"Prevention of Depression and Suicide – Making it happen"

Thematic Conference on Prevention of Depression and Suicide, Organised jointly by the Ministry of Health of the Republic of Hungary and the European Commissions' Directorate of Health and Consumers, with the support of the Swedish EU Presidency and in collaboration with the WHO Regional Office for Europe

CONCLUSIONS FROM THE CONFERENCE

Priorities for Policy and Action to Address Prevention of Depression and Suicide

- Participants called for real leadership to promote and protect mental health of the population by effective implementation of the European Pact for Mental Health and Wellbeing.

- Participants called for inclusion of service users, people with a history of mental health problems, and their carers in policy making to prevent depression and suicide.

- Furthermore, participants concluded that:

  - Action to prevent depression and suicide is needed to reduce the huge public health impact, the suffering and the costs connected to these issues.

  - Every EU Member State needs strategic national and regional suicide prevention programmes, based on best available evidence and interlinked to other public policies. Effective programmes and strategies need to address multiple sectors and levels, from individual to societal.

  - The economic crisis has an impact on mental wellbeing, and increases risk of psychological distress, alcohol abuse and suicides. Thus action against depression and suicide should be integrated into the response to the economic crisis to strengthen protective factors and to reduce risk factors. Such actions include reintegration into the labour market, increased intake to educational settings, and adequate social protection.

  - Depression and suicide must be seen in a social and cultural context, and actions should address societal factors as well as individual factors by building partnerships, mobilisation of inter-sectoral local networks, support for community activity and strengthening of family ties.

  - Stigma of depression and suicide needs to be addressed as a major barrier to prevention and early recognition and treatment.

  - Prevention of depression has to start in childhood by building resilience and creating socio-emotional competence and coping skills.

  - Alcohol use is a risk factor for depression and suicide, and active alcohol policy measures to restrict alcohol availability are needed.

  - Prevention of suicide needs to involve multiple stakeholders and acknowledge the role of non-professionals. Vulnerable and high-risk groups should be especially targeted.

  - Capacity building in primary care to enhance mental health promotion, prevention, and recognition as well as low-threshold psychological and medical treatment of depression and suicidality are key priorities.

  - Widely mainstreamed patient-centred and multiform community-based mental health care improves access to specialised care to provide effective treatment of depression and prevention of suicide in

a stepped care model, relying on the positive impact of retained social networks and service user influence. The shift to community care must not shift the burden to families and informal carers.

- e-health applications for mental health promotion, prevention and even treatment are promising and European-wide collaboration is needed to develop effective and well-integrated e-health solutions and to bridge the digital divide.

- The European Union and Member States need to enhance routine data collection of depression, suicide and their risk and protective factors. Good quality data is needed to monitor change over time in depression and suicide and to target actions. Timely data is especially important now to monitor the effect of crisis.

- Research investments are needed to enhance prevention of depression and suicide in Europe. Research and policy actors have to learn to work more closely together, to be more responsive to each other and to involve or be led by service users. Research priorities involve multi-disciplinary standardisation of mental health concepts, longitudinal cohort studies as well as promotion and prevention effectiveness and cost-effectiveness studies.

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CONFERENCE MINUTES

Thursday 10th December

OPENING SESSION: WELCOME

Michael HÜBEL, Head of the "Health Determinants" Unit of the Directorate General for Health and Consumers at the European Commission, welcomed all participants to the Thematic Conference. He noted the pan-European spreading of awareness of the European Pact on Mental Health and Well-being; with Thematic events planned in different European locations, and expressed his gratitude to the Hungarian Ministry of Health for hosting the event and for their valuable effort and contributions in the planning and preparation of the conference.

The Minister of Health of Hungary, **Tamás SZÉKELY**, highlighted the importance of the topics to be addressed at the conference, pointing to the huge burden that depression places on European societies, particularly mentioning the burden represented by milder cases, and the particular challenge faced in Hungary of a high suicide rate. He gave an account of a recent survey on mental health in Hungary which gave an important and detailed view of the situation in the country with regards to depression and suicide. Related to this he reported on the success of Hungary in recent years in reducing greatly this suicide rate. Finally, he expressed his pleasure on behalf of all at the Ministry of Health for the opportunity to host this European Thematic Conference.

Androulla VASSILIOU, European Commissioner for Health, addressing the conference by video message, described depression and suicide as some of the most pressing public health challenges, stressing both the economic cost and the amount of human suffering caused by them. The commissioner outlined three priorities in this area: the raising of political awareness and placing depression; adoption of a multi-sectoral approach to the problems arising, and; the need for an increased focus on prevention, further to treatment and care of depression.
Ms Vassiliou highlighted supporting action proposed by the Commission, including the EU Compass database on good practices and policies and the potential creation of a working group with member states who would be invited to develop with the Commission services a vision and suggestions of conclusions from the Pact implementation.
She mentioned the emerging evidence for the impact of the economic crisis on depression and suicide, and urged governmental and non-governmental stakeholders to join together to act and respond to the human suffering caused by depression and suicide.
Finally, she informed participants of her upcoming new position as Commissioner for Education, Culture, Multilingualism and Youth and of her intention to continue to have a role in the implementation of the Mental Health Pact.

Matt MUIJEN, regional adviser for mental health for the World Health Organization's Regional Office for Europe, stressed that the cross-cutting theme of suicide is of great importance for Europe, tragically touching so many members of society, and that prevention of suicide forms a part of the essence of the Helsinki Declaration. He noted that suicide is an indicator, not only of depression but also of the quality of health care in European Member States. Dr Muijen highlighted the need for societies to provide a social

safety net and address issues of unemployment and community mental health services as well as reduce stigma and raise awareness of the possibilities for preventing depression and suicide. Finally, he expressed his enthusiasm in working together to take the topic forward and look for practical solutions to current problems in this area.

PLENARY SESSION: KEY NOTE PRESENTATIONS

As chair of the session, **Melinda MEDGYASZAI**, Hungarian Secretary of State, welcomed the conference participants to Hungary and introduced the speakers of the session.

Michael HÜBEL, Head of the Health Determinants Unit of DG SANCO, gave a brief overview of the current state of affairs in Europe in the prevention of depression and suicide, highlighting that less than half of European member states have a national suicide prevention programme or strategy, particularly among new member states.

Mr Hübel went over the calendar of all 5 Thematic Conferences and gave a brief outline of ongoing work on the EU Compass database of good practices and policies in mental health and the growing collection of statements of support and commitment for future implementation of the European Pact for Mental Health and Well-being.

He outlined the key messages and actions developed for this priority area, giving examples of effective action already implemented in Europe. He also gave an account of supportive initiatives at the EU level from the Commission.

Mr Hübel finished by summarising expectations and emphasising the valuable experiential perspective in this field. He outlined steps for Member States following the conference:

- Collect good practices and statements of commitment
- Agree follow-up actions
- Update on measures taken
- Create Working Group with interested Member States to reflect on steps beyond thematic conferences

Hans-Ulrich WITTCHEN, from the Institute for Clinical Psychology and Psychotherapy, Germany, argued that depression is the public health priority of the 21st century in Europe, representing the principal societal burden for the EU. He noted that expression of depression varies by age and gender, and according to different patterns of episodes and severity, and stressed that the challenge is to optimise interventions to account for these different patterns and risk groups.

Dr Wittchen also highlighted the financial burden of depression, pointing out that the majority of costs are indirect and raising the question of whether we should raise direct costs to address this issue. He stated, however, that the growing burden of depression only partly represents a failure of treatment, and noted there is room for improvement – in particular in the broadening of options offered to those suffering from depression and improved identification of cases.

Finally, he raised the important point of familial transmission of depression and called for primary prevention efforts to be gender specific and targeted at parents.

Danuta WASSERMAN, from the Karolinska Institute, Sweden, and **Zoltán RHIMER**, from Semmelweis University, Hungary addressed the question of what policy can do about the problem of suicide.

Prof. Wasserman gave an overview of suicide rates across Europe, noting that it is the largest cause of mortality among young people and that the number reported represents only part of the real number of deaths by suicide. Moving to implementation, she highlighted the WHO data and recommendations of 1990 and the UN 1996 components for preventive strategies. As particular determinants of mental health status and suicide, she mentioned employment as a protective factor and alcohol and substance problems as risk factors, both having greater impact on young people, particularly young men.

