Eur Arch Psychiatry Clin Neurosci (2009) 259 (Suppl 2):S119–S122
DOI 10.1007/s00406-009-0050-0

European psychiatry: needs, challenges and structures

Cyril Höschl

Abstract European psychiatry stays now on the crossroad due to conceptual challenges, drifts of political power from the national to the European level, the current economical situation, arising ethical concerns and an emphasis on patients rights. The latter challenge mainly the structure of mental health care demanding a more important role of patients and families. The needs of harmonisation of research, educational, legislative, and political activities in the field of mental health on the European level are briefly discussed.

Keywords European psychiatry · Mental health · Mental health policy

Psychiatry—a medical discipline or public health service?

Regardless emerging harmonisation and even unification of European policy in various aspects of cultural, scientific, and social life, health care in Europe still remains under the almost exclusive responsibility of national and regional governments. Public health, however, represents an exception, although there are lot of things remain to be grasped from European perspective, e.g., harmonisation of vaccination schemas, hygienic standards, common action in prevention, health protection, and tackling pandemic threats. On the other hand, a lot has been achieved due to the effort of European bodies like DG SANCO (Directorate General for 'Health and Consumers'), the World Health Organization (WHO, [11]), governmental (e.g., ministerial conference in Helsinki [4]), and non-governmental organisations [5, 7].

Psychiatry as a medical discipline on one side shares the fate of other medical disciplines as being regulated by national governments. On the other side, being a profession dealing also with mental health it overlaps with non-medical domains such as social care, wellbeing, consumers' protection, human rights, gender issues, ethics, etc.

Historically, psychiatry in a narrow, medical sense has its limits, which should be clearly defined to avoid its abuse and misuse by political power [3]. Psychiatry as a medical discipline accumulates the knowledge on the relationship of biology and psychopathology. It investigates the brain and its relationship to human experience and behaviour. Psychiatry in this capacity may help to understand the instances in which undesirable social phenomena (addictive behaviour, cultism, terrorism, some kinds of violence) are associated with biological or psychological patterns recognised as a source of psychopathology and lead to disability and/or dysfunction.

On the other hand, social psychiatry is concerned with social influences on human mental health. It is a discipline that allows psychiatrists to understand the relationship between the manifestation, course and outcome of the mental disturbance and social factors. It can provide partial social explanations for psychiatric phenomena. Nevertheless, it cannot provide psychiatric explanations for social phenomena. Psychiatry is not a social service. It does not provide expertise in taking care of the helpless people if the helplessness is the effect of social factors rather than a

C. Höschl (✉)
Prague Psychiatric Centre, 3rd Faculty of Medicine,
Charles University, Ustavni 91, 181 03 Praha 8,
Czech Republic
e-mail: hoschl@pcp.lf3.cuni.cz

C. Höschl
1st Department of Psychiatry, University of P. J. Safarik,
Kosice, Slovakia

disease process. Psychiatry is not a psychological counselling service for the unhappy, unfortunate, weary and dissatisfied. It may tell them that their plight is not a disease but a human condition. Perhaps psychologists and other specialists may be the right professionals to seek for help [3]. During 20th century, these limits of psychiatry were rather obscured and the discipline was several times in its history abused by political power to repress political opponents, minorities, disabled and otherwise socially less adapted or excluded persons [1, 8].

In Europe, and to some extend worldwide, psychiatry has its source in few achievements in medicine of the 18th and 19th century, mainly in Germany (e.g., W. Griessinger, E. Kraepelin, E. Bleuler), France (J.-É. Esquirol, J.-P. Falret, Ph. Pinel, B. Morel), and the United Kingdom (W. Tuke). Since the 20th century, psychiatry developed globally more and more under the influence of North American research progress in neuroscience and related disciplines. These common denominators as well as common challenges of a globalised world justify to some extent our contemporary attempts to find a common way forward.

