



MINDFUL - Mental health information and determinants for the European level

**Final technical report**  
**Annex 2: Mental health monitoring systems in the**  
**new EU Member States**

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## I. Introduction

This project has arisen from the gap in previous work on mental health indicators for use throughout the European Union and previous research on the state of mental health in the European Union caused by its enlargement. On the one hand it adds to the evaluation of the state of mental health in the EU by including the new EU Member States in the research. On the other hand, it questions the quality and quantity of already existing data on mental health by analysing the mental health indicators and process of data collection and management. As such it aims to contribute to inadequacies in mental health research in the EU and to improve grounds on which to develop a more refined unified mental health monitoring system, which would provide better evidence for policy and actions.

This project was intended to tackle differences and similarities in mental health information systems in the new EU Member States, as to provide better understanding of the lack of mental health data, process of mental health data collection, problems of mental health data comparability and mental health problems in the enlarged EU.

Therefore, the main research questions that guided this project concern the following topics:

- Availability of mental health indicators;
- Comparability of mental health indicators between the new and the old EU Member states;
- Accessibility of the data on the state of mental health;
- Data on mental health in the New EU Member states.

## II. Methodology

### *Management of partnership project*

The project action plan, including time schedule and budget plan, has been defined according to the contract between STAKES and The Institute of Public Health of the Republic of Slovenia.

For the project coordinator dr. Tanja Kamin has been appointed in October 2004. The core project team has been given the organizational structure with clear responsibilities and tasks. The core team consists of dr. Andrej Marušič., dr. Mojca Dernovšek, dr. Tanja Kamin, dr. Helena Jeriček, Maja Zorko, Saša Roškar, Nina Pirnat.

### *Participators*

The Institute of Public Health of the Republic of Slovenia has signed the subcontracts with the following institutions:

HUNGARY	LABO '99 KFT 2092, Budakcszi Jokai-u 24/a	Dr. Lajtavari Lazslo
LITHUANIA	MTVC - Training, research and development centre Antakalnio 22b,	Marija Veniute

	LT-10305 Vilnius	
LATVIA	Psychiatry centre University Department of Psychiatry Tvaika Str 2 LV 1005, Riga	Maris Taube
POLAND	Institute of Psychiatry and Neurology Sobieskiego 9 02-957 Warsaw	Dr. Ewe Stepien
THE CZECH REPUBLIC	Prague Psychiatric Center, Ustavni 91, 181 03 Praha 8	Dr. Eva Dragomirecká
ESTONIA	Department of Public Health University of Tartu Ravila 19 Tartu EE50411	Dr. Raul-Allan Kiivet
SLOVAKIA	Psychiatricka klinika FNLP, Rastislavova 43, prac.tr.SNP 1 Kosice, 04011	Dr. Eva Palova, Dr. Bibiana Kalinacova
CYPRUS	Ministry of Health of the Republic of Cyprus Platonou 7, Pantea Mesa Gitonia 4007 Limassol - Cyprus.	Vassilis Hadjivassilis

From Croatia Elizabete Radonic, from Psychiatric hospital Vrapce, has participated in the project at all three meetings as a representative of a future applicant EU country.

### *Meetings*

Three meetings with project partners were according to the plan organized three times:

- 1<sup>st</sup> meeting was held in Ljubljana on 3<sup>rd</sup> and 4<sup>th</sup> of December 2004
- 2<sup>nd</sup> meeting was held in Portoroz from 21<sup>st</sup> to 23<sup>rd</sup> April 2005
- 3<sup>rd</sup> meeting was held in Ljubljana from 23<sup>rd</sup> to 24<sup>th</sup> February 2006.

### *Procedure*

Experts from all ten new EU Member States and from one future applicant countries were invited to participate in the project. The countries to be formally included in the project “Examining the MH monitoring systems in the new EU states” were: Czech Republic,

Cyprus, Hungary, Estonia, Lithuania, Latvia, Malta, Poland, Slovakia and Slovenia, as a leader of the project.

On the *first meeting in Ljubljana from 3 to 4 December 2004* the project was introduced and the strategy for the research was adopted. The project “Examining the MH monitoring systems in the new EU member states” has been discussed with the experts from Slovenia, Poland, Hungary, Slovakia, Czech Republic, Cyprus, Estonia and Lithuania. The representative from Latvia was not able to participate at the meeting and Malta has not shown enough interest to participate in the project at all. All project participants have been informed with content of the project as well as with formal, organizational structure of the project, including details on contract: obligations and budget.

