PARALLEL SESSION 3

Friday 7 November, 10:30–12:00

A.3. Workshop: Current EU developments in the field of health

Chairs: Andrzej Rys European Commission (tbc)*
Organizer: D. G. Sanco, European Commission
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This workshop will focus on current EU developments in the field of health. The workshop intends to cover developments in relation to the new health strategy, stakeholder involvement as well as information and communications tools and activities.

B.3. Workshop: Culture and mental health

Chairs: Jutta Lindert (Germany), Gunnar Tellnes (Norway)*
Organiser: EUPHA section on Public Mental Health
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Background

Major mental disorders are found across all cultures. Culture is defined as a heritage or set of beliefs, norms and values. It refers to the shared attributes and shared meanings of one group. Culture can account for variations in how people communicate their mental health symptoms and which ones they report. Some aspects of culture may also underlie culture-bound syndromes—sets of symptoms much more common in some societies than in others. More often, culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have and how much stigma they attach to mental illness. Culture applies to the professionals who investigate and treat them. Public Health professionals embody a 'culture' in the sense that they too have a shared set of beliefs, norms and values. This means that people view mental illness symptoms, diagnoses and treatments in ways that sometimes diverge when the cultural backgrounds of the consumer and provider are dissimilar. This divergence of viewpoints can create barriers to effective care.

Aim

The prevalence of mental disorders among minorities is widely discussed. We aim to contribute to the understanding of the roles of culture in the mental health field to contribute designing and delivering services that are responsive to people from diverse cultures.

Methods

The topic of culture and health will be highlighted in four presentations. Cinthia Menel-Lemos from the Public Health Agency will give an overview on funded project in the area of mental health of migrants and ethnic minorities. Jutta Lindert and Sonia will present research studies on culture and mental health (Jutta Lindert) and on culture and mental health linked to sexual health (Sonia). To conclude Aldo Morrone will give an overview on culturally adapted mental health services.

Expected results

The main message of the workshop might be that 'culture counts.' The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but cultural differences must be accounted for to ensure that all people living in Europe receive mental health care tailored to their needs.

Health programme 2003–08—European actions to tackle social exclusion, mental, and migration health

Cinthia Menel Lemos

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Background

Since 1997, mental health issues (e.g. depression, suicide) are finding increasing attention within the Community's health and other policies, through projects and political activities. The report, 'Action for Mental Health,' gives an overview of the projects and other activities, which the European Commission supported from 1997–2004. Within the Health programme 2003–08, the objectives were to support actions for improving information and knowledge for the development of public health, and promoting health and preventing disease through addressing health determinants across all policies and activities. The European Commission has co-financed 23 projects on social determinants and 12 on mental health. The EU 'Mental Health Green Paper' addresses the strategies for the promotion of mental health and prevention of mental ill-health. The target vulnerable groups are defined as persons with low social and economic status, who have lost their jobs or are not in employment, and especially migrants and ethnic minorities.

Methods

An assessment of the projects funded under the PHP 2003–08 will be performed against the European Mental Health Strategy concepts. The projects submitted under the health determinants strand, particularly those addressing the priorities on mental health and social determinants of health, will be analysed to measure their contribution to the achievement of the EU Mental Health strategy especially their contribution to assessing and improving migrants' mental health.

Results

The degree of achievement of the EU Mental Health strategy through the project implementation will be assessed. The data available for estimation of the burden of mental ill health, particularly those on migrants and ethnic minorities' mental health will be compiled. The synergies between the projects addressing different priority areas, but working migrant and ethnic minorities will be highlighted. The sharing of good practices and lessons learnt, especially on the accessibility of health promotion and prevention activities will be documented.

Conclusions

The identification of good practices examples that can orient the improvement of mental health policy for migrants can contribute to tuning of health services towards evidence—based responsiveness of services.

