors, social support, stigma and access to physical health care for those affected by mental health problems. At policy level, major objectives should be to increase general awareness of the physical health needs of persons with mental health problems and ensure funding for the required service improvements. A recent World Psychiatry Association statement calls on policymakers:

- to designate persons with mental health problems as a health disparity population,
- to stimulate educational programs for the health care community,
- to improve access to and care of physical health of those affected by mental ill-health,
- to initiate campaigns to reduce stigma and discrimination,
- to integrate mental and physical health policy.

Jeroen Nilis was the third speaker, and his testimonial was a powerful illustration of life with a physical and mental problem. Jeroen was born with a rather severe physical handicap from birth and mental disorders and psychoses were quite prominent in his family. His youth and school education period was normal and relatively happy. He managed to get a university degree in 1995 but lost his disability allowance, despite legal battles. His first psychosis manifested itself in 1997. Two other episodes followed in 2005 and 2007; the final one was triggered by the fact that he had stopped taking his medication. While medication did help, it caused huge weight gain as well as an overall feeling of disengagement and being out of touch.
Stopping and restarting medication had a negative effect, but when appropriate medication was found, Jeroen found he could lead a normal life and hold down a job. He undertook action to overcome his psychosis by increasing his knowledge of the condition, physical exercise and gardening and practicing yoga. Eastern philosophies such a Zen-Buddhism and Tao also helped him to come to

terms with his disability; it also helped him to accept that he would always be prone to stress and psychosis. Jeroen now takes his daily medication and is being followed by a team consisting of his GP, psychiatrist and psychiatric home care providers. He is also writing a book, entitled '*Destined to become psychotic'* in which he describes his medical experiences.

The fourth speaker**, Rebecca Muller (Secretary General of GAMIAN)** informed the audience of the June 2012 GAMIAN Regional Seminar, which was dedicated to the links between physical and mental health. On this occasion, 25 patients from 14 different countries exchanged their views and experiences regarding this subject. It was found that stigma clearly plays a role in the lack of awareness and attention in relation to the link between mental and physical health. Mental health professionals, but also patients and their family members should be more aware of this issue and address it more actively. Patients have a right to information about their illness and patients need to be in charge of their own rehabilitation process. They should ask questions regarding treatment and speak openly with their psychiatrist about the prescribed medication, addressing side effects that can impact negatively on quality of life. GP's and psychiatrist should communicate better; having a case manager assembling all information on one patient might help. Some other conclusions stemming from the regional seminar related to the need

- to better train health professionals in relation to the link between physical and mental health,
- for patients to obtain honest and clear info about their treatment and its side effects,
- for health professionals to pay sufficient attention to physical symptoms and should do everything possible to reduce them as this will contribute to the quality of life of the patients.
- to remove the barriers to get help for physical problems:
  - financial reasons (consultation fee of GP)
  - stigma (patients do not want the GP to know about their psychiatric problems)
- for patients to take good care of themselves: take responsibility and assume their part in the treatment, within the therapeutic alliance between patients and professionals.

The next speaker, **David McDaid (London School of Economics)** focused on the outcome of a study carried out by the LSE on the cost of co-morbidity. From previous research; it is a known fact that people with severe mental health problems have worse physical health and life expectancy than the general population. There are some studies from outside Europe that have focused on some aspects of economic impact of the combination of physical and mental health problem; however, to date, little has been done to determine the costs of avoidable physical comorbidity in people with mental health problems. The LSE study therefore aimed to strengthen the evidence base in Europe and estimate the additional costs to the health care system and society of common physical health problems in people with mental health problems. It addressed the additional costs of type II diabetes and all cardiovascular disease and did not include direct costs of poor mental health. The costs were estimated for all EU-27 countries in 2010, looking at individuals with three different mental health problems: schizophrenia, bipolar disorder and major depression. The study consisted of a simulation modelling synthesising data on risk of comorbidity and costs to health/other sectors. Model parameters were identified from literature review including:

- increase in risk of diabetes and cardiovascular disease in each Member State
- cost for all of the adult population (15+) living with co-morbidity
- country specific costs of diabetes and cardiovascular care
- productivity losses due to work absenteeism, premature death and need for family care

The results show that, poor mental health is associated with an additional 3,39 million cases of Type II diabetes (T2D) and 2.36 million cases of cardiovascular disease (CVD) in the EU. The annual costs to EU health care systems of dealing with excess cases of T2D and CVD can be estimated at €11.2 & €5.2 billion (2010 prices). In addition, the costs of lost productivity due to morbidity, premature mortality and need for informal care are estimated to be €10.6 (T2D) & €4.5 (CVD) billion per annum.