She gave an overview of the member states already with a suicide prevention strategy in place and the facilitators for suicide prevention programmes, stressing the importance of these being approved by parliament and receiving governmental support.

Finally, she raised the issue of stigma and noted evidence for negative attitudes among health care professionals leading sometimes to apathy towards the prevention of suicides and saving these lives. She highlighted the SEYLE project as an important initiative among young people.

Prof. Rihmer focused on the role of improved recognition and treatments via GP training in preventing suicides, referring to key evidence from the Gotland study and Nuremburg alliance against depression. He also highlighted the Hungarian case where GP training and subsequent increases in prescriptions of antidepressants could be seen to correlate with recent declines in suicide rate. In conclusion he stressed that better/earlier recognition and more effective/widespread treatment of depression is one means, but a very important one, of suicide prevention.

Lewis WOLPERT, Emeritus Professor of Biology at University College, London, UK, started his presentation of the experiential perspective of depression by stating that if you could describe your severe depression, you haven't truly experienced it. He raised the interesting point that there seemed to be some adaptive quality to sadness, which had become uncoupled from its usefulness in the onset of severe depression, which he termed "Malignant sadness".
He highlighted the culturally different expressions of depressive states and differing amounts of somatisation, which he thought to be related to how acceptable or not it is to be diagnosed with depression. Related to this, he stressed the negative effect that stigma has on those affected by depression, reducing their capacity and inclination to seek help early on or to offer solidarity. His proposal for action, in light of this, was for stronger educational measures for children on issues related to mental health. He emphasised that in pilot studies of mental health education, even educating about risk factors was not proven to have a primary preventive effect, but the action raised the possibility of several positive outcomes: Education could reduce common misconceptions about mental disorders, could encourage appropriate and timely help-seeking and could reduce the burden on carers – informing them that they cannot cure, only support those they care for suffering from depression.

PLENARY SESSION: HIGH LEVEL ROUND TABLE – STRATEGIES, POLICY FRAMEWORKS AND TARGETS – INSTRUMENTS FOR EFFECTIVE PREVENTION OF DEPRESSION AND SUICIDE

As session chair, **John BOWIS**, Former Member of the European Parliament, opened the session by talking about the importance of moving towards a vision for positive mental health, rather than simply coping with mental illness. He also highlighted the strength of public campaigns in supporting action policies for mental health by raising awareness and increasing political will.
He invited the round table participants to discuss the priorities for effective policy in prevention of depression and suicide from each of their perspectives.

PARTICIPANTS:

Melinda MEDGYASZAI, Secretary of State, Hungary, stressed the importance of "a personal touch" in developing the policy framework or strategy. She emphasised that recognising the possibility that each one of us could suffer at some point from depression could help the planning process, focussing on potential facilitators and barriers to access and healthcare and enhancing the understanding and support given.
Ms Medgyaszai highlighted the power of action at the community level, linking it to our human nature as a social animal with a need to live in communities.
Finally, she reminded the participants of the timely nature of this event, being held just before Christmas, a time at which suicide rates are often higher than the rest of the year.

In connection with this last point, John Bowis mentioned an interesting implementation aspect of telephone support lines from the UK. The organisation would ring people on their birthdays as a preventive measure to combat loneliness and prevent suicides.

The Slovenian mental health policy was presented by **Mojca Zvezdana DERNOVSEK**, WHO Representative for Mental Health in Slovenia, and **Nusa Konec JURICIC**, from the National Working Group for Mental Health Programme, Slovenia. The recent Mental Health Act was adopted by parliament in June 2008 and put into effect from August 2009.
Ms Dernovšek summarised the priorities and goals of the National Programme and Action Plan for mental health, and described the positive public response to the proposal which was elicited through public discussion earlier this year.
Ms Konec Juričič focussed on the suicide prevention goal of the national mental health programme. She explained that suicide prevention receives a lot of public attention and that the national suicide rate is high, being between 25 - 30 per 100,000. However, she pointed out that there is tremendous variability across the country which is clearly related to social inequalities and problematic alcohol consumption. The Celje region, which is particularly adversely affected, has been targeted for an intensive programme, including the establishment of an inter-sector interdisciplinary group -The Regional group for suicide prevention.
She concluded by stating that the suicide rate can be decreased by countinuous and co-ordinated activities at many different levels – international, national, regional and local - with vertlcal and horizontal links playing an important mediating role.

Louis APPLEBY, National Director for Mental Health in England, discussed the drivers of change and reform in mental health policy and the role of appropriate targets in supporting this change. Using the example of the 20% reduction in suicide rate in England, he stressed that targets do not work on their own, but require specific activities addressed at key risk groups and situations. He highlighted the work of IAPT (improving access to psychological therapies), based on NICE guidance, which aims to train a large number of therapists and was driven forwards by the strong economic arguments for treating mild to moderate depression and helping people back to work and tax paying. In contrast, he also outlined the new English vision for mental health, "New Horizons", which is not structured around targets or a large financial injection.
Finally, Professor Appleby described the 6 key points of influence which he saw as necessarily in alignment for political and effective changes to occur:

1. Statement of government priority (and accompanying press coverage)
2. Strategic plan backed by consensus
3. Clinical model based on evidence

4. Resources (or value for money arguments)
5. Measurement and incentives
6. Workforce reform, including leadership skills (local)

The Portuguese National Coordinator for Mental Health, **José Miguel CALDAS DE ALMEIDA**, described measures being undertaken from the regional to national levels to prevent depression and suicide in Portugal. He presented the national plan for mental health, approved in 2008, which includes the prevention of depression and suicide in several areas: policy development, information and the media, training primary health care professionals, access to local mental health services and partnerships. He stressed that the next challenge is to collaborate closely with other sectors, such as employment and social security. Professor Caldas de Almeida mentioned 4 regional initiatives:

- Alliance against depression project: part of EAAD – a 4-level project with the goal of improving care for patients suffering from depression
- Depanx programme: Community action-program for the prevention & treatment of depressive & anxiety disorders with liaison collaborative stepped care
- OSPI project (Optimized Suicide Prevention Programs and their Implementation in Europe)
- Y project

He described the most important of these – the regional alliance against depression which was evaluated 5 years ago. The four levels addressed by the alliance are: 1. Cooperation with primary care (e.g. advanced training); 2. Public Relations, information for the broad public (poster, leaflets, events); 3. Help offers for patients and relatives (self-help, high risk groups); 4. Cooperation with community facilitators (e.g. priests, teachers, police).
Finally, Professor Caldas de Almeida outlined the lessons learnt from the work in Portugal:

- A national plan is extremely important
- European projects (alliances) makes a difference
- It is not enough to train PHC staff – local care, new services and support with a stepped care approach need to be developed
- It helps to have health ministers who are interested and have some knowledge of mental health issues.

In response to this presentation, John Bowis pointed out the importance of addressing suicide in the prison populations, as this group is seven times more likely to die from suicide than the general population.

Mario MAJ, President of the World Psychiatric Association (WPA), commended the conference organisers for holding an event focussing on actions and interventions. He pointed out that the WPA has, among its 134 Member Societies, 47 national psychiatric societies representing European countries, providing an opportunity to form a network of relevance in this area. He gave 5 key points for advance in the area of prevention of depression and suicide:
Firstly, he stressed the importance of a developmental perspective in the prevention of depression, citing research evidence that adverse experiences during childhood, in particular physical and sexual abuse, are a strong risk factor for both depression and suicide. He highlighted interventions targeting family adversity, such as the New Beginnings Programme.
Second, Professor Maj pointed to the intricate links between depression and physical health. He mentioned the WPA programme currently ongoing on that issue, and in particular the train-the-trainers workshops the WPA is organising for primary health care workers, emphasising that supervision following training of these professionals is of critical value.
Thirdly, referring to research, he noted that efficacy trials dominate the field and that there is a lack of implementation and effectiveness studies for preventive interventions.
Fourth, he pointed out that mental health is not simply the absence of mental disorders, but includes a positive component which should now be maximised, with interventions focussing on enhancing skills such as coping and resilience, self-esteem and self-regulation.
Finally, he urged the researchers interested in prevention of mental disorders and those working in developmental neurosciences to communicate better, cross fertilise and overcome the separation and distance between their research fields. He also pointed out that Europe has much to learn and teach to

other parts of the world and that there are global opportunities for synergies with worldwide funding agencies and networks, for example in USA and Australia.