In advance to the first meeting, participants of the project received material with the basic information on the MINDFUL project and subproject “Examining the MH monitoring systems in the new EU member states.” Experts were introduced to the proposed ECHI list.

On the *second meeting in Portoroz in Slovenia from 21 April to 23 April 2005* the mental health monitoring instrument was further discussed. The aim was to shape the elementary profile on mental health monitoring systems of the new EU countries.

Each country member was asked to study the surveys on mental health in their countries in more detail in comparison to the proposed ECHI indicator list. Each expert has in advance received a questionnaire, which we have developed to detect available indicators for monitoring mental health in the new EU states. As a tool for comparison, proposed ECHI list was included in the questionnaire. It aimed to provide data on comparability of mental health indicators between the new EU member states and other EU member states.

The questions were aiming to get information about:

- the existence of particular mental health indicator in the mental health monitoring system of each partner country
- who collects the data (with particular indicators) on mental health
- how is data on mental health collected in the country in general
- who is the population of the mental health research

The research was conducted in a descriptive and analytical manner and by the following strategy:

- designing a questioner for country representatives, for exploring availability, accessibility and comparability issues of mental health indicators suggested by ECHI list for measuring mental health; mental health indicator was defined as a measure on the state of mental health; they may be items in health surveys or statistical data collected routinely or occasionally;
- gathering the available data on mental health state for four points in time: years 1990, 1995, 2000, and last available in order to identify trends in the state of mental health in the new Member States;
- in-depth discussions with 10 “experts” – country representatives, on mental health information systems in their countries, on gathered mental health data and on the needs for and adequateness of proposed ECHI list for measuring mental health;

- telephone survey, using proposed ECHI list for measuring determinants of mental health, such as psychological distress, psychological well-being, psychological impairment, sense of mastery, sense of support, social isolation, negative life events etc. has been designed and implemented on a national representative sample of adult population (n = 846) in Slovenia in June 2006<sup>1</sup>.

### III. Results

In general, observed health indicators for monitoring mental health of the population could be divided to the opinion kind (personal assessment of mixture of biological, social and psychological dimensions of ones own health) and objectified (absence and presence of ill health, health care system data, structural and other indicators describing positive mental health). Both groups of statistical data are equally important for assessment of mental health state in a country and could be collected by health surveys or routinely. However, the study shows that in the mental health monitoring systems of the new EU member states primarily the second group of indicator exist for mental health assessment, and even these vary considerably across the countries.

These variations will be first discussed on the level of availability of indicators, secondly on the level of comparability of the data and thirdly on the level of accessibility of the data. It should be noted again that indicators were studied against the ECHI list recommendations. This report will only summarize the main findings that bring attention to the main difficulties in unifying the mental health monitoring systems across EU.

#### *3.1. Availability of mental health indicators*

Availability of an indicator was in this project defined as the existence of an indicator in a national mental health monitoring system. Indicators could be available on a regular basis, available on an occasional basis (within occasional surveys) or not available at all, regardless on what sample they have been used. Therefore we were questioning whether the measurement system as defined in the proposed ECHI list exists in a particularly country and if it has been ever used. As will be explained later, the availability of an indicator doesn't necessary guarantee the accessibility of the data gathered with an indicator, neither the comparability of the data in the countries through time and/or between the countries.

Countries included in the research differ to a great extent regarding the availability of indicators for measuring the state of mental health. The table evidently suggests that there is a considerable gap towards the unified mental health monitoring system in the EU.

The majority of available mental health indicators represent part of the routine indicators related to morbidity, mortality and health care system, and are mostly used for administrative purposes. Differences in national legislation, regulations, and administrative practices, which have due to political and economical reformation changed through the last decade in the new EU member states, may cause significant bias in interpretation of the data and in longitudinal and/or international data comparisons, although the indicators share the same definitions. In the project it has been realised that conclusions on availability of the indicators with the same definition must be cautious as well. For example, the participating countries have been

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<sup>1</sup> This research has been conducted with the financial support of ARRS, Slovenian Research Agency.

reporting the availability of the majority of mental health system indicators sharing the same definitions. However, through the in-depth discussions with the country representatives, differences in understanding of particular elements of the indicator's definition occurred. For example, countries differently interpret, what is a mental hospital bed, what is an alcohol related death etc. For instance, alcohol related death definition is too vague; sometimes reporters include both, the cases with alcohol related disease and cases of death caused by drunken people, such as car accidents, freezing to death etc. It is recommended, therefore, that *definitions of the indicators and the indicator's elements should be more exclusively operationalized in order to provide better comparability of the data.*

The most visible gap in mental health monitoring systems across the new EU member states, similarly as in the old EU member states, presents the lack of indicators assessing mental health determinants, and opinion kind of indicators assessing the status of mental health of the general population. Since most of persons with mental health difficulties are never hospitalized and or never treated, survey indicators for measuring mental health at the general population level are extremely important for assuring longitudinal mental health state assessment and evaluation of mental health policy programmes and interventions. Such indicators are in the majority of studied countries not available at all. In the countries where they exist, they are defined differently as in the suggested ECHI list and had been applied on the representative population sample only once in the last decade.