Cultural dynamics in mental and reproductive health of immigrant women

Sonia Dias

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Background
The limited data available suggest that immigrant women in Portugal are at high risk for negative sexual and reproductive health outcomes and underutilize health care services. The study aims to understand immigrant-women perception, attitudes, and needs in relation to sexual and reproductive health and explore their perspectives of health care services related to these issues.
Methods
Eight focus groups were conducted in 2005 with a purposeful sample of 64 low-income African and Brazilian immigrant women, aged 18–45 years, living in Lisbon, Portugal, for at least two years. Content analysis was used to analyse the data obtained.
Results
We identified differences related to cultural beliefs and norms between African and Brazilian women that play an important role in the adoption of practices related to mental, sexual, and reproductive health. Participants described a dynamic process between the challenges they faced moving to a different society and cultural expectations that determine perceptions, attitudes, and consequently choices that can make them more vulnerable to sexual and reproductive health. There is an interception of social, cultural, economic and personal factors that characterize diverse immigration's experiences. Data from women's discourse reveal that frequently they faced situations characterized by human rights violation, discrimination, social inequalities and exclusion. The results showed that women faced reduced access to health- care services due to structural, administrative, social, economic and cultural barriers. According to the opinion of the women participating in the focus groups many of these problems are connected to a lack of migrant-oriented health services, insufficient training of health professionals in caring for those from different cultural backgrounds and a lack of sensitivity by health providers to multiethnic society.
Conclusions
Our findings suggest that efforts must be tailored to the specific needs of immigrant women with different sexual and reproductive experiences and expectations, and must address the cultural, social, economic and psychological context in which they live. In order to ensure effective healthcare, providers must be sensitive enough to deal with different cultural and value systems that have an impact on decision-making related to sexual and reproductive health and use of healthcare services.

Mental health among refugees and migrants—a systematic review

Jutta Lindert

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Background
Worldwide about 200 million migrants have left their home countries for reasons that include war, environmental disasters and economic strains. Prevalence rates of depressive and anxiety symptoms among migrants (refugees and labour migrants) vary greatly among studies. We aimed to systematically review studies and to identify factors that might affect the frequency of depression and anxiety.
Methods
Systematic literature searches in the databases MEDLINE and EMBASE on studies published from January 1994 to July 2007 and reviews of textbooks and reference lists. We included population- based studies reporting prevalence rates of depression and/or anxiety and/or post-traumatic stress according to DSM- or ICD- criteria in adults. Studies were analysed in relation to immigration status ('voluntary' vs 'involuntary'), sampling methods ('probability vs non-probability') and emigration and immigration countries' Gross National Product (GNP). Pooled estimates were calculated using the Dersimonian–Laird estimator for proportions.
Results
The literature search generated 348 records with 37 meeting our inclusion criteria ($n = 17\,025$ labour migrants; $n = 7659$ refugees and asylum seekers; $n = 413$ 'mixed groups' total: $N = 20\,108$) involving 18 countries. Pooled prevalence rates for depression and anxiety among labour migrants were almost half of the rates for refugees [depression: 20% (95% CI 14–26) vs 44% (95% CI 27–62); anxiety: 21% (95% CI 14–29) vs 40% (95% CI 23–49)]. Similar differences were seen for prevalence rates of post-traumatic stress disorder (PTSD) among labour migrants and refugees. Symptoms were associated with the immigration status and economic situation of the host country.
Conclusions
Our findings give support to the notion that mental health in labour migrants and refugees needs to be considered separately. Factors related to the situation in the host country may improve mental health in labour migrants but not in refugees.

Culture and mental health among refugees and victims of torture

Aldo Morrone

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Background
In 2001, the Department of Preventive Medicine of Migration, Tourism and Tropical Dermatology at the Scientific Research Dermatological Institute S. Gallicano, Rome (INMP) started a service for asylum seekers, refugees and victims of torture. We adopted a multidisciplinary intervention system to meet the problems underlying the events reported by the asylum seekers and the victims of torture on the basis of identification of the strategy to be adopted to achieve their psycho–physical recovery.
Methods
The intervention methodology is multidisciplinary and includes the following professional profiles: cultural–linguistic mediators, medical practitioners, psychologists and psychotherapists and anthropologists. The operational procedures of the professionals involved alternate between the complementary modalities: individual and shared with others. The performed activities are: reception and supply of relevant information, legal and anthropological counselling, medical examinations, diagnostic tests, psychological interviews, release of documents and certificates for the agencies/institutions in charge of considering the asylum applications, social assistance, training and research.
Results
From 22 January 2002 to 17 May 2007 our service has given assistance to 244 persons (80.3% males, 19.7% females) of 31 nationalities. The most represented nationality is Kurdish

(48.8%). More than half of the sample have a mean age of 30 years and are unmarried (53.7%). 25.4% were persecuted in the country of origin for supporting political opinions. More than half of the sample were subject to some form of violence and/or torture. Observation of the categories of the assigned diagnoses showed that 83.8% of the sample obtained a diagnosis of 'psychological disorders,' corresponding, by 98.9%, to 'protracted post-traumatic tress disorder.'