DISCUSSION

Several points were made by conference participants during the discussion:

- Prevention of depression is potentially possible, through strengthening resilience, psychological mediation and softening the impact of harsh life events on vulnerable children, but evidence is still scarce and progress to be made.
- A broader and clearer definition of mental illness and specifically depression was called for, acknowledging the positive or adaptive aspects of depression (such as creativity or re-evaluation) and its contemporary and culturally defined nature, and yet continuing to focus on alleviating the suffering caused by these disorders.
- Different strategies are required to approach the prevention of depression and prevention of suicide either with or without a preceding depression or other mental disorder.
- The growing debate and public interest in the ethics of euthanasia may erode the political priority of suicide prevention and pose a threat to the work underway in many countries by presenting the concept of the rational suicide.
- The importance of NGOs as key actors in the prevention of depression and suicide was stressed, in particular with relevance to their continuing existence over time, compared with grant-supported preventive projects.
- The important role of alcohol policy and restrictions in preventing suicides was raised and several participants cited instances of this in European member states.
- It is important to reduce the gap between those suffering from depression and to recognise that the disorder could affect all types of people.

PARALLEL SESSION 1: DETERMINANTS AND RISK FACTORS OF DEPRESSION

CHAIRS:
Dolores GAUCI - President, Gamian - Europe
Maria VUORILEHTO - Ministry of Social Affairs and Health, Finland

PRESENTATION: Depression and Suicide: what do service users expect policy to do about it?

Jonathan NAESS from Stand to Reason in the UK, a service user-led organisation aimed at reducing discrimination and stigma towards people with mental ill health, described mental health as a social and not exclusively a medical issue, in that their mental health allows people to work and contribute to society. He presented the positive face of recovery and expressed the need to change the currently dominating culture by using the available economic arguments. In this way, the business case for prevention of depression and alleviation of suffering could be made, with the intention of motivating companies to improve and implement their own mental health policies. Political will was described as a crucial catalyst to these actions. Finally, the importance of achieving a broad consensus within the mental health sector was stressed, through improving the links between NGOs, users and health care professionals and following examples from regions outside Europe.

REACTIONS AND PRESENTATIONS OF POLICIES AND INITIATIVES:

Christina VAN DER FELTZ-CORNELIS, from the Trimbos Institute (Netherlands), presented some of the most relevant elements of The Netherlands' national depression policy, whose ultimate goals are depression and suicide prevention, as well as provision of optimal treatment. These elements include a disease management approach (chains of care), the definition of standards of care, the reports on suicide prevention or the National Depression Initiative, of which implementation is underway. Depression is one of the priorities of the national public health policy for 2007-2010 and the Ministry of Health's aims include integrated care, communication and financing throughout the whole chain of care. The need to enhance care delivery, financing and sustainibility through policies was stressed.

Pablo GARCÍA CUBILLANA, from the Ministry of Health and Social Policy in Spain described the key components of the Spanish Strategy for Mental Health which was launched in 2007. The specific goals relating to the prevention of depression and suicide, such as increasing effective action against social exclusion, reducing the risk of stress in workplaces, or providing support to carers, were shared with the session participants, together with a number of good practice examples which are being developed in this area. Mr García Cubillana concluded that the National Strategy has given a new impulse to the promotion of mental health and the prevention of mental illness in Spain, although it was also stressed that its effective implementation requires additional effort, such as translating initiatives into strategic actions frameworks

David STUCKLER, from the Department of Sociology, Oxford University (UK), described the effects of economic and financial crises on mortality rates and analysed the role of factors such as social cohesion or social protection in minimising these effects. Increases in unemployment have been linked to rises in suicide rates but recent research has found that the effect of unemployment on suicides can be reduced and even averted with greater social spending. The speaker's final recommendations included: 1.Providing social and health stimuli. And in the case of budget cuts: 2. Ring fence funds for labour market protection and health services; 3. Protect mental health services; 4. Protect vulnerable groups such as those with debts, the unemployed, those with low SES and migrants.

Jürgen SCHEFTLEIN from the European Commission (Directorate General for Health and Consumers, Unit "Health Determinants") described the European Commission response to the crisis, including the Commission Communication "Driving European Recovery" (4 March 2009), which contained concrete recommendations for supporting individuals through the crisis such as ensuring rapid (re)integration into the labour market, supporting the most vulnerable, strengthening social protection and investing in social

and health infrastructure. Additional elements, such as the recently presented Second Joint Social Protection Committee/Commission report on Social Monitoring of the Crisis (30 November 2009), or the Communication “Solidarity in Health – Reducing health inequalities in the EU” (20 October 2009), were also presented. It was concluded that the crisis had also offered some positive consequences, including a greater sensitivity to mental health aspects in health and social policies and a better knowledge of the links between socioeconomic determinants and mental health.

Kevin DENCH from the European Commission (Directorate General for Employment, Social Affairs and Equal Opportunities, Unit "Inclusion, Social Policy Aspects of Migration, Streamlining of Social Policies"), described additional tools developed by Commission to reduce the negative psychosocial effects of the current economic crisis, such as the Open Method of Coordination for Social Protection and Social Inclusion. Having good social policies and effective means of collaboration between Member States was described as crucial to counteract the negative effects of the crisis and to allow the maintenance of inclusive sustainable market economies.

DISCUSSION:

The importance of good national registries on the effects of the crisis on mental health was stressed by a number of participants. The development of national registries on the effects of the crisis on mental health was proposed, as an additional key action for the conference background document.

PARALLEL SESSION 2: DETERMINANTS AND RISK FACTORS OF SUICIDE

CHAIRS:
Constantin JANNES – Mental Health Europe (MHE)
Merike SISASK – Estonian-Swedish Mental Health and Suicidology Institute (ERSI), representing the Ministry of Social Affairs, Estonia

PRESENTATION: A menu of evidence-based actions for preventing suicidal behaviour

Armin SCHMIDTKE and **Danuta WASSERMAN** from the Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health, Karolinska Institute, Sweden outlined a number of different preventive measures for addressing suicide in different diagnostic groups. Much of the current knowledge has been provided by the WHO/EU project MONSUE, a multi-centre study on attempted suicide in 26 European countries. Professors Schmidtke and Wasserman noted that depression was linked to 50% of completed and attempted suicides but that in terms of the preventive value of pharmaceuticals, the greatest prevention effects were seen from treatment of schizophrenia. It was stressed that the main suicide points and methods should be determined and changes over time monitored, before interventions are then proposed, when possible. Brief interventions such as the Telecheck-telehelp initiative, with regular short calls from a constant trained health worker, have been shown to be effective in reducing suicides and admissions. Finally, the role of public attitudes, especially among healthcare personnel, and dominant cultural mores, in particular relating to gender, were flagged as important.

In the short discussion following the presentation, the importance of using the latest knowledge to prescribe the lowest possible dose of neuroleptics and other pharmaceuticals with unpleasant side-effects (such as Lithium), as well as good follow-up following prescription, were noted as valuable measures to improve compliance and the comfort of those on such medication.
Studies to verify effectiveness of CBT and DBT among young men (rather than women) in preventing or treating self harm were also mentioned as a key priority.

REACTIONS AND PRESENTATIONS OF POLICIES AND INITIATIVES:

Ella ARENSMANN from the National Suicide Research Foundation (NSRF) and **Geoff DAY** from the National Office for Suicide Prevention (NOSP) in Ireland gave an account of the lessons learnt from the National Suicide Prevention Strategy.
Dr Day argued that we have to look at all those who consider harming or killing themselves, not only those with depression and that we should take measures based on sociological evidence, developing social protective factors such as family ties and community activity which have been eroded by recent trends such as migration form rural to urban areas. The Irish strategy and 10 year plan, with the 26 action areas developed through wide consultation, aimed to reach out with assistance on a continuum from promotion and prevention through to treatment and post-vention to families of those completing suicide. Specific action to support young people and the LBGT community were also mentioned as examples of addressing wider risk factors than mental illness alone.
Dr Arensmann described further “Reach Out”, the Irish strategy which runs until 2014. Following priorities identified through research findings, Reach Out aims to address the large number of undisclosed self-harm sufferers as well as those reported suicides and attempts. The strategy includes a suicide support and information system and a proactive approach to supporting bereaved family members (of open verdicts as well as those recorded as suicides). Measures such as the withdrawal of certain paracetamol-based pain killers and awareness training of A&E nurses were highlighted as effective action within the strategy. NGOs were involved through the public consultation.