It needs to be borne in mind however that not all productivity losses are avoidable as some of these are associated with poor mental health.
Interestingly, the study also looked at the potential economic benefits of achieving a modest 1% reduction in excess risk of diabetes and CVD across the EU. It was found that this could avoid a cost of around €628 million.
In conclusion, David stated that a conservative analysis shows that the cost of physical illness in people with poor mental health is greater than the population average. The economic impact affects women as much as men. Major depression seems to be associated with highest total level of costs; schizophrenia is associated with higher costs per case due to much higher risk of physical health problems. There is a key role of primary care and public health in terms of health promotion and disease prevention as well as a huge need to better co-ordinate mental and physical health care. There is also a need and potential for cost effective actions as well as a need for the careful evaluation of effective and cost effectiveness of strategies to address physical and mental health.

The final speaker was **Juergen Scheftlein (Policy Officer, DG SANCO),** who started by thanking the Interest Group on addressing this vitally important topic. This is important to the Commission as mental health continues to be considered as the underdog. The Commission aims to ensure awareness of the importance of mental health and promotion of prevention and treatment. This was reflected in the work surrounding the European Mental Health Pact, which was designed to convince policy makers and health professionals to look more into mental health issues.
Training of mental health professionals on physical health issues is equally important. The field of physical activity is where mental and physical health clearly comes together.
Juergen provided some examples of EU funded activities which address physical and mental health in a holistic way, such as the ALCOVE Joint Action addressing the improvement of the diagnosis of Alzheimer's disease and other forms of dementia and support to people affected and their carers. Juergen pointed out that because of the Physical and Mental Health Charter, the Commission has issued a call for projects inviting projects addressing both health dimensions to come forward. In response, the HELPS project was co-funded which developed a tool to promote the physical health status of residents with mental disorders, mental disability or dependency living in social and health care institutions.
The Commission's work in this area is now entering a new phase: the focus is on chronic disease. The intention is not to focus on individual disease areas but rather look at all the different diseases in an integrated way. This work is strengthened by the UN Convention on non-communicable disease; there are opportunities to look at commonalities between diseases. Unfortunately, despite the Commission pushing for the inclusion of mental health, the UN Convention focuses on physical illness only. However, the UN will come forward with a global and EU mental health strategy to make up for this lack.
Mental health plays an important part on the non-communicable disease agenda, as there are common ways of preventing and managing chronic disease. The Interest group meeting demonstrates the need to look at the links between physical and mental health and identify where the gains and gaps are. The tendency towards greater integration of care from the hospital to the community brings the two closer together.

<u>Discussion</u>

- The European Parliament has three areas of action, i.e. policy, financial support and legislative frameworks. Legislation is difficult in this area as the health remit of the EU is limited. However, stigma in relation to mental health follows a similar pattern as gender based stigma, so the policy and financial instruments could be helpful. The term 'mental health mainstreaming' was used to describe a process where mental health would be included in all relevant areas of policy development as a matter of course.

- In terms of mainstreaming mental health, questions were raised as to which Commissioner could be most usefully addressed. It was suggested to take a human rights angle rather than stick to a health approach only. Stigmatisation and discrimination might be a more powerful

'hook' for action than public health (e.g. health inequalities). The Charter of Fundamental Human Rights is now part of the Treaty and therefore provides a solid justification for EU action in this area; the Interest Group should follow this through, and prepare some robust arguments for action.