However, quite recently, reflecting an increasing emphasis on human rights, ethics, and public health, attention was increasingly paid not only to the definition of the disease concept as such of psychiatry, but also to mental health in general, and therefore to issues of quality of life and well-being. This development, together with the emerging European identity, presently results in the development of new needs and challenges of European psychiatry, which seem no more to be just a part of regional health care policies. Thus, keeping in mind the danger of the misuse of psychiatry as a tool of political repression, we are now confronted with the challenge of a re-conceptualisation of our discipline. On one hand, psychiatry is fighting stigma, on the other hand it needs to find a new place in taking care for human beings in all their complexity.

What are the current needs of psychiatry on the European level?

Despite of information technology, we still lack a comprehensive assessment of the quality of psychiatric services and identification of their regional and cultural differences in Europe. The hierarchy of present needs of psychiatric patients are surely different in Moldavia and Luxembourg. Questions related to the quality of life and mental health-care are related to indicators such as the density of a population (highest in the Netherlands, lowest in Norway), the proportions of the municipal and the rural population (in Belgium 97% of people live in cities, in Finland and Ireland this percentage is less than 60%), the average age of a population (highest in Sweden and Italy, youngest in Ireland and Holland), economic prosperity (in EU 15 the highest Gross Domestic Product (GDP) is found in Luxembourg, whereas the GDP is lowest in Greece and Portugal), health care expenditures (in EU 15 highest in Germany, Norway, and Luxembourg, lowest in Greece, Portugal and Spain), geography (climate), religion, food (proportion of fish and vegetable, iodine supply), etc. Psychological distress assessed by the "Eurobarometer" seems to be lowest in the Netherlands and Sweden, and highest in Portugal and in Italy, but this indicator shows great variability according to the method used, and in addition some countries are missing in the comparison. Probability to develop a mental disorder is relatively low in Italy, and high in France. The highest alcohol consumption per capita is found in Luxembourg (17.5 ltr/capita$_{>15yrs}$/year) followed by Ireland and France, while it is lowest in Norway and Sweden (6–7 ltr/capita$_{>15yrs}$/year). Relatively low alcohol consumption rates are also found in Italy and Greece (about 9 ltr/capita$_{>15yrs}$/year). Alcohol consumption recently decreased in countries producing wine (Italy, Portugal, Spain), but significantly increased in Ireland and Luxembourg. High percentages of smoking are found in Greece, less so in Norway. Paradoxically, in Greece there is only a comparatively low cardiovascular mortality rate as well as a low standardised mortality rate related to smoking. It is in the medium range, lower than for example in Norway and practically the same as in the Netherlands and Sweden [2, 5]. Similar variability is also shown by indicators of suicidality like the annual suicide rate (highest in the "Baltic" countries of the former Soviet Union, Slovenia, Finland, and Hungary, lowest in Greece, Italy, Spain, UK, and Malta (Eurostat, [13]). On the other hand, the ultimate goals in terms of tackling stigma, assuring access to psychiatric treatment according to the state-of-the-art and best scientific evidence, the respect to human dignity and the rights of patients, are the same in all European countries.

Thus, the first step would be a demographic, social, and epidemiological map of Europe related to mental health. Second, a comparative overview of mental health care services and their quality is highly needed. Third, the standards of mental health care and minimum treatment requirements should be formulated. Fourth, these standards should be based on evidence and should be followed in new European recommendations for curricula in all steps of medical education and personal development programmes.

Who is responsible to implement and manage these ambitious goals?

One should keep in mind that in this effort we do not start from scratch. There are many institutions already active in