The project has identified existence of similar to ECHI list indicators for mental health assessment at the general population level in majority of the countries, for example indicators on life satisfaction, social networks, happiness, sense of control, sense of social inclusion etc. However they were most often part of the public opinion surveys, research on quality of life or other small scale social research, of which the findings could not be generalized to the whole population. *Potential for synergistic benefits between health sector and social sciences, university departments, high schools and criminal departments, which often explore indicators relevant for mental health assessment, needs to be further explored.*

According to the available mental health indicators we could conclude that mental health information systems in the studied countries are more oriented towards services and mental health system users and not particularly to general populations. With the exception of two participated countries (Estonia and Czech Republic), no real epidemiological survey on mental health has been carried out so far. This gives somehow distorted picture of mental health status in a particular country. For instance, utilization indicator – treatment based morbidity is often reflected as an incidence and prevalence etc. Data collected with, for example, an indicator “social phobia” in majority of countries reflect number of hospitalized patients with social phobia diagnose. This number doesn't include those who are treated by general practitioners, what else other members of the population. An estimate for Slovenia, for example, is, that number of those suffering from social phobia symptoms is 2 times bigger than the official indicator measures. If this estimation is correct, Slovenia would have in 2003 at least 18 instead of 9 such cases in the population of 2 million.

Discussions with countries representatives have revealed that there have been some changes in inclusion and exclusion of different indicators in the mental health monitoring system in the last decade. Some countries are in the process of development of new mental health indicators that are going to be included in their health monitoring system. Cyprus, for example, is about to except a new mental health monitoring system, which is developed totally independently of ECHI propositions. *Since recently many countries are trying to fill*

*the gap in mental health monitoring system according to their needs and understanding of mental health, it is suggested that common mental health monitoring recommendations from the EU level for all the EU states and future applicant countries would be given. Once the new systems are established and applied, it will take more time or even resistance to change them according to the new EU suggestions and standards. It would be therefore important to include in these suggestions also the new and future applicant countries.*

The project has also identified poor use of the databases and benchmarking. Even for gathered data, due to the lack of knowledge, poor information technology, shortage of human resources etc. a lot of data related to mental health that gets gathered rests in the databases without further analysis and publishing.

### *3.2. Comparability of the data*

#### *Definitions of an indicator*

Comparability of the mental health data at the cross country level is questionable. Many available indicators are having either a different definition either certain elements of a definition are differently interpreted in different countries. For example indicator “total national expenditure on psychiatric service” is understood differently. In some cases it measures expenditure in health sector and in other sectors, social sector for instance. In most cases the indicator measures only expenditure in health sector, what gives incorrect picture and makes comparison between the countries difficult.

#### *Sample*

The study revealed that indicators although with the same or similar definitions are often used on differently defined population samples. On our study we have identified that prevalence on a population level could be estimated on the basis of hospitalized cases. Sometimes the data are gathered only on a regional level on a regional sample or on an opportunistic sample. Even understanding of a population samples might be different. Samples of “adult population”, for example, in some countries include persons from 16 to 65 years old and in some from 18 to 70 years old. *It is recommended that in order to be able to speak of comparability of data on representative sample of a country's population, the age interval of the population's sample is unified across countries.*

#### *Deficient reporting*

It often happens that individuals, such as general practitioners that are responsible for reporting on routine statistics to statistical offices for different reasons do not report or they report insufficiently. Sometimes this is due to different events, such as reforms in national health systems, strikes, overburdened staff, or financial, reimbursement issues etc. This background information on circumstances should be considered in data interpretation and analysis of statistical trends and comparisons. For instance, Polish data about suicide for the period from 1997 to 1998, show significantly lower suicide rate from previous years. This statistical fact was influenced by a general strike, during which medical doctors among other things did not complete death certificates and thus record and report the data on suicides. Biased data reporting is sometimes, as participators have exposed, stimulated by financial interests, since in cases of co-morbidity often the one diagnose is reported that has higher economical value for particular institution. Similar biased reporting might be influenced by other organizational issues. For instance, in Lithuania, the external causes of death are similar to other neighbouring countries. At the same time the suicide rate is in Lithuania significantly

higher and homicide rate, even in the most violent areas, very low. Is it possible that the number of homicides is for certain reason hidden in the suicide rate?