- There are a number of initiatives on the EU policy agenda which are relevant to support mental health mainstreaming such as Horizon2020 and the Health for Growth programme. Different studies and initiatives could be financed by either of those and DG Sanco could stimulate this type research, which would contribute to an evidence based policy approach, strengthening the organisation of health systems and the delivery of health services. Access to physical and mental health care and quality of care could also be the topics of research, as better access saves money in the longer term.

- The Innovative Medicines Initiative is another useful activity to bear in mind, as it is clear that new drugs with fewer side effects are needed as a matter of urgency. Strengthening the health angle of the European Structural Funds is another possibility. Mental health challenges are also increasingly recognised in education policy (e.g. early school leaving and mental health).

- The Clinical Trials Directive, currently going through the Parliament, could also be a good initiative to tackle. If the aims are to ensure a high standard of new medicines with fewer and less serious side effects, drug development should be addressed at the start of the process. The Interest Group could put forward amendments to this effect and should advocate standards in relation to mental health medication and put a throng position forward; as mental health problems are being stigmatised, maybe the same holds true for mental illness medication.

- Other arguments that might trigger action relate to cost aspects; especially in the work place, mental ill health brings along huge costs and productivity loss. Cost effect analysis and the cost impact of stigmatisation can provide good arguments for action.

- The approach should be for the health sector to expand cooperation with other policy domains, as the health sector can support other sectors (if only by ensuring better prevention and management of mental illness).

- At the moment, there is a lot of policy attention for orphan and personalised medicines. However, it might be more practical to focus on those areas where stigma and discrimination are still a major issue, such as mental health. Pharmaceutical innovation is badly needed in this area. Patients need choice of medicines and treatment; treatments should have fewer and less severe side effects.

- Member States are in charge of health services, access to and quality and organisation of health care organisation so this will be difficult to address at EU level. However, national medical associations are quite autonomous terms of professional performance, so working with professional organizations (as well as with academia) at national level might be a useful way forward. What needs to be avoided is duplication of on-going debates and guidelines development processes.

- Questions were asked about how guidelines are being developed and why their implementation and uptake does not always work. This is sometimes related to the lack of knowledge on the side of those who develop them. Sometimes guidelines development is supported by specific pharmaceutical companies and there can be conflicts of interests there. The focus should be on healthy lifestyles rather than on pharmacotherapy only. It is not always clear who is responsible for the implementation of guidelines; prescribers should

also be responsible as they are involved with screening, healthy, access to care and medicines. They have the full overview of the specifics of an individual's situation.

- The Charter that was developed by the Physical and Mental Health Platform lists a number of areas where action could and should be taken. This was adopted 4,5 years ago, and since then, more knowledge on some of the chapters of the Charter has been accumulated; there are additional elements of proof from medical and user perspectives. Despite increased knowledge and ample evidence for the need to take action, the same discussions are still taking place. Priority actions need to be identified and progressed.

- It was also argued that there is an urgent need for better data, as the level of knowledge and the evidence base varies between countries. Robust data are needed if the economic impact of the link between mental and physical health is to be stated with confidence. The LSE study presented in the meeting is a useful start

- While it can be argued that personalised medicine is a thing if the future, it was argued that treatment can already be made much more personal; huge costs savings could already be made. What is required is more information on the pathway of mental illness. Unfortunately, pharmaceutical companies are pulling out of the mental health area. Industry might be in a good position to point out the disparities and gaps, as well as provide information on reimbursement systems for different medicines.

- It would be interesting to see whether different reimbursement regulations are in place for medicines for the treatment of mental health and those to treat physical health . LSE is about to launch a study in this field, looking into the incentives for addressing mental health treatment.

- It is clear that mental health in relation to obesity would be considered part of current EU level actions to combat weight gain and promote healthy lifestyles.

Conclusions

Closing the meeting, Antonyia Parvanova MEP concluded that there is a need to look at many angles that can help address mental and physical health in a holistic way. Gaps in the current EU agenda need to be identified and addressed. Education and training of health professionals and educational social campaigns are possible fields of action. Clearly, medicines for treating mental illness should be improved; patients should have choice and the quality for mental health problems should not be lower than those for physical health problems.