Marjolijn VAN DEN BERG from EUREGHA (European Regional and Local Health Authorities) gave an account of action on suicide carried out at the local/regional level. She described work in Flanders as a key example of regional initiatives. The Flemish suicide prevention action plan is modelled on the suicidal process and aims to decrease mortality by suicide by 8 % from 2000 (baseline) to 2010. Aspects of the 5-

strand strategy include mental health coaches in schools (promotion of mental health), helplines and chat facilities for those at risk and help lines for GPs with suicidal patients (optimising helplines and online assistance). Another strategy is to influence triggers: Media guidelines were set up to avoid a press coverage of suicides in an way that may in itself be a trigger for others. Evaluation of the implementation of media guidelines has shown good results in the way journalists report on suicides. Mrs van den Berg emphasised the importance of repeated implementations of media guidelines as the effect diminishes over time. One way of doing this is to present journalists with a yearly media prize, for the best news item regarding a suicide. The fifth strategy deals with prevention of suicide in high risk groups, such as people who have lost a loved one on suicide, people who have previously attempted suicide and young people with early signs of schizophrenia and/ or psychosis.
An important outcome of the action plan so far, is that suicide rates have indeed dropped to the level that had been set as a target.

Following this presentation there was a discussion in the session about the possibilities for primary prevention and the lack of evidence for effective measures. Mrs van den Berg expressed the opinion that any additional resilience adds to the force of primary prevention and also pointed out that responsibility at the EU level is limited to promotion and prevention.

Herbert SOMMER, from the German Federal Ministry of Health, described the legislative process of restricting Paracetamol sales as a means of suicide prevention. In Germany, this drug has been given prescription only status for packets of more than 10g and consequently placed on the prescription ordinance register. Although mostly positive, studies of the outcomes of restricting paracetamol package size show mixed results. A 3% decrease in mortality and 5% decrease in hospital stays at liver clinics was contrasted with a small rise in intoxications.

John MCCARTHY, from Mad Pride, Ireland, argued for the strengthening of community and the greater acceptance of those with mental health differences to prevent suicide. He voiced his strong opinion that the medical model of mental illness is counter-productive and exacerbates mental health problems through fear of labelling, stigmatisation and compulsory treatment. He presented 2 activities run almost without a budget by Mad Ireland: the Full Shilling Club – a supportive group of peers with experience of mental health problems, and Mad Pride Family Fun Day – a community event with the message “celebrate difference, stop loneliness”. Finally, Mr McCarthy stressed the need for communities to accept and be encouraged to care for those with mental health differences. He urged the session to start debate on the value or ethics of prevention and posed the question: what about crisis intervention housing without the medical model?

SESSION 3: BUILDING PARTNERSHIPS WITH OTHER POLICIES AND SECTORS

CHAIRS:
Jutta LINDERT – Mental Health Section, European Public Health Association (EUPHA)
Ray XERRI – Ministry of Health, Malta

PRESENTATION: The European Alliance Against Depression

Ulrich HEGERL from the University of Leipzig, Germany, began by stating the deficiencies in the treatment of depression: under-diagnosis and under-treatment. In response to the deficiencies, the Nuremberg alliance of depression was developed as a 4-level intervention: public campaign on depression, training of GPs, co-operation with multipliers, and support to relatives and self-help groups. The successful Nuremberg alliance has now developed into the German Alliance against depression and the European Alliance Against Depression (EAAD), which was formed in 2004 with funding from the European Commission. **Maria KOPP** from Semmelweis University Budapest, Hungary, reported on the Hungarian EAAD programme in Szolnok region, which resulted in clear reductions in the number of suicides in the region in 2005 and 2006. Since 2008, the EAAD work is being carried on in selected countries by the OSPI (Optimised Suicide Prevention) Programme funded by DG Research. Professor Kopp emphasised the role of strengthening local networks of stakeholders. Strengthening the collaboration among the local professional involved and NGOs, i.e. a multi-focal and social capital building approach, seemed to be the most important aspect of programme success.

The discussion following this presentation concluded that improvement in management of depression is a core component in suicide prevention. The economic downturn has been accompanied by a clear increase in 2008 suicide rates in Hungary and especially in the Szolnok region, calling for continued efforts.

RESPONSES:

Jean-Louis PLEYNET, Head of IST Integrated Health Services for France & Benelux, presented the IBM France approach to prevention of mental and psychosocial problems. He started by observing what changes are occurring in the workplace environment (mainly for tertiary activities) and pointed out that the preparedness of the management, project leaders, health and safety staff and the Unions Representatives to face the psychosocial risks are key factors. He briefly described one potential approach to building the basis for a programme for the governance of psychosocial risk and presented a map of the current governance programme developed in IBM France. Education and the opportunity for people to express themselves on issues related to their day-to-day work are the main drives included in this governance programme.
Mr Pleynet pointed out the need to involve management and health and safety staff as well as the social partners in this work. The French model includes benchmarking and exchange of experience on preventive efforts among companies.

Stefan FRÜHWALD from Caritas St. Poelten, Austria and **Karl DREXLER** from the Austrian Direction of Prison Administration, presented the “Viennese Instrument for Suicidality in Correctional Institutions“(VISCI), aimed at screening new prison inmates for suicidality. Suicide rates in prisoners are considerably higher than in the general population. A better identification of mental health and alcohol use problems and avoidance of placing prisoners at high risk in solitary accommodation are key components of successful suicide prevention in prisons. VISCI routine administration in Austrian Correctional Institutions was introduced in December 2007. During the first year, VISCI was administered with 8248 admissions. During this year, 6 suicides occurred in all 28 Austrian jails and prisons, a marked reduction of suicide incidents compared to the years before implementation of screening procedures and interventions.

Mariann SKAR, from EUROCARE (European Alcohol Policy Alliance) highlighted the impact of alcohol policy on suicide. The numbers indicate that alcohol is a major contributor to suicide and closely related to depression. The EU was encouraged to adopt a minimum alcohol tax rate and to provide Member States

with flexibility to individually control affordability and availability of alcohol. Tighter strict restrictions on alcohol marketing and better labelling of alcohol products are needed. Dr Skar argued that labelling should include health warnings, such as “Don’t drink when depressed” or “Alcohol may cause mental health problems”.

In the concluding discussion Heleen Riper mentioned the national Dutch initiative to build partnerships in a two-stage approach. First meetings were arranged and then tools for regional stakeholders were provided. A stop smoking programme was used as a best practice model for prevention of alcohol harm and depression in the Netherlands.
Michael Hübel from DG SANCO pointed out the challenge to form public health partnerships specific enough for mental health.
Finally, the co-chair Ray Xerri underlined the need to speak the language of the respective sector, rather than using only health sector vocabulary in collaborating on these issues.

PLENARY SESSION – MAINSTREAMING MENTAL HEALTH IN HEALTH DISCIPLINES

CHAIRS:
István BITTER – National Psychiatric Centre and National Mental Health Programme Council, Hungary
Teresa DI FIANDRA – Ministry of Health, Italy

PRESENTATION:

Maria VUORILEHTO from the Ministry of Social Affairs and Health, Finland, described the current trends and figures for Finnish mental health, defined the scope of primary care and outlined Finland's policy to mainstream mental health in primary care (PC). There are three Government-level policy plans and programmes that define mental health services in PC:

1) The national plan for mental health and substance abuse work "Mieli-2009" – this comprises 18 proposals to define the development of mental health and substance abuse work until 2015;
2) The action plan "An Effective Health Centre" to strengthen PC services – which proposes new methods to facilitate access to care, such as re-distribution of responsibility and increase in low-threshold consultations with nurses;
3) The "MASTO project" to reduce depression-related work disability – prevention, early recognition and early treatment of depression.

Dr Vuorilehto then described on the individual case level how the professionals involved in these plans collaborated and highlighted the challenges which the national plan "Mieli-2009" posed of primary health care services, such as the provision of preventive group interventions in maternity clinics, training of specialist nurses for depression and the use of information technology.

