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“Improving the mental health of the population”: can the European Union help?

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FOREWORD—What this Report is about

In January 2005, the World Health Organization (WHO) convened a conference of health ministers to discuss mental health problems across Europe. The conference produced a Declaration recognising that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations. An Action Plan was drawn up to support this Declaration, and the European Commission was asked for support to take this forward.

The publication of the Commission's Green Paper, "Improving the mental health of the population: Towards a strategy on mental health for the European Union", in October 2005, was the first step in the Commission's response.

This Report brings together evidence relating to the Green Paper from a wide range of individuals and organisations.

Around one in four adult Europeans experience a mental health problem in any one year, often as a result of an anxiety disorder or depression, and sometimes as a result of a more severe disorder such as schizophrenia. There are also high rates of emotional and behavioural disorders among children and adolescents, and of mental health problems among older people. The impact on individuals and their families is enormous: in the United Kingdom alone, the cost to the economy is estimated at over £77 billion every year.

All too often, people suffering from mental health problems can experience social exclusion, stigma and discrimination. Many employers have low expectations of what people with mental health problems can achieve; and there are often barriers against such people engaging in community life. Basic human rights may also be denied to people with mental health problems.

The consensus among organisations in the UK, representing both service providers and service users, is that front-line services for the treatment of mental health problems should primarily be based in the community, but that hospitals still need to play an important role as specialist providers. Compulsory treatment or detention should only be used as a last resort where other alternatives have failed.

We urge a wider public recognition of the considerable body of evidence which indicates the substantial social and economic impact of mental health problems. Our view is that, for promoting better mental health and delivering better services, there is an important role for the EU to facilitate the exchange of information and best practice, alongside the more specialised roles of the WHO and of the legislative and policy-making responsibilities of national governments.

“Improving the mental health of the population”: can the European Union help?

CHAPTER 1: SETTING THE SCENE

The purpose of our Inquiry

1. It is time to bring mental illness out of the dark corners where it has for too long been consigned by fear, prejudice and ignorance. People with mental health problems should be helped to participate in society as fully as they are able, including in employment. This is, however, a major long-term task requiring sustained political determination and a clear sense of priorities.

2. We welcome the attention to mental health across the European Union (EU) generated by the European Commission’s Green Paper—“Improving the mental health of the population: Towards a strategy on mental health for the European Union”. Our Report, which brings together a wide range of evidence on the Green Paper, is intended as a contribution to raising the public’s awareness and knowledge of some of the issues involved.

The human and economic costs of mental ill health

3. The Commission report recent estimates that one in four adult Europeans experience a mental health problem in any one year, often as a result of an anxiety disorder or depression. Emotional and behavioural problems are also highly prevalent among children. For many, the impact on their quality of life will be enormous, affecting their ability to function, their personal relationships and social roles, their work and incomes, and their very sense of self. An extreme consequence is that, across the European Union, some 58,000 citizens each year commit suicide, a number that is greater than the annual death toll from road accidents. Many other people deliberately harm themselves. In addition, because mental health problems may last for long periods, they can take a tremendous toll on the emotional capabilities and economic circumstances of relatives who care for those affected.[1]

4. The impact on the EU economy of mental ill health is estimated to be equivalent to a reduction of 3% to 4% of total GDP.[2] In the United Kingdom alone, mental health problems are estimated to cost over £77 billion every year through the costs of medical or social care, production output losses, and a monetary valuation of the intangible human cost of disability, suffering and distress.[3] A mental health problem is now the most common reason for someone claiming Incapacity Benefit in the UK: the number making claims for benefit because of stress has trebled in ten years.

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[1] Commission Green Paper *Improving the mental health of the population: Towards a strategy on mental health for the European Union*: section 3 and Annex 2.