this field, like non-governmental organizations (NGOs), our civic society, professional organizations including the World Psychiatric Association (WPA) and intergovernmental agencies like the Council of Europe, the European Commission (EC), and the WHO. These international organisations have counterparts on the national level: local NGOs, professional organizations including medical chambers and associations, health care centres, health care and social welfare departments, etc. It is important to harmonise the activities of this network and define the responsibilities and tasks of the respective bodies. We should not forget that there are already quite successful programmes focused similar mental healthcare-related topics: IMHPA (Implementing Mental Health Promotion Action [18]), the European Platform for Mental Health (EMHPA [6]), HP Source [17] (a voluntary, international collaboration of researchers, practitioners and policy makers, having the common goal to maximise the efficiency and effectiveness of health promotion policy, infrastructures and practices), Mental Health Working Party, MINDFUL, and many of others [12]. WHO is playing an important role in this process as an institution concentrating on the development of partnerships, the provision of health information (Mental Health Atlas [20]), the production and dissemination of best evidence, supporting governments with policy and service development, and advocating the empowerment of users and carers. On the national level, specialised institutions (e.g., WHO collaborating centres) could be assigned to take this responsibility as WHO counterparts.

In order to achieve the aims outlined above, an efficient system of evaluation, communication and management should be established. To avoid redundancy and uncooperativeness, it cannot be done without a close collaboration of the EC and other European bodies on one side, and national governments and professional associations on the other side. Moreover, it cannot be done free of charge. Thus, an efficient system of financial support on each level (WHO, EC, governmental, departmental, national grant agencies, NGOs, industry, etc.,) should be set up in advance.

Ideology by itself is not enough to produce major transformations on an European level. It is only when increasing health concerns and economic pressures (budget deficits and increasing costs of health care) markedly strengthen the political will that changes start taking place on a large scale [4]. Concerns should be articulated and evidence must be publicly communicated, easily available, convincing, and transparent. In other words, the whole process also needs steady support of media pressuring on policy makers and informing the public.

Here the professional societies could play a more active and important role. On the European level, the newly reformed European Psychiatric Association (EPA) is the hot candidate to take responsibility for a harmonisation in mental health care and education. EPA, as the largest pan-European psychiatric society based on individual membership and collaborating at the same time with the counterpart national societies, seems to be one of the most appropriate representative bodies to tackle challenges given by the need of a transformation of mental health care across Europe toward progressive, patient oriented services, by the gap between what is needed and what is in fact provided, by the unbearably prolonged access to novel treatments (the time from a discovery of a new remedy to its practical use), and by ethical (human rights), legal (coercive measures, forensic aspects) and practical (stigma, European „guidelines") requirements. EPA motivation to play the active role in all these areas is given by the necessity to communicate and to harmonize public health issues including mental health on the European level, which would contribute to the mutual benefit of all stakeholders, particularly patients and their families, decrease the social and economical burden which mental disorders represent (now it is estimated to be up to 30% of the total ill-health burden expressed as years spent in disability [9, 10]), increase the investment into psychiatry (in average, only less than 4% of the health care budget is allocated to mental healthcare in Europe), formulate the identity of psychiatry as a medical discipline, and increase the European competitiveness in research. To achieve these goals, EPA has inevitably to collaborate closely with national psychiatric associations (the "Platform" for such collaboration has already been established), the European Brain Council (EBC; EPA is a full member), WHO, EC (EPA has a participatory status in mental health care), and other professional and advocate bodies such as ECNP (European College of Neuro-Psychopharmacology), GAMIAN (Global Alliance of Mental Illness Advocacy Networks [16]), EUFAMI (European Federation of Associations of Families of People with Mental Illness [14]), and other patient and family organizations. Within the frame of these collaborations, EPA already launched several projects, e.g., AEP—Academia of Excellence in Psychiatry (H. Sass), an online Research Network (H.-J. Möller and Ian Ragan from EBC), the initiative for an European Recommended Guidance (W. Gaebel), and some others. In addition, EPA organises regularly joint symposia with ECNP (Slovakia, Hungary, Poland, Spain-Madrid, France-Nice) and APA (American Psychiatric Association). EPA implemented very successfully a Young Psychiatrists Programme, and organizes international core symposia, section symposia and workshops during annual congresses. EPA also delivers continuing medical education (CME) courses, itinerant courses in different European regions, awards research and prevention prizes, etc. EPA also co-sponsors major national