RESPONSES:

Jan DE MAESENEER from the European Forum on Primary Care, Ghent University, Belgium, talked as a physician and academic on the role of primary care in tackling depression and suicide. He argued that primary health care is a valuable resource and is needed now more than ever to bridge gaps between the community and health services. The speaker stressed that we should avoid medicalising the economic crisis and that an increase in psychiatric care is not the solution to problems posed by the recession. Rather, social and economic policy should take into account health impact and place a greater priority on increasing social and mental capital. In particular, it is important to safeguard the wellness of European GPs in order to optimise their performance. From his own experience with patients that completed suicide, he stressed the importance of an attitude of respect, modesty and humility. He also emphasised the need to focus prevention efforts on children in deprived areas.
Finally, Dr de Maeseneer raised the question of whether there might be a "culture of suicide" which we are failing to address, which would explain the large differences in suicide rates across Flanders.
As priorities for action, he called for investment in community mental health, investment in primary health care, intersectoral action for health and measures to increase social and mental capital.

Erzsébet PODMANICZKY from the umbrella organisation, the Standing Committee of European Doctors (CPME), discussed the training and education of primary health care physicians as related to the prevention of depression and suicide. She noted the scarcity in Europe of training in neurology for family doctors and mentioned scientific evidence of the positive effects of postgraduate studies for GPs. There is evidence from Sweden, Germany and Hungary for the beneficial effects of GP education in suicide prevention, and from the UK in improving outcomes for depression.

Domenico BERARDI from the University of Bologna, Italy, described the "G. Leggieri" Programme for integration between Primary Care and Mental Health services in the Emilia-Romagna Region. The Leggieri programme collaborating group has been involved in studies in fields of epidemiology, recognition and diagnosis and liaison. On a clinical level, the programme consists of stepped collaborative intervention between primary and secondary care. There are 5 paths of care with increasing levels of complexity for

different severity of mental health problems. The programme involves the training of specialised link workers who connect the community mental health centres and primary care professionals. Currently, consultation-liaison services are available in 87% of health districts, and formal Leggieri steering groups set up in each health trust and in each district of the region. Dr Berardi finished by highlighting positive and negative aspects of the implementation and outcomes of the programme, contrasting the possibility of avoiding disruption to the established professional structure and the sustainability of the programme with the additional workload put on GPs by participation and the fact that nurses are not used as a resource.

Norman SARTORIUS, President of the Association for the Improvement of Mental Health Programmes, highlighted the importance of comorbidity between mental and physical illnesses and argued that this is one of the major challenges to health systems looking to improve well-being, alongside the widespread stigma attached to mental illness and the unclear definition of mental health and interventions to deal with it. He emphasised the magnitude of comorbidity of common mental and physical illnesses, outlined several ways by which mental disorders cause or exacerbate physical illnesses (and vice versa), listed some of the reasons that prevent sufferers from obtaining adequate care, and also mentioned the enormous cost of comorbidity. However, Dr Sartorius also pointed to the opportunities presented for prevention of both mental and physical illness by addressing comorbidity in all its complexity. Finally, he called for the widespread notion that physical and mental disorders should be treated separately and in sequence to be scrapped and for reform of health care systems and partnerships with other sectors to effectively treat comorbid conditions.

During the discussion, the point was made of the unclear place and role of psychologists, and Arne Holte argued for these professionals to be moved into primary care clinics as the most effective way to mainstream mental heath in health services.
In addition to this, it was noted that the session in general focused largely on medical aspects of treatment and GPs as the main professionals in primary care. Several participants and the session chair, Teresa Di Fiandra, urged for a broader concept of “mainstreaming mental health” to include a wider range of health and social services. Examples of this wider mainstreaming could be the correct involvement of several other professionals, in addition to GPs in primary care, and practices of social prescribing which address the social dimensions of depression and other mental health problems
The lack of expertise by experience was also noted and it was felt by many participants that this should be strengthened in order to provide truly patient-centred care and treatment.

Friday 11th December

PLENARY SESSION – ACCESS TO MENTAL HEALTH CARE

CHAIRS:
Kevin JONES – EUFAMI
Tamás KURIMAY – Member State Representative, Hungary

As session chair, Dr Kurimay drew attention to the important role of the background paper and the key messages to be addressed in this conference as a working event.

PRESENTATION:
Matt MUIJEN, from the WHO Regional Office for Europe, emphasised the main mental health determinants: a) individual mental health, b) societal factors and c) the quality of health care, and stressed that raising awareness of the importance of these must be prioritised in the coming decades. Stigma has to be tackled collectively and people with mental health problems have to be empowered and supported as well as their families. Mental health services need to be (re-)designed and competent workforces trained with knowledge based on the experience of service users and carers.
Dr Muijen referred to the differences in suicide rates in the EU Member States, which include countries with some of the highest suicide rates in the world and highlighted structural determinants of suicide like gender, ethnicity, status, (relative) poverty, social class and country as well as modifiable factors such as bonding, education, lifestyle, employment and income.
He pointed out that alcohol consumption has mental consequences like depression and other disorders, social functioning and suicide. It has been suggested that countries with high suicide rates also have a high alcohol intake. Active alcohol policies could be a first important step to lowering suicide rates, among other outcomes.
The speaker highlighted the problem of stigmatisation where suicide attempters are dismissed as "merely attention seeking gestures ". He stressed that families and friends are also stigmatised and blamed and therefore have their suffering multiplied, often without receiving adequate support. Programmes and activities should be in place to tackle stigma and discrimination. Dr Muijen stressed that these programmes need to be evaluated and proven to be effective focusing on suicide and on common as well severe and enduring mental health problems.
Dr Muijen referred to the WHO EURO Baseline Report from 2008 and presented differences in European countries' treatment, primary care, primary care training, home treatment and services users' and carers' feedback on services and its quality. Users' and carers' feedback is important to establish high quality mental health services. He identified aspects to be tackled such as stigma, availability, effectiveness, competences, investment, strategy, balance and integration.
Finally Dr Muijen stressed the importance of connecting different determinants and risk factors with each other, stating that as long as these dimensions are not connected, it will be difficult to move forward.

RESPONSES:

National Coordinator for Mental Health in Portugal, **José Maria CALDAS DE ALMEIDA**, gave a short historical overview on development and recent reforms of mental health services starting in Portugal in 2006. The government initiated a National Commission for restructuring mental health services following identification of access difficulties in rural areas and problems in availability and quality. Professor Almeida listed the main areas of the action plan and highlighted the key objectives including a major emphasis on the development of local mental health services; promotion of quality of care delivery in these services; promotion of networking; development of programmes and services of rehabilitation and deinstitutionalisation of severely mentally ill and the closure and restructuring of psychiatric hospitals.
A focus has also been on children and adolescents, e.g. through development of programmes at primary care level and creation of specialised services. He highlighted that evaluation of services and satisfaction of users are key actions. Prof. Almeida underlined the development of human resources (e.g. through training of professionals) and intersectoral co-operation as well as prevention and promotion programmes (e.g.

through anti-stigma programmes, depression and suicide programmes or alcohol abuse programmes). He pointed at the importance of development projects, research capacity and funding available to support mental health research. Finally the speaker underlined, alongside implementations on national and regional level, the importance of cooperation with the EU and European, Portuguese speaking countries as well as African countries.

André JOUBERT, from the Expert Platform on Depression, Lundbeck International Neuroscience Foundation, Joubert introduced the Expert Platform on Depression. The Expert platform is a neutral multi-stakeholder coalition of healthcare professionals (psychiatrists, psychologists, GPs) and healthcare organisations (patients, carers, health economists and the workplace) which aims to support the implementation of the EU Pact for Mental Health and Well-being; prevent depression and suicide (e.g. in the elderly population or at the workplace) and develop policy recommendations for stakeholder actions to address depression in Europe.
In connection with the EU-Commission (DG SANCO) the Lundbeck Foundation carried out a European survey on the following depression-related topics: health systems, infrastructures, other available structures, self-help facilities, information and quality of care. 23 countries responded so far and preliminary results were presented. Dr Joubert stated that health systems in general are well covered, but great differences exist across Member States in healthcare infrastructure and with regard to access to psychotherapy. Coverage of psychotherapists working in outpatient care varies the most, from 0.01 (Latvia) to 100 (Luxembourg, Romania) per 100,000.
Finally, Dr Joubert stressed the need for EU Member States to support and invest in infrastructures to prevent and treat depression (like telephone case management, internet based psychotherapy); access to self-help groups across all regions; information provision via the internet; and; improving the quality of care across all regions (through collaborative, integrated and stepped care).