In general, professionals and private entities across countries show rather low interest to report the data. In many cases the reporters think they have to fill too many forms and report the data of which only a small proportion gets published somewhere. Non-reporting could be improved by different strategies. One of the mechanisms, often exposed by participators of the project, was related to legal issue. In majority of the countries the only obligatory information to be reported is related to financial information. If the data are to be comparable, *the consistent reporting could be influenced by adequate rewording and penalization of the data collectors and reporters. As well feedback of data analytics and data keepers back to the reporters on the usefulness of data could stimulate the reporters for better reporting.* Another mechanism to influence prompt reporting is less passive role of the data keepers. These usually just wait for the data to be sent in.

*Who is bounded by contract to report the data?*

At a national level mental health monitoring system in general includes information flows at multiple levels and between many organizations; from mental health service providers to regional health agencies, national health institute, central statistical office, health insurance, state mental health centre (if existing) and ministry of health. In the studied countries only those entities are bound to report the data that are somehow contracted with the national public health system. Private mental health service providers and also mental health service providers that are not situated under national public health system do not report the data. For example, in Lithuania private mental health care providers provide only financial data to the State Patient's Fund but only if they are contracted by it. In this way a lot of data is lost and *governments should influence the reporting from both, state social sector and all relevant private sectors.*

### *3.3. Accessibility of the data*

By accessibility we have defined the way data gathered with an available indicator in question have been accessible. Data might be accessible to the public in printed or electronic publications; they may be accessible on request with or without payment and not accessible at all or accessible only to the owner of a database. Data may be accessible also on the international level (for example if the data are reported to EUROSTAT or other international database) or only on the national level.

Availability of the indicators and consequently the data on mental health does not mean that the data is accessible to the public or even to the researchers. With the process of privatisation, which is very common to all new EU members, being countries in transition, there is a trend towards less publicly accessible data. To this trend contribute also other issues, for example, legal restraints for better personal information protection. It often happens therefore that previously accessible data are becoming non accessible or only accessible against the payment. This data are usually related to financial and drug related issues, such as sickness compensations, disability pensions etc. Governments could influence the accessibility of the data that are important for the interventions and policy programmes. *We would advice that in the process of privatisation certain types of data stay in the public interests and public – state ownership.*

#### IV. Conclusions and recommendations

The state of mental health in a country can be observed on at least five dimensions:

- a. mental health of the population
- b. mental health care sources
- c. mental health policies
- d. mental health information systems
- e. cultural meanings of mental health (media, stigma, etc).

This project has shown that mental health monitoring systems in the new EU member states, similarly as in the old EU member states, are focused on the mental health care sources, particularly hospitals, and on some of the routine statistics on morbidity and mortality. The availability of such data doesn't mean that this data are also the most relevant for detecting mental health problems and defining needed interventions. Many of the determinants of mental health problems lie outside the area of health care. This presents a challenge for development of mental health policies, which are to often issued almost exclusively by health sector. Once mental health is understood as more than just opposition to mental illness, more determinants, viewpoints and consequently sectors should be included in mental health monitoring and policy design.

Information about mental health across the new EU Member States should be collected in a more appropriate ways to enable more valid comparisons. For this reason definitions of the indicators should be better operationalized and consolidated across the EU member states, sample definitions better defined and important contextual factors that influence data interpretation provided.

A lot of research relevant for mental health of the population assessment already exists. Synergistic benefits between different sectors and existing research projects could be explored and better used. Mental health component could be included in various surveys beside health surveys, not least surveys on quality of life, human development etc.

Special population groups (vulnerable groups such as unemployed, children, immigrants older people) should be specially addressed with the research. More comprehensive indicators for certain population groups should be developed.

Reporting to the national and international data bases should be made obligatory and responsible institutions should be properly sanctioned for non-compliance. For this reasons the chain of relevant institutions collecting the data and reporting them forward should be established, with clear formally defined relations, and published.

In the process of privatization more and more data will be accessible only against the payment. Governments should ensure that certain data, important for policy development, stay in the public domain and available for research analysis.

Certain countries operate with significantly smaller budgets than others. This consequently has an impact on the complexity of any monitoring and research systems across the countries. EU should set priorities on the mental health monitoring area and with proportionally distributed founding help organize to certain degree standardized information systems across EU Member States.