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Viewpoint

Mental health and politics since the eurozone crisis: The role of mental health professionals

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ABSTRACT

Some of the most immediate health effects of the 2008 economic crisis concerned the mind, not the body. Rates of generalized anxiety, chronic depression, and even suicide spiked in many European societies. This viewpoint highlights the role of mental health professionals in responding to this emergency, and argues that their sustained mobilization is necessary to its long-term resolution.

Some of the most immediate health effects of the 2008 economic crisis concerned the mind, not the body. Rates of generalized anxiety, chronic depression, and even suicide spiked in many European societies. In a 2016 review of research concerning the downturn's effect on mental health, the European Psychiatric Association found a "broad consensus" that the unemployment, indebtedness, precarious working conditions, inequalities, social isolation, and housing instability produced by economic crisis had negatively affected mental health. [1] Responses to this public health emergency varied, often in ways predictably determined by other political and economic factors – but one factor remained constant: the sustained mobilization of mental health workers in support of public mental health services.

1. Mental health outcomes

To be sure, the bulk of the incidence in mental health disorders comprises "common," not "serious," conditions. This clinical distinction is significant. Unlike people with serious mental illness (e.g., schizophrenia, bipolar disorder), people with common mental disorders (e.g., generalized anxiety, substance abuse) do not present psychotic symptoms, and as a result, they often require less intensive care. The most common mental health effects of the economic crisis are diminished psychological well-being, depression, anxiety, insomnia, alcohol abuse, and suicidal behavior. Pejorative references to the "worried well" often intimate the conclusion that this group diverts valuable mental health resources from those with more serious conditions (and often fewer financial means).

Yet common disorders also can lead to significant personal suffering, high service use, and when left unattended, devastating social consequences.[1] Perhaps the most striking crisis-induced mental health development is the increase in suicides. In Greece, researchers found that austerity measures increased the total suicide rate by 35.7%. The epidemic spread as others became aware of the uptick: after a cash-strapped pensioner commit suicide in front of the Greek parliament in April 2012, the national suicide rate temporarily increased by another 29.7%. [2] Researchers have observed similar trends elsewhere, especially among males. One study estimated that the British recession led to about 1000 excess suicides in England, 846 of them male [3]; and another, cross-country, study found that an one percentage point increase in unemployment would increase the number of male suicides in the EU-27 by approximately 500 each year [4].

Also worrisome are the changes in alcohol abuse and addictive behavior. In many countries, the unemployed, indebted, and evicted have turned to cheap drugs and binge drinking to pacify their distress. A post-crisis study of the illicit drug content in Italian wastewater found that, while the daily loads of expensive drugs (cocaine, heroin) had fallen since before the crisis, the daily loads of inexpensive drugs (methamphetamine, cannabis) had increased. [5] Similarly the number of alcohol-related disorders in Spain increased by 4.6% between 2006–2010, which researchers traced to the combined risks of household unemployment and mortgage payment difficulties [6].

The prevalence of poor mental health in Italy, for example, increased by 4% between 2005 and 2013. The effects of the crisis are particularly pronounced among young males, unemployed

[1] Moreover, those with pre-existing serious conditions suffer doubly during economic crisis, experiencing both an uptick in milder symptoms and often losing access to treatment for their severe conditions (Ibid).

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persons, and low-income individuals, especially those in Southern Europe and other countries severely affected by the crisis. This is not to say that other countries have not observed related trends. The paucity of media attention on the incidence of alcoholism in Sweden, poor sleep in Finland, or psychotropic drug consumption in France should not lead one to assume immunity elsewhere. [1,7]

2. Government and political responses

European governments hence find themselves in a crisis of their own making. On the one hand, fiscal and economic authorities are responsible for the severe economic austerity that prompted and protracted the increase in poor mental health. On the other hand, health and welfare authorities are responsible for redressing it, often with limited means. Governments have addressed this dilemma in different ways. Several factors condition their responses.

Among the most important determinants of national responses to the mental health crisis are, in fact, supranational factors: the economic impositions of European Commission, the European Central Bank and the International Monetary Fund (often referred to as the "troika") constrain the abilities of both national economic authorities and national welfare authorities to address the crisis. For example in Greece, which imposed some of the most severe austerity measures in Europe, annual state spending on mental health was halved in 2012, and it has been cut further in each subsequent year. [8] By contrast, countries facing fewer troika restraints have more control over the policy levers that could improve mental health.

Yet merely controlling national policy levers cannot predict a country's ability to rebound from the crisis, nor its willingness to boost the mental health infrastructure. Historical policy trends and institutional arrangements determine the baseline conditions for reform. For example in Spain, the robust National Health Service took measures to treat the increase of mental health conditions at the primary care level. [6] In the Spanish case, both the avoidance of a Greek-style comprehensive bailout and the institutional capacity of its health service contributed to this response.

The ultimate decision to reform–and how – rests on politicians and policy-makers. It is difficult to gauge the effect of the populist turn on the European mental health crisis, but at the very minimum, its rhetorical emphasis on social solidarity (often at the exclusion of non-nationals) suggests a political willingness to expand employment, increase social benefit transfers, and develop health resources. For example, the populist coalition that currently governs Italy has enacted a basic income scheme. [9] Although highly controversial, the policy aligns expert recommendations to reduce social and income inequality in the interest of improving mental health [1]. Some observers might interpret these recommendations as supportive of the League-Five Star policy.

3. The common denominator

Despite these differences, nearly every European country facing an uptick in poor mental health has encountered a similar concomitant trend: resistance to austerity from mental health professionals. Cuts to mental health services have mobilized the psychiatric workforce. As suicides and depression increased in Greece, for example, the patient populations of psychiatric hospitals doubled their maximum capacity. In response, hospital unions denounced both the cuts to public psychiatric hospitals and the cuts to public sector pension. The Health Ministry now runs a pilot program to ensure round-the-clock access to psychiatric care, and is opening 19 new mental health clinics. [8,10] Similar developments have occurred across Europe, where union leaders representing public mental health workers have led protests, garnered media attention, and pressured policy-makers to increase payments to mental health services.

This common denominator – the mobilization of public mental health workers – underscores the critical role of professionals in sustaining and expanding psychiatric care. People with chronic and severe mental illnesses often lack the ability to demand services from government. Absent that demand, the scope and generosity of psychiatric services often depend on the advocacy of those employed by them – that is, of psychiatrists, psychiatric nurses, clinical psychologists, social workers, and administrators. Mental health professionals must continue to support these services, both during and after times of economic duress – for despite the passage of time, the legacy of the European economic crises remains a public mental health concern.

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