Arne HOLTE, from the European Federation of Psychologists' Associations (EFPA), the association which monitors quality standard of education and treatment in Europe through training and education. Psychologists can join the EFPA register which certifies a certain standard of training and qualifications (more information: www.efpa.eu/europsy).
He discussed psychotherapeutic methods and accessibility using the example of Norway. To improve access, eight different models for access to psychologists' services have been developed in Norway. Different combinations have been investigated, such as private practices where no referral and no fees apply for the first three sessions for psychotherapy. For further treatment a referral from a physician is needed. Another Norwegian model is low threshold service in primary health care where psychologists based at the primary health care centre and services target explicitly children and adolescents.
Dr Holte mentioned general problems in accessing psychological services in Europe. He stressed that there are major barriers in insufficient laws, physician's referral systems, professional associations, weak politicians and in some countries even the lack of adequately trained psychologists.
Finally, Dr Holte pointed out the different combinations between suicide and depression (where 50-60% of suicides are preceded by depression, whilst 95% of depressive episodes do not result in suicide) and argued for the good practice possibilities from a public health perspective in getting psychotherapy and primary care to collaborate.

Eszter VIDOR, representing the Hungarian Patient Organisation for Bipolar Disease, "Darkest Day, Brightest Night", highlighted the difficulties she had experienced from a service user's perspective in Hungary and the Hungarian health care system for people with mental health disorders. She questioned if service users are sufferers of a dysfunctional system? Ms Vidor presented the "Darkest Day , Brightest Night" organisation, which aims to reduce the high level of stigmatisation of mental health disorders in Hungarian society and to improve access to treatment for people with mental health disorders. She reported that according to public opinion having a mental disorder is (still) a terrible disaster. Ms Vidor explained that the organisation opened a telephone helpline six years ago and received within this period 16.000 phone calls, of which 8500 callers have been bipolar patients or a member of their families. She highlighted the need for more and better access to treatment, more information and support for mental disorders in Hungary.

Ms Vidor went on to point out obstacles in fostering cooperation between non-governmental organisations and the health care sector, such as the lack of transparency and difficulties getting the attention of the health care sector, as well as of the general public. There are also ethical privacy rights problems due to lack of training of psychiatrists and GP's in this aspect.
Finally, Ms Vidor formulated three wishes for the future:
1) Double the numbers of psychologists
2) Make psychotherapy more available
3) Have efficient resources available

Following the presentations, session chair Kevin Jones highlighting the key role of families in giving patients/people continuity, stability and support. For the family, the mental disorder of a family member is often a private challenge of its own as many people remain untreated and illnesses remain unreported. Stigma extends often to the whole family unit. He stressed the need for a high quality of information and an end to stigmatisation, stating that the family has to play a very important role in treatment.

SESSION 4: e-HEALTH, INTERNET AND MEDIA

CHAIRS:
Pol GERITS, representing the Belgian Ministry of Health, summarised the key messages for the session and reminded participants of the aim of the session and discussion. He mentioned several good practices in Belgium in this area: the implementation of guidelines for the media, the website of Flemish Working Group on Suicide Survivors and help through online chat sessions for young people.

Vincenzo COSTIGLIOLA, President of the European Depression Association (EDA), reminded participants of European Depression day on the 7th October, which was started in 2004. He urged all to contribute to fighting stigma and spreading information (particularly to practitioners).

PRESENTATION: INTERNET AND MEDIA AS TOOLS TO TACKLE DEPRESSION AND SUICIDE

Heleen RIPER from the Trimbos Institute, Netherlands, also on behalf of **Filip SMIT**, first presented the rationale for strengthening online prevention and looking for smart methods to cope with the growing health challenge. The speaker then outlined a good practice example – Colour your life, a Dutch language site - to explore the questions of whether online preventive methods are available, effective, cost effective, sustainable and scaleable. She presented data demonstrating that effect sizes for online interventions increase with a greater involvement of clinical personnel and that population health gains are larger with more general online prevention and brief interventions.
In conclusion, Dr Riper presented future challenges for prevention through the internet and media channels: Bridging the digital divide – the recruitment of low SES and migrant populations; the integration of eHealth initiatives into regular prevention and care; reaching into new settings, such as in work places and prisons; addressing complex psychological disorders, such as psychoses; strengthening evidence-based research & implementation, and; looking for EU collaboration to enrich cross-fertilisation in Europe and maximise efficiency and effectiveness.

RESPONSES:

Thomas NIEDERKROTENTHALER, from the, Center for Public Health, MedUni Wien, Austria, gave a highly practical presentation on implementing media guidelines on suicide reporting. He highlighted the risks presented by inadequate or harmful media reporting of suicide, including the possibility that reporting could have mixed or even positive effects. Dr Niederkrotenthaler focused on issues important for implementation and forming collaborative partnerships with the reporting media, with the overall aim of fewer individual suicidal acts reported, and better quality reporting for those reported. Reporting of background information such as individual mastery of crisis may be an important tool to promote suicide prevention. He summarised the roles of different public health, support services and low to high-level media professionals in an interdisciplinary collaboration, explaining the different pressures working for and against health promotion to each of the media professionals. He also stressed the importance of positive guidance and prizes for good reporting rather than only restrictions.
Finally, Dr Niederkrotenthaler gave an example of the health impact through reduction of suicides in the Viennese subway following a campaign on print media guidelines. This campaign was associated with an improved quality of reporting and a decrease of suicide rates, which was most pronounced in regions with strong media collaboration. The Austrian implementation model seems to be effective in promoting suicide prevention.

Viktor KALDO, replacing Clive Needle from EuroHealthNet, presented a practice of guided self-help for depression via the internet, provided by the Karolinska institute. The rationale behind this practice is the gap between prescription of drug treatments and talking therapy, and the scarcity of trained therapists which is the cause of this gap. The programme provides full-scale psychological treatment, but with facilitated access through the internet and other new technology such as mobile phones, and reduced

waiting times. Dr Kaldo presented the next stage of the programme – scaling up to provide treatments to a wider range and number of those with mental health problems.

Thomas MÜLLER-RÖRICH, an experiential expert and founder of the German Depression Liga, outlined the opportunities presented by the internet for service users, in particular as a low-threshold means of communicating. He presented two good practices:

- The internet board of the German Alliance Against Depression – started in 2001 and currently has 9900 users. It offers social contact, support and practical advice.
- Nethelp4u – an email helpline for young people with moderators

Dr Müller-Rörich mentioned many benefits online support and advice through the board or chat fora, such as ease of access, anonymity, continuity and the chance to form lasting friendships which persist offline. He highlighted the importance for service users of writing in the knowledge that posts would be read and how this helps to reduce depression and loneliness.
Finally, the speaker stressed the need for moderators on such sites and also warned that online initiatives should aim to enhance and not replace real offline contact.

Matic MEGLIC, from the University of Primorska, Slovenia, first outlined the various ways eHealth can support mental health and well-being, such as through e-learning, e-business, remote care, process support automation, and new communication channels. He then presented “improvehealth”, an internet based service with the aim of improving care management for patients with depressive disorder and increasing patient empowerment. As far as implementation is concerned, he noted that health care practitioners were sometimes resistant to technology assisted care, until it was officially accepted and no longer in the pilot phase. He also mentioned that some patients sometimes needed additional technical support in getting to use eHealth services. Dr Meglic summarised the preliminary research findings of a trial of the ”improvehealth” service, showing that attrition was low, adherence showed an improvement over traditional care and clinical outcomes were positive. Future steps for “improvehealth” will be cost-benefit calculations, model of national implementation, exchange of views with other countries, as well as widening the service to include support for other conditions.