[2] Mental health in the workplace: Introduction. Prepared by Ms. Phyllis Gabriel and Ms. Marjo-Riitta Liimatainen. International Labour Office, Geneva, October 2000. ISBN 92-2-112223-9

[3] Sainsbury Centre for Mental Health—*The economic and social costs of mental illness in England*, June 2003

5. Among the most challenging consequences of mental health problems are the ways in which society reacts and responds. While a person with a problem of physical ill health is usually regarded with sympathy, someone with a mental health problem may experience ridicule, prejudice and discrimination. The stigmatisation of mental illness can lead to social exclusion, and may sometimes prevent people with a mental health problem from seeking help for fear of being labelled. In many countries, basic human rights are denied people with mental health problems, not least the right to live in community settings. Compulsory treatment remains a highly controversial issue. In many European countries, both within the European Union and outside it, there are large numbers of people hidden away—often locked away—in remote, run-down, under-staffed asylums.

6. Another major challenge across the EU is the widespread under-recognition of mental health problems, and consequently their under-treatment. Stigma may discourage individuals from seeking treatment, and family shame may hinder referral of a loved one. Primary health care staff may not recognise the psychological problems that often underpin or accompany poor physical health. Even if they do, they may not have access to the kinds of treatment that are needed: under-resourcing of mental health care systems is a Europe-wide issue.

7. The scale of these challenges varies markedly across the EU and in the wider Europe. Some Member States have made great strides to protect the rights of individuals with mental health problems, while others continue to discriminate in numerous and damaging ways. Countries such as Italy and the UK have closed almost all of their “asylums”, moving the locus of care into community settings where individuals have a better chance to access integrated services and using inpatient beds in general hospitals for short-term treatment. But many other countries continue to incarcerate people for long periods with little hope of a return to an “ordinary” life; asylums accommodate large numbers of people in some Eastern European countries, but also in Belgium and the Netherlands.[4] In some countries, people with even quite severe mental health problems are supported in paid employment; while in most countries economic inactivity unfortunately remains the norm, with its attendant consequences for economic and social marginalisation. Some, but only a few, countries have recognised the value of mental health promotion and prevention, experimenting with a range of initiatives designed to stop the emergence of mental health problems in the first place or offering early intervention services at the first sign of need.

8. Variations of this kind across—and indeed within—existing and potential future EU Member States have often prompted calls for action to eradicate undesirable patterns of treatment and experience for people with mental health problems. At the same time, such variations provide a building block for improvement, for across the EU there are copious examples of good practice from which others can and should learn.

9. One further challenge warrants emphasis. Mental health problems, because of their chronic nature and breadth of impact, can have a substantial impact on many domains of an individual’s life. They lead to multiple needs, and could in principle therefore elicit service responses from a number of

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[4] Knapp et al, editors, *Mental Health Policy and Practice across Europe*, Open University Press, 2007

agencies. The need for coordinated action is another pervasive feature across Europe. Most mental health systems have yet to respond adequately.

The WHO Helsinki Declaration and Action Plan

10. In January 2005, the Office of the European Region of the World Health Organization (WHO) convened a Conference of European Health Ministers in Helsinki to discuss the issue of mental health problems across Europe (including Member States of the European Union as well as other countries covered by the WHO Europe Region). The outcome of the Conference was the endorsement by all the Ministers attending of a Declaration[5] recognising that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens. Ministers attending the Helsinki Conference also drew up a Plan for Action,[6] which is reproduced in Appendix 4 of this Report. They perceived that the task of coordinating EU-wide action in the areas identified would require the resources of the European Commission in addition to the much more limited resources available to the WHO Europe Region Office. They therefore included a request for support from the European Commission in the WHO Conference Declaration.

11. **We support the Mental Health Action Plan agreed by European Health Ministers at the 2005 WHO Helsinki Conference.**

The European Commission Green Paper

12. The publication of the EU Commission Green Paper in October 2005 was the first step in the Commission's response to the invitation from the Health Ministers of Member States to support the WHO Action Plan. The aim of the Green Paper was to launch a debate with the European institutions, Governments, health professionals, stakeholders in other sectors, civil society including patient organisations, and the research community about the relevance of good mental health for the EU, the need for a strategy at EU-level and its possible priorities.[7] In so doing, the EU set out to build on the political impetus created by the WHO's Helsinki Declaration to take much needed action in the mental health field. The case was put forward that the creation of a European Strategy for Mental Health could have positive benefits for the EU's strategic objectives of long-term economic prosperity and a better quality of life.