events and projects such as the German Research Network on Schizophrenia (W. Gaebel), the Brain and Behaviour Congress in Thessaloniki (K. Fountoulakis), Percorsi Internazionali di studio in Psichiatria in Rome (E. Sacchetti, A. Siracusano) and others. EPA also actively participated in the ESF/EMRC (European Science Foundation/European Medical Research Council) Consensus Conference on 'Investigator-Driven Clinical Trials'. The mainstream of EPA activity is focused on education [15]. EPA is represented in the UEMS (the European Union of Medical Specialists [19]). We do believe that a fruitful collaboration with major national psychiatric associations and colleges (DGPPN, Royal College of Psychiatrists—RCP) will significantly contribute to the successful implementation of these ambitious goals [4].

In summary, hand in hand with the emerging identity of the community of European nations on the political (no more frontiers, free movement of people and ideas), economical (free movement of goods), and cultural level, the need of reflection of this process also in other fields including mental healthcare inevitably occurs. It is a challenge for the respective bodies, both on the European and the national level, to establish an active network for collaboration in mental health research and policy, and to allocate responsibilities for the implementation of benchmarking, the mapping of needs and structures, defining standards of minimum care, establishing ethical rules and treatment guidelines. Last but not the least, the educational process in all forms of training in mental health should be harmonised on an European level. Professional European societies such as EPA could now start to play a more important role in this process than before.

Acknowledgment Supported by the Research project No. MZ0PCP2005 of the Czech Ministry of Health.

Conflict of interest statement Cyril Höschl is a faculty member of Lundbeck Psychiatric Institute (Lundbeck International Neuroscience Foundation), Servier (research), and in advisory boards of Bristol-Myers Squibb and United Biosource Corporation. He has given lectures for Eli Lilly & co., and other lectures for industry contracted exclusively with Academia Medica Pragensis, Prague, Czech Republic. He received grants from Eli Lilly & co.

References

1. Bonnie RJ (2002) Political abuse of psychiatry in the Soviet Union and in China: complexities and controversies. J Am Acad Psychiatry Law 30:136–144
2. Carta MG, Kovess V, Hardoy MC, Brugha T, Fryers T, Lehtinen V, Xavier M (2004) Psychosocial wellbeing and psychiatric care in the European Communities: analysis of macro indicators. Soc Psychiatry Psychiatr Epidemiol 39:883–892
3. Höschl C, Libiger J (2000) Rights and responsibilities of the psychiatric profession. Acta Psychiatr Scand 101(Suppl 3999):40–41
4. Höschl C (2005) Helsinki Ministerial Conference—National perspectives. Die Psychiatrie 2:111–113
5. Höschl C (2005) 3rd Meeting of the working party on mental health. EC, Luxembourg, May 30–31. Psychiatrie 9:248–249
6. Jané-Llopis E (2007) Mental health promotion: concepts and strategies for reaching the population. Health Promot J Austr 18:191–197
7. Kelly BD (2008) The emerging mental health strategy of the European Union: a multi-level work-in-progress. Health Policy 85:60–70
8. López-Muñoz F, Alamo C, Dudley M, Rubio G, García-García P, Molina JD, Okasha A (2007) Psychiatry and political-institutional abuse from the historical perspective: the ethical lessons of the Nuremberg Trial on their 60th anniversary. Prog Neuropsychopharmacol Biol Psychiatry 31:791–806
9. Murray CJL, Lopez AD (eds) (1996) The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. In: Global burden of disease and injury series, vol 1. Harvard University Press, Cambridge, pp 1–900
10. Olesen J, Leonardi M (2003) The burden of brain diseases in Europe. Eur J Neurol 10:471–477
11. Rutz W (2003) Rethinking mental health: a European WHO perspective. World Psychiatry 2:125–127
12. http://ec.europa.eu/
13. http://epp.eurostat.ec.europa.eu/
14. http://www.eufami.org/
15. http://www.europsy.net/
16. http://www.gamian.eu/
17. http://www.hp-source.net
18. http://www.imhpa.net
19. http://www.uems.net/
20. http://www.who.int/mental_health/evidence/atlas/