During the session discussion time, participants made many additional points.
It was noted that the guidelines for printed media can be adapted and positive effects replicated for online media. However, internet standards should still be further strengthened and guidelines for chat fora need to be developed.
It was also stressed by several discussants that eHealth in particular is a demand driven area and that it may be easier to provide online interventions to young people (such as those discussed at the last Thematic Conference in Stockholm) and those of higher SES in urban areas. New ways to reach those groups on the other side of the digital divide, either through lack of technical knowledge or due to geographical location, need to be developed. Currently, non-text based online programmes are being developed in the Netherlands to overcome problems of illiteracy among internet users.

SESSION 5: IMPROVING THE KNOWLEDGE BASE

CHAIR:
Stephen PLATT – School of Clinical Sciences & Community Health, University of Edinburgh, UK
Thor ROGAN – Deputy Director-General, Ministry of Health, Norway

As chair, Thor Rogan opened the session by highlighting the lack of knowledge and the huge challenge ahead to extend and create data systems in the field of depression and suicide. He welcomed and introduced the speakers.

PRESENTATION:

Louis APPLEBY, National Coordinator for Mental Health, England, highlighted the current dilemma between research and policy: that research builds on principles of evidence based medicine, but studies are time consuming and results often not published or available in time. On the other hand, politicians look for the best available information, but do not have the time to wait for researchers and their results, as decisions have to be made quickly. An absence of full research evidence is often accepted in policy making, for example in England where cooperative work between research and policy actions have reduced numbers of suicides in high risk population groups, such as young men, prisoners and ex-prisoners, and recently discharged psychiatric patients.
The speaker outlined the six goals of the English National Suicide Prevention strategy which include promoting research on suicide prevention and improving monitoring of progress. In particular, the monitoring of suicide rates has been recognised as necessary and has to be continuously implemented. He highlighted that early data are also useful for monitoring, because they provide the chance to react earlier to upcoming trends in suicidal behaviours.
Professor Appleby introduced two English projects:

1) IAPT- Improving Access to Psychological Therapy, a programme aiming to improve access to evidence-based talking therapies in the NHS through an expansion of the psychological therapy workforce and services.
2) New Horizons is a comprehensive programme of actions for improving the mental well-being of the whole population as well as improving services for people with poor mental health by 2020. New Horizons tackles depression by prevention (improving mental health in children), treatment (expanding types of therapies available and GP training) and reduced impact through employment support and updated suicide prevention strategies.

The speaker stated that research on its own is not enough; it has to be useful for the government as well. Finally, he referred to the explicit need for researchers to provide (better) evidence for treatment and effectiveness and challenged them to deliver requirements and messages.

RESPONSES:

Jordi ALONSO, from the Institut Municipal d'Investigació Mèdica (IMIM), Spain, focused on the role in research of epidemiology and how it can contribute to the unmet needs in mental health care. He listed ways in which epidemiology can contribute to the data on the distribution of depression and suicide, for example by highlighting a high magnitude of depression and suicidality; a large toll in disability and premature mortality, and marked variation in prevalence by place and socio-demographic background. Dr Alonso outlined findings from current epidemiological studies which show different and unclear results, bringing him to the question of what drives the differences between countries. Might it be only cultural rather than health differences? Can we compare countries at all?
Dr Alonso called for health research to be driven by effectiveness, efficiency and equity aspects. He emphasised the important impact epidemiology and health research can have on future strategies to reduce depression and suicides and their implementation. He made the connection by highlighting the implementation of science through a) translational roadblocks (First in study efficacy, then effectiveness and guidelines to practice), b) adoption of principles, c) early implementation and d) persistence of implementation.

Finally, Dr Alonso outlined challenges for health research: an operational definition of the need for mental health care; comparative cost-effectiveness of prevention strategies and universal outcome measures.

Federico PAOLI, from the DG SANCO "Health Information" Unit at the European Commission, presented the current databases and information projects at the European level, whereby he focused on EU mental health monitoring and indicators by reviewing the existing evidence on mental health, suicide and depression on EU level. He reported on the ECHI (European Community Health Indicators) shortlist of 88 indicators of which 43 are already regularly implemented (mostly with EUROSTAT data). Eurobarometers on mental health and well-being and on parent's view of the mental health of their children have been published. Eurofound (the European foundation for the improvement of living and working conditions) overview on life quality data derived from the Second EU quality of Life Survey has been published. Several projects were funded by the EU Public Health Programme for investigating evidence in the field of mental health. The speaker also referred to the European Health Information Survey (EHIS), which will provide data for developing indicators on mental health and depression in 18 participating Member States, with results expected at the end of 2010.
A further development is EHES (European Health Examination Survey), which expands those questions asked in the EHIS to include anthropometric and physiological measurements, measurements of functioning, clinical examinations and determination on blood and other tissue samples.
Mr Paoli stated that the EU can support further development by project funding through the Public Health Programme (projects, tenders and joint actions) and FP7. A Health Information Committee exists as a consultative structure with representatives from all the Member States to support the overall implementation mechanisms for the health information strategy. Eventually, the rotation of presidencies, as well as their permanent presence in the European Council, gives Member States the opportunity to focus on special topics and to influence the set up of priorities for health policies.
More information at DG SANCO: http://ec.europa.eu/dgs/health_consumer/index_en.htm

Veronique BERNARD, from the Directorate General for Research, Unit "Medical and public health research", European Commission, presented the mechanisms by which EU-level research is funded and structured. EU research policy aims at strengthening competitiveness, citizen welfare and supporting other EU policies. She mentioned the 7th Framework Programme for Research and Technological Development (FP7 -more information at: http://cordis.europa.eu/fp7/health) as one of the main research instruments for funding European research ensuring "European added value" and to complement and boost the effectiveness of national research programmes. FP7 aims to break down barriers between countries and encourages participation and cooperation between countries (e.g. multinational consortia), between different types of organisations (across private and public sectors) and between disciplines (multidisciplinary and translational research).
Ms Bernard stressed that at DG Research health themes are distributed in three pillars. The first pillar incorporates biotechnology, generic tools and technologies for health. The second pillar focuses on translating research for human health. The third pillar is newly established and focuses on optimising the delivery of health care. It consists of new research methods (to generate a sound scientific basis; to underpin informed policy decisions on health systems and to achieve more effective and efficient evidence-based strategies of health promotion, disease prevention, diagnosis and therapy) and additional necessary research areas will be targeted.

Anne-Laure DONSKOY, representing the European Network of (ex-)Users and Survivors of Psychiatry (ENUSP), called for a higher visibility of service users and urged research bodies to give them the opportunity to have more responsibilities especially at conferences like this one. She focused on user involvement in research and the benefits for research and its results. She mentioned that reasons for not involving service users might be the lack of commitment and lack of willingness to give service users full control and responsibilities of research processes. She formulated the problem on how sciences constructed the world and knowledge without accepting other ways to construct the world also in relation to knowledge building. Ms Donskoy stressed the need to take user's voices into account and listen to them and demanded more qualitative research. She also called for a greater service user involvement in the political field, an involvement of value due to their phenomenological experience in surviving depressions, self-harm and suicide attempts.

Ms Donskoy referred to self-harm research where often researchers present themselves as experts whilst excluding the subjects of their research. Further she criticised the widespread assumption that self-harm is necessarily connected to suicide and is often just seen as a proxy indicator, instead of as a survival or coping mechanism in itself. She referred to the missing attitudes of understanding and different levels of meaning and experiences.
Finally, the speaker asked critically if researchers who have not been affected by self- harm behaviour can ask the right questions. In her opinion the focus has to be put on the first episode of self harm and the right research questions have to be asked of before- between- and after episodes.

Discussions focused on service user involvement in research and questions regarding the EU research strategies.

PLENARY SESSION: REPORTING BACK FROM THE PARALLEL SESSIONS

CHAIR:
Ms Melinda MEDGYASZAI – Secretary of State, Hungary

RAPORTEURS:
Charles PULL from the Centre Hospitalier de Luxembourg, referred in his report to the determinants and risk factors of depression session. He mentioned the protective and risk factors of depression mentioned in the background paper and referred to the key messages: Some determinants are modifiable by policy action. Action against depression and suicide should be integrated into the response to the economic crisis to strengthen protective factors and to reduce risk factors.
Dr Pull reviewed the presentations of Session 1 and pointed to the fact that costs of mental health will remain the same even in times of financial crisis. He urged that the burden should not be shifted to individual or families.
Dr Pull summarised that there is a need for cost-effective treatment programmes, better data, commitment to invest in mental health and to look at positive affects of the crisis.