13. In particular, the Commission proposed that the Strategy could focus on four aspects.[8]

    (a) Promote the mental health of all;

    (b) Address mental ill health through preventive action;

    (c) Improve the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity; and

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[5] *Mental Health Declaration for Europe: Facing the challenges, building solutions*, WHO 2005

[6] *Mental Health Action Plan for Europe: Facing the challenges, building solutions*, WHO 2005

[7] op. cit. p.3

[8] op. cit. p.8

(d) Develop a mental health information, research and knowledge system for the EU.

14. The Commission argue that the establishment of a strategy at EU level could add value in a number of areas to the actions of Member States acting alone. There is, they argue, "widespread agreement that the human, social and economic dimension of mental health need wider recognition by policy makers and greater public awareness. Important initiatives are being taken at the level of Member States, the EU and the WHO".[9] The concept of an EU "Platform" approach is advanced for creating a framework for the exchange of information and development of best practice. It is envisaged that a wide range of stakeholders would be involved including: policy makers, professional experts from the health and non-health sectors, and patient and civil society organisations.

The conduct of our Inquiry

15. The Members of our Social Policy and Consumer Affairs Sub-Committee (Sub-Committee G) who conducted the Inquiry, showing their declared interests, are listed in Appendix 1.

16. Our Call for Evidence is in Appendix 2. We are most grateful for the evidence that we received in response to this; and we thank, in particular, those witnesses who gave us evidence in person. Those who gave us evidence are listed in Appendix 3, and the evidence we received is printed in Volume 2 of this Report.[10]

17. We acknowledge with considerable thanks the expertise and hard work of our Specialist Adviser for the Inquiry—Professor Martin Knapp—who played a key role in helping us to prepare this Report.

18. **We make this Report to the House for debate.**

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[9] op. cit. p.13

[10] In addition, a number of references are made in the report to documents which are not printed; these are available for inspection in the Parliamentary Archives (Tel. 020 7219 5316).

CHAPTER 2: DEFINING MENTAL WELL-BEING AND MENTAL HEALTH PROBLEMS

The concept of mental well-being

19. As the World Health Organization emphasises, mental health is not merely the absence of disease or infirmity, but rather a condition of complete mental well-being. In turn, the concept of mental well-being is seen by the WHO to be a state in which individuals recognise their abilities, are able to cope with normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined goals.

20. This approach to the definition of mental health has widespread support, although preferences as regards terminology vary. For example, the Samaritans organisation suggested that mental health is increasingly becoming synonymous with well-being. The Samaritans now refer to "emotional health" since this is seen as a less threatening and less medical term (pp 164–167). In similar vein, Mind argued that "mental well-being" was preferable to "mental (ill) health" on the grounds that the concept of well-being was something that all European citizens could readily relate to their own lives and experiences. It was naturally associated with a whole range of life factors and events, not with a narrow set of clinical and forensic interventions (pp 54–60). The Scottish Association for Mental Health (SAMH) recommended use of the term "mental health problems" rather than "mental illness" or "disorder", because this was a less stigmatising form of words (pp 167–170).

21. Of course, the spectrum of mental health problems is wide. Dr Matt Muijen (Regional Adviser for Mental Health at the European Region of the World Health Organisation) warned against clustering all mental health problems together when they need very different interventions and have different outcomes (Q 205). Some severe mental health problems—such as schizophrenia, bipolar disorder, severe depression, obsessive compulsive disorder, severe dementia or some forms of personality disorder—were likely to manifest themselves in ways that would suggest to a member of the general public that something is wrong. These more severe mental health problems were also likely to be recognised by health care professionals, although not always very early in the course of the illness. Towards the other end of the spectrum were milder conditions, which may not so easily be recognised as problematic or indeed as treatable disorders. For example, mild or moderate depression or anxiety might simply be dismissed by the sufferer or by a relative as part of the normal stresses of everyday life, despite the debilitation that usually results and the often marked effects on quality of life. Similarly, the early stages of cognitive decline that might be diagnosed as a form of dementia, or the sadness exhibited by many older people might be viewed as just part of the normal processes of ageing. As Age Concern England pointed out, treatable mental health problems experienced by many older people tended to be missed by care systems in the UK (pp 108–110).

22. The Commission Green Paper follows a broad definition of mental health problems, including: mental health problems and strain, impaired

functioning associated with distress, symptoms, and diagnosable mental disorders, such as schizophrenia and depression.

23. The Committee accepted the evidence of a number of expert witnesses, including that of Professor Thornicroft (Consultant psychiatrist at the South London and Maudsley NHS Trust) that an international consensus existed on the forms of suffering that should be included within the broad remit of mental health problems, in line with the Green Paper approach. When these criteria were applied to national populations across the world, there was a consistent finding that around 25 to 30 per cent of people, in any one year, suffered mental health problems which were serious enough to affect work, social relations or everyday functioning (Q 48).

24. Mr McDaid (Mental health policy analyst at the London School of Economics) commented that the Green Paper deliberately takes a broad definition of mental health problems in order to emphasise the importance of mental wellbeing (Q 48). Of relevance to Mr McDaid's point is the evidence from the National Health Service (NHS) and Regional Public Health Group London, which suggested that the Commission should be asked to consider whether the aims of mental health strategy might be better served by using the term "emotional well-being" in place of "mental health". The argument put forward was that the use of this terminology could help to overcome the entrenched and institutional stigma attached to the subject of mental health and mental illness (pp 145–147).

The extent of mental health problems

25. Following the broader definition of mental health problems, Annex 2 of the Green Paper includes a table in which recently generated estimates[11] are given of the numbers of people in the EU who are affected by different types of mental health problem over a one-year period. In total, summing over all disorders, the estimates shown in the table indicate that 27.4% of the EU population aged 18 to 65 suffer from one type or another of mental health problem during each one-year period.

26. Professor Stefan Priebe (Head of the Unit for Social and Community Psychiatry at Newham Centre for Mental Health) took a rather different line. His view was that the wide definition of mental health problems used in the Commission Green Paper reflects a dilemma in psychiatry. He recognised the academic basis of the figures of 25 to 27 per cent quoted by the Commission to represent the proportion of national populations which, in any one year, suffer mental problems. However, he questioned whether a concept of "mental ill health" which applied to such a high percentage of people could really make sense.

27. Professor Priebe's argument was that if, as stated in the Green Paper, "there is agreement that a first priority is to provide effective and high-quality mental health care and treatment services accessible to those with mental ill health", it would be entirely impractical to supply mental health services for a segment of the population as large as 25 to 27 per cent. Professor Priebe concluded that either the concept of mental ill health or that of its effective

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[11] Hans-Ulrich Wittchen and Frank Jacobi (2005): "Size and burden of mental disorders in Europe: a critical review and appraisal of 27 studies". *European Neuropsychopharmacology*, vol. 5, no. 4, pp 357-376.

treatment may need revising; and that any useful debate on the future of mental ill health could not avoid this dilemma. (pp 159–161).

28. Notwithstanding the passage quoted from the Green Paper by Professor Priebe, Mr Scheftlein from the European Commission told us that he did not think that every mental health problem needed medical intervention (Q 13). He explained that the Green Paper set out a public health approach to mental health and did not present it as a medical issue alone (Q 11). A similar point was made to us by Ms Camilla Parker (a legal and policy consultant working on the field of mental health disability and human rights). She expressed the view that, for the purposes of promoting mental health issues, some very broad, and inclusive, concepts of mental health were valuable. She added that, in contrast, for the discussion of people with severe conditions perceived to be dangerous, some very clear criteria were needed of mental illness, alongside other criteria, in order to ensure that only in limited circumstances did people become subject to compulsory detention or treatment (Q 179).

29. There will obviously continue to be debate about where to draw boundaries between "illness" and "distress" (or "stress"). There are standard diagnostic classificatory systems in use across the world that aim to structure, regularise and institutionalise definitions. But, as noted by the Commission and others, there are advantages in not getting too mired in medical models of mental health[12] (QQ 48, 124).

30. Wherever the boundaries are eventually drawn, a number of observations come through clearly from the arguments in the Green Paper and also from much of our evidence. These would appear to apply to all EU Member States:

    (a) The prevalence of mental illness is higher than most members of the general public appreciate.

    (b) Many people with a diagnosable mental health problem do not refer themselves or get referred to the health system for treatment.

    (c) Some people who are receiving mental health treatment no longer need it, probably because they have recovered.

    (d) Health professionals still have a low rate of recognition of many mental health problems.

    (e) Health systems do not provide sufficient or good enough treatment for most mental health problems.

31. In each of these five respects, the situation has undoubtedly improved in most EU Member States over the past decade or longer. There is, for example, better appreciation of the large number of people who suffer mental health problems. There is, in some countries at least, a greater willingness on the part of people with more common mental health problems (such as mild depression or anxiety) to approach a health professional for treatment. But, as our evidence makes plain (see later chapters), despite improvements in recent years, across the EU there is a pervasive tendency to under-recognise, under-resource and under-treat.

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[12] op. cit. p. 5

32. In later chapters the distinction will be made between different mental health problems. For instance, there are particular human rights issues concerning people with severe mental health problems who face compulsory treatment or who spend long periods of their lives in asylums; these same issues generally do not arise for people with mild depression or anxiety. The stigmatising of mental health problems and the people who suffer from them is also differently experienced by people at the different ends of the "severity spectrum" (see chapter 6).

33. **We welcome the recognition by the Commission of the considerable extent of mental health problems; and we recommend that action is taken to ensure that people with diagnosable and treatable problems get access to appropriate, evidence-based care.**

Learning or intellectual disability

34. Another definitional issue raised by our witnesses concerned learning disability. This condition or need is sometimes called learning difficulty or intellectual disability, and—in the US—mental retardation. Getting the term right is important, partly to avoid confusion with more general "learning difficulties" within mainstream education systems, and partly because people with this characteristic express preferences about the terminology.

35. MENCAP (a leading UK charity that works with adults and children who have a learning disability), pointed out that a learning disability was not the same as "mental ill health". MENCAP explained that a learning disability was lifelong and untreatable, and affected the way people learned, understood, communicated and interacted with others. They said that people with learning disabilities faced different challenges, and had different needs, from people with mental health problems. Against this background, MENCAP criticised the use the terminology "mentally ill or disabled people" in the Green Paper, without any reference to the factors which distinguished the two conditions. MENCAP's recommendation was that any future Commission document in this field should either confine itself to discussion of mental health problems and drop reference to disability; or make it explicit that the scope of concern did include disability, in which case it should make clear the different issues that arose for these groups of people (pp 132–133).

36. There are, of course, people with learning disabilities who also have mental health problems. Indeed, the mental health needs of many people with learning disabilities—which are difficult to assess—are often missed by services, and appropriate treatment is not provided.[13] The Mental Disability Advocacy Center, in their evidence to the Inquiry (pp 134–140), noted that people with intellectual disabilities and mental health problems had been particularly neglected and excluded.

37. The Open Society Mental Health Initiative (MHI) also commented on the lack of clarity in the Green Paper about the distinction between the categories of people with mental health problems and those with intellectual disabilities (a term they prefer to use rather than learning disabilities). MHI's view was that the people with intellectual/learning disabilities should be

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[13] Eric Emerson et al. (2001) *Learning Disabilities: The Fundamental Facts*, Foundation for People with Learning Disabilities, London

covered by an EU strategy and that this group and the issues they face should be identified much more clearly in future documents. There were undoubted similarities between the experiences of people with learning disabilities and people with mental health problems, not least their marginalisation within society and the fact that in many Member States of the EU large numbers of people continued to languish for most of their lives in forgotten institutions. However, there were also many other ways in which the two groups had very different experiences and needs, and it did not help to confuse the policy and practice issues (pp 155–159).

38. Dr Matt Muijen explained to us that, in the Green Paper, the word "disability" was mentioned but that this was intended to refer to disability in the workplace. He added that learning disability was not included in the 2005 WHO Helsinki Declaration, and that his understanding was that the strategy for mental health set out in the Commission Green Paper was not intended to include learning disability (QQ 215–218). He nevertheless recognised what he called WHO's "embarrassing" lack of activity in the learning disability field. Ms Rosie Winterton MP, Minister of State for Health Services, explained that the Government's view was that the needs of people with learning disabilities were ultimately different from the needs of people with mental health problems, and the Government did not think that service users would necessarily appreciate being bracketed together in a single strategy (p 107).

39. **We consider that it is wrong to group together learning disability and mental health problems for the purposes of the programme of action for mental health envisaged in the Green Paper. The two conditions are clearly separate and, indeed, a person with a learning disability, just as any other person, may or may not suffer from a mental health problem. We recommend, however, that the Commission give serious consideration to launching an action programme to address concerns about people with learning disabilities in Europe, how they are supported and the lives they are able to lead.**

CHAPTER 3: THE SOCIAL AND ECONOMIC IMPACT OF MENTAL HEALTH PROBLEMS

40. Mental health problems have wide social and economic consequences. A World Health Organization Fact Sheet[14] identifies some of the social and economic costs of mental ill health. These impacts can be grouped under five heads, moving out from the individual with the mental health problem, to their family, the health and social care system, and then the wider society and economy:

    (a) lost production from premature deaths caused by suicide (generally equivalent to, and in some countries greater, than deaths from road traffic accidents);

    (b) lost production from people with mental illness who are unable to work, in the short, medium or long term;

    (c) lost productivity from family members caring for the mentally-ill person;

    (d) reduced productivity from people being ill while at work;

    (e) cost of accidents by people who are psychologically disturbed, especially dangerous in people like train drivers, airline pilots, factory workers;

    (f) supporting dependents of the mentally ill person;

    (g) direct and indirect financial costs for families caring for the mentally-ill person;

    (h) unemployment, alienation, and crime in young people whose childhood problems, e.g., depression, behaviour disorder, were not sufficiently well addressed for them to benefit fully from the education available;

    (i) poor cognitive development in the children of mentally ill parents; and the

    (j) emotional burden and diminished quality of life for family members.

Impacts on individuals

41. Mental health problems have distressing symptoms, as the clinical labels used to describe some of them so graphically convey—deep troughs of depression, periods of unremitting anxiety, mania, panic, traumatic stress, obsessional behaviour, cognitive decline. There are treatments for many of these symptoms, but some of the widely used medications can have unpleasant side effects. The voluntary organisation Rethink (one of the leading mental health charities in the UK) described how people with severe mental health problems want more investment in drug research aimed at finding ways to reduce the side effects of medication (pp 60–63).

42. As many witnesses pointed out, mental health problems can clearly have enormous undesirable consequences for quality of life. The NHS Confederation (pp 144–145) noted how the quality of life effects were felt in individuals' personal relationships and social networks, as well as damaging

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[14] WHO Fact Sheet No. 218 *Mental health problems: the undefined and hidden burden*. Revised November 2001.

their employment prospects and career progression. Some of those consequences stemmed directly from the symptoms of illness and their effects on individuals' abilities to enjoy life, to express themselves, to function normally and to interact with others. But other quality of life consequences stemmed from the ways that other people reacted to a mental health problem, with stigma and discrimination being especially widespread and damaging (see chapter 5). Social exclusion was a common experience. Rethink argued that better access to education, housing, transport, employment, leisure facilities and social networks could also improve the quality of life of someone with mental health problems (pp 60–63).

43. It was also the case, as the Minister pointed out, that poor quality of life could itself be a cause of mental health problems (Q 228). Policies intended to improve poor housing, employment rates and urban renewal could therefore all contribute to the promotion of better mental health (see chapter 7 of this report).

44. Mental health problems such as depression, eating disorders and schizophrenia are associated with much higher then normal mortality rates. Suicide is one of the leading causes of premature death in Europe, often among young people. There are marked variations in suicide rates across the EU, with especially high rates in Lithuania, Slovenia, Hungary, Estonia, Latvia and Finland.[15] Many factors have been argued to play a part in explaining differences between countries, including genes, lifestyle, alcohol consumption, weather and health care. Cultural factors and a reluctance to record deaths as suicides undoubtedly also explain some of the inter-country variation, and suggest that the figures quoted in the Green Paper and in other official documents are probably underestimates because of under-reporting. In the UK as a whole, suicide rates have been falling in recent years, but this general trend masks some significant increases in Scotland and Northern Ireland.

45. In addition, as the Samaritans organisation commented, many people with mental health problems committed acts of deliberate self-harm (pp 164–167). They expressed disappointment that the Green Paper did not mention self-harm, and emphasised that policies needed to recognise the prevalence of such behaviour, while mental health interventions needed to be based on an understanding of self-harm.

46. Suicide is not the only cause of premature mortality. As Rethink pointed out (pp 60–63), mental health was fundamentally linked to physical health, so that regular health checks would help to tackle many of the physical ailments that affected people with mental health problems, often the result of their medication. Ensuring that primary care workers were better trained and were given the adequate resources would help them to address the physical needs of those with mental health problems.

47. Another area of concern is employment. Work provides an opportunity not only for someone to earn wages, and thereby achieve greater financial security, but also confers social status and identity, a sense of achievement and a means of structuring one's time. Mental health problems may develop if work is stressful, perhaps because of the nature or organisation of the job, unsupportive line-management, long or unsocial hours, lack of control or

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[15] Brock A, Baker A, Griffiths C *et al. Suicide trends and geographical variations in the United Kingdom, 1991–2004*. Health Stat Q. 2006;31:6–22

flexibility, or when pay and other rewards are not commensurate with effort expended. One study has suggested that, across the EU, work-related stress is now thought to affect one third of the workforce.[16]

48. There is also evidence from across Europe of increasing absenteeism and early retirement due to mental health problems, and also evidence of reduced performance when people are actually at work, because of their mental state (pp 60–63). Data collected by the Mental Health Economics European Network, funded by the European Commission, for example, showed that 31.9 million lost working days in France in 2000 were attributed to depression, and that mental health problems accounted for a quarter of all cases of long-term sick leave in Sweden. Between 1995 and 2002 there was a 74% increase in the number of people registered as long-term sick due to mental health problems in Germany.[17]

49. Several witnesses also pointed out that the link between mental health problems and employment problems can additionally flow in the other direction. People with mental health problems find it difficult to secure paid employment and to retain it. They are often overlooked for promotion and general career advancement. Rethink quoted statistics from the Department of Work and Pensions that people with long-term mental health problems were less likely to be in employment than people with other disabilities (21% compared to 49%) (pp 60–63). An obvious and immediate consequence was dependence on benefits and/or poverty. As Mind pointed out, it was contrary to the basic principles of justice and community of the EU to condemn people to poverty simply because they were too ill to work. But in helping people after a period of poor mental health, it was important to ensure that individuals did not feel coerced into work before they were ready, and also that good support was available for those people who could not take up employment (pp 54–60). Opportunities for part-time working and greater flexibility in the benefits system would also make it easier for people to return to employment. Rethink supported these arguments, additionally suggesting greater use of job-sharing arrangements and voluntary work (pp 60–63).

Impacts on families

50. Rethink noted that mental ill health not only affected those who experience it but those who provide informal care for them; their friends and families (pp 60–63). A few years ago, a study funded by the Commission looked at the families of people with schizophrenia in five European cities. It found that the principal family carer spent on average between 6 and 9 hours per day supporting their relative with schizophrenia. The "impacts" most commonly reported by family members were restrictions on social activities, disruption to family life and feelings of loss.[18]

51. Stresses and strains are particularly associated with care. Rethink estimated that there were 1.5 million carers of people with mental health problems in the UK. They emphasised the importance of supporting these informal social

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[16] I Ivanov (2005) *Mental health and working life*. WHO Ministerial Conference on Mental Health Briefing Paper, Copenhagen: World Health Organization Regional Office for Europe.

[17] See Chapter 4 of Martin Knapp et al. (2007) Mental Health Policy and Practice across Europe, Open University Press.

[18] Lorenza Magliano et al. (1998) Burden on the families of patients with schizophrenia: results of the BIOMED I study, *Journal of Social Psychiatry and Psychiatric Epidemiology.*

networks to enable better social inclusion for individuals experiencing mental health problems and their families. They urged that the European Union's mental health strategy should recognise the impacts on carers' own health and wellbeing, and should therefore include recommendations for supporting carers (pp 60–63). West Sussex County Council (pp 174–176) argued that the EU Strategy needed to consider the mental health needs of carers. Similarly, Kent County Council emphasised the need to acknowledge the huge contributions made by people who care for people with mental health problems and the debt that society owed them (pp 123–124).

52. Research described by the UK Social Exclusion Unit[19] suggests that, in supporting people with mental health problems, carers themselves are twice as likely to have mental health problems if they provided substantial care. The emotional and health impacts for carers could certainly be substantial. This is why one of the standards of England's National Service Framework for Mental Health targets the support of carers.

53. The economic impacts on families can be large. There are considerable costs borne by families, mainly because one or more parents often has to give up work or take a part-time or lower paid job. Given that mental health problems are more prevalent in lower income groups, if the (largely hidden) individual and family costs are ignored when policy or practice decisions are taken, this might exacerbate the social exclusion of what is already a quite marginalised group. Siblings of children who exhibit antisocial behaviour will often suffer difficulties themselves.

54. At the other end of the age spectrum, the spouses and children of most people with dementia will carry a large part of the responsibility of care. While most carers will gain satisfaction from their contributions to maintaining the quality of life of a loved relative, they will also carry a lot of burden and strain. It is well known that carer well-being (including health status and coping skills) is a key influence on the decision to admit an older person to a care home.

55. One of the most tangible effects of caring is reduced opportunity to work and reduced income. In the report Dementia UK,[20] it is estimated that this lost income could annually amount to £690 million each year. This same report included an estimate of the economic value of informal care provided (mainly) by family members, which is equivalent to more than a third of the annual cost of dementia in the UK.

56. Families of people with mental health problems might also experience stigma, which can add to their feelings of marginalisation, neglect and disadvantage (see chapter 6).

Impacts on the health and social care system

57. Health and social care systems across Europe obviously carry primary responsibility for delivering the "formal" services needed by people with mental health problems. Calculations by the European Brain Council[21] relating to 28 European countries (all of Western Europe and eight Eastern

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[19] *Mental Health and Social Exclusion*, Office of the Deputy Prime Minister, June 2004, p.4

[20] *The rising cost of dementia in the UK. Are we prepared?*, Alzheimer's Society 2007

[21] Patrik Andlin-Sobocki et al. (2005) *Cost of disorders of the brain in Europe, European Journal of Neurology*, 12, 1–27

European countries) estimated the total cost of mental health problems as €295 billion in 2004. Of this amount, they calculated that 20% was accounted for by inpatient hospital care, 3% drugs, 12% outpatient care, 13% social services, 3% informal care, 2% other directs costs, 33% sick leave, 7% early retirement, and 7% premature death. In other words, half the total was as a result of health and social care treatment and support.

58. The 2007 Alzheimer's Society report, "Dementia UK", estimated service costs of almost £11 billion. If service arrangements today were replicated in the future, the costs of long-term care for people with dementia would be likely to treble over the next thirty years.[22] By that time, based on these projections, long-term care for people with dementia would account for 1% of GDP.

59. The Commission point out in the Green Paper that the service consequences of mental health problems are enduring, drawing