Conclusions

Considering the clinical and diagnostic results derived from the sample, the high prevalence rate of the 'protracted post-traumatic stress disorder' diagnosis has represented an element of discussion and debate among the professional subjects involved. The exchange among experts has confirmed the thesis, about the inadequacy of the psycho-diagnostic diagnoses considered in DSM IV when referred to patients from non-western countries. We recommend improvement in mental healthcare services for migrants and minorities respecting the fact that symptoms of mental ill-health may be shaped by culture.

C.3. Session: On child and adolescent public health 1

Differences in consumption of recreative drugs by university students living with their parents or alone in Belgium and the Netherlands

Cècile Boot

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Background

University students report a lower health status compared to their working peers. Studying at university is associated with the consumption of tobacco, alcohol and recreational drugs. This unhealthy lifestyle may be associated with moving outside parental control during the study. The aim of this study was to investigate differences between university students living with their parents and students living alone or with peers regarding consumption of recreational drugs in Belgium (Antwerp) and in the Netherlands (Amsterdam).

Methods

The results of a questionnaire study in Amsterdam (8258 students in 2005) and Antwerp (5530 students in 2005) were used for this analysis. Both questionnaires contained items about consumption of recreational drugs. Moreover, in the Amsterdam questionnaire, the students were asked whether they considered their consumption of these substances a problem. Students living with their parents were compared with students living alone or with peers.

Results

In Amsterdam, students living alone reported consumption of recreational drugs (OR = 1.54; 95% CI 1.26–1.89) more often than students living with their parents. In Antwerp, students living alone reported more frequent amphetamine and ecstasy use ($r = 0.39$, $P < 0.01$ and $r = 0.30$, $P < 0.05$, respectively) than students living with their parents. In Antwerp, the frequency of use of ecstasy is also positively correlated with drug abuse in general ($r = 0.35$, $P < 0.01$). Furthermore, Amsterdam students living alone considered their use of recreational drugs as a problem more often (OR = 1.69; 95% CI 1.33–2.15) than students living with their parents.

Conclusion

In Amsterdam as well as in Antwerp, students living alone or with peers may be at higher risk for problems concerning their consumption of recreational drugs than students living with their parents. These findings may have implications for targeted prevention programmes.

Comprehensive health assessments of pupils in school healthcare in Finland—are the national guidelines followed?

Hanna Happonen

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Background

In Finland, municipality-run health centres are responsible for organising school healthcare. According to the National Quality Guidelines a total of three comprehensive health assessments (CHAs) should be conducted during the 9-year compulsory education (7–16 years). Compared to traditional health examinations and screening programmes in schools, the CHA has a wider scope. It consists of a health and well-being examination of the pupil, conducted by a doctor and a nurse, to which parents are invited. Moreover, parents are asked to describe the pupil's and family's situation, and teachers are consulted for information about the pupil's well-being. Feedback from the CHA is given to all parties (pupil, parents and teachers) and individual health and welfare plan for pupils and summaries for grade-levels are prepared. The aim of this nationwide study was to examine how well the recommendations set for CHAs are implemented in the Finnish health centres.

Methods

A survey targeting health centre managers ($N = 231$) was conducted in 2007 with questions on the implementation of CHA. The response rate was 81%.

Results

Only one-third (37%) of the health centres reported conducting three CHAs, 32% reported two, 19% one and 12% none. However, there was large variation between the health centres regarding the content of the CHA. Nearly all health centres arranged pupils' health examinations by doctor and nurse, 88% reported parents' participation and description of child health and well-being and 5% prepared a grade-level summary. Only 72% of the health centres reported the decision to commit to unified practice, which may explain the variation in the content of CHA.

Conclusions

Only a minority of health centres follow the national guidelines. There is large variation in the content and number of CHAs during the school years between health centres, which creates inequalities in access to and quality of the school preventive services.