Stephen PLATT, from the University of Edinburgh, Scotland/UK, reported on the determinants and risk factor of suicide session and summarised the important aspects of this session by highlighting the barriers which need to be addressed by future actions. He called for a better recognition of suicide, better trained personnel, better treatment, better access to services and the need to tackle poor media reporting and to identify new risks groups such as migrants. Dr Platt stated that the session identified a high importance of regional strategies for suicide, having high level political commitment and reviewing the role of GPs in suicide prevention and intervention by improving skills and competences. Platt stressed the need to target health care provision and to develop new strategies and models to target especially young males seeking help in critical suicide ideation situations.

Kristian WAHLBECK, from the University of Helsinki, Finland, reported on the session: Building partnerships with other policies and sectors by formulating the key message: Engage in cross-sectoral partnerships at the EU, Member State and regional level. After presenting the key activities (European Alliance Against Depression (EAAD), IBM France- health and safety preventive approach, VISCI screening instrument to identify suicide risk among new prison inmates and partnership with other policy arenas: alcohol policy), Professor Wahlbeck pointed to the way forward, translating research into practise by a) building inter-sectoral community networks committed to suicide prevention and seeing its effectiveness; b) acknowledging that preventive actions by non-health professionals are effective; c) closer collaboration between mental health and alcohol policy and d) learning to speak the language of non-health sectors.

Chris O'SULLIVANN, from the Scottish Development Centre for Mental Health, reported on the Internet's role in providing health services; Internet forums and their potential to influence recovery; and media guidelines, which were the activities presented in the eHealth session. Mr O'Sullivan summarised the action framework by focusing on the effectiveness and cost-effectiveness of eHealth and pointing out that eHealth already operates effectively in several Member States. He stressed that guided self-help online is the often a most effective option, but requires moderators and guides with careful training, e.g. in primary care. The challenge is to integrate eHealth into other services. Mr O'Sullivan argued for further action to implement media guidelines as they are effective when they include the right stakeholders.

David MCDAID, from the London School of Economics, UK, presented the different approaches and responses of the Improving the knowledge base session. He listed existing barriers such academic research not always timely being, poor communication of findings, the need for improved quality of comparative data and the solely medically focused model in research. McDaid argued for prioritising actions by a) enhancing collection of data as part of routine monitoring at both national and EU level, b) considering whether most appropriate questions and indicators are being used in surveys, c) looking at the need for a better understanding process of implementation in knowledge transfer; d) strengthening the role of service user researchers within the research process and e) learning from the past as too often experiences are forgotten or mistakes repeated.

FEEDBACK ON THE CONFERENCE

Matt MUIJEN summarised the important key challenges for the future:
1) the need for good credible research
2) targeting the prevention on vulnerable groups
3) access to low-threshold services offering effective intervention
4) partnership building, with strong leadership and
5) influencing decision makers

Karin HJELMER from the Ministry of Health and Social Affairs, Sweden, thanked the Hungarian organisers. She underlined the importance of this conference by having the possibility to exchange good practices in suicide prevention and mental health promotion and stressed that societal intervention must continue. She gave a quick overview of the political situation in Sweden, where a suicide act has been implemented in the updated public health policy agenda in 2008.The suicide act has nine strategies to follow up and focuses on individual and structural factors. Sweden has chosen a special focus on public health and alcohol policy during the Swedish European presidency where mental health and prevention of depression and suicide are important aspects.

The President of Mental Health Europe (MHE) **Nace KOVAC**, argued that action on depression and suicide has to be taken forward and drawn to the attention of policy. In times of crisis it is difficult to contribute but it might be also a chance to address people and groups in a new way and to improve social protection and exchange good practice.
In a concluding statement, Mr Kovac called on EU leaders to take real leadership and a) to take responsibility for the protection of the mental health and well-being of the population; b) to ensure the effective implementation of the European Pact for Mental Health and Well-being; c) to develop a more egalitarian and inclusive social model in which the non-profit sector is an essential actor; d) to encourage national governments to put the fight against poverty and exclusion high on their political agenda; e) to improve the social protection systems in the different Member States, which is especially important in Hungary and the Baltic States where the economic and social situation is at its worst; f) to promote exchange of good practice between the different Member States; g) to promote and foster cross-sectoral co-operation between policy makers in the different related areas – social policies – public health policies – human rights policies and h) to involve people with a mental health history and their carers in the design of policies, their development and implementation.

Gabriel IVBIJARO, from the World Organisation of Family Doctors (Wonca), Chair of the Wonca Working Party on Mental Health, described Wonca's collaboration with the WHO in producing the joint report 'Integrating mental health into primary care: a global perspective' and in contributing to the improvement of access to mental health through participation in the WHO mhGAP (mental health gap) Action Programme . As a practising General Practitioner (GP) working in primary care, he outlined the evidence supporting the importance of strengthening primary care in order to support mental health. He stressed that suicide prevention is an important task for public health and noted that each suicide is the product of particular circumstances and results in an individual tragedy with family ramifications and every effort should be made for prevention.
He emphasised that we have already have practical tools which we need to use in order to move forward. Dr Ivbijaro noted extreme polarisation between different mental health professionals and service users during this conference, and stressed that is not the way forward, urging that we have to put the patient first and not just our professional interests. He stated that integration has to be made a reality and suggested the need of reaffirmation the European definition of General Practitioners. He accentuated the need for the availability of an appropriate skill mix of psychiatrists, social workers, psychologists, counsellors, occupational therapists, family doctors, nurses, housing officers and other workers necessary to support the wider social determinants of health benefit. Dr Ivbijaro emphasised that special attention should be placed on service users and their families.

Pablo GARCÍA CUBILLANA from the Ministry of Health and Social Policy, Spain, welcomed the forthcoming Thematic EU-conference: Mental Health and Well-being in Older People, to be held on 19th and 20th April 2010 in Spain.

The Thematic Conference and related work will be organised around 5 sub-themes:

1. Mental health promotion in old age: Active Ageing and Wellbeing
2. Prevention of mental disorders and support for those mentally ill
3. Dependence and structures for care
4. Social dimension and vulnerable groups
5. Training and interventions for carers

The main objectives of the event are a) raising awareness about the importance of promoting mental health and well-being and of preventing mental disorders in older people; b) discussing a framework for action based on the background document and its key messages; c) enabling an exchange at EU-level on policy activities and good practices by stakeholders and research projects in Member States, supported by a Commission database and finally d) providing input for a possible EC summary High Level Event in 2011.

CONCLUDING REMARKS

Melinda MEDGYASZAI, Hungarian Secretary of State, urged for attention to be paid to the role of patients and their families, as 80% of care is delivered by carers. She stressed that it is important to learn from families and service users. She warned of attitudes in this area where distinctions are made between: "us and them" and "me and you", arguing that we are all the same and that it is important to work together and to collaborate and cooperate to prevent depression and suicide. She stated the need to recognise that raising self awareness, learning coping techniques and building resilience are important to prevent both physical and mental illness. Therefore especially the education of children in these vital skills is important, as well as educating them to reduce the stigma of mental illness.
Ms Medgyaszai raised the issue of values, pointing out that we are living in luxury in Europe and nevertheless have very high depression and suicide rates. She stressed the need of measuring values, such as being happy, in a new way. Finally, she stated that, as social animals, working together and in the company of other human beings is important and achievable.

PLENARY: CLOSING STATEMENT

Michael HÜBEL, Director for Public Health and Risk Assessment, Directorate General for Health and Consumers, European Commission, Hübel thanked Ms Medgyaszai for her excellent summary and the Hungarian organisers for preparing and arranging a very well organised conference, where everybody felt very warmly welcomed.
He also expressed his thanks to the WHO and Swedish presidency and voiced his appreciation of the background papers. He stressed that strong leadership, health experts, users and the civil society are needed to implement and transfer key priorities into action and to improve policies. Mr Hübel underlined the need for both national and regional strategies and he looked forward to integrating (service) users' perspectives even more by asking them to challenge health professionals, researchers, politicians and the general public. Mr Hübel stated that the conference working documents would be revised to take comments during the event into account and urged participants to use the momentum to initiate action on returning home. He told participants that he went away encouraged by this second Thematic Event to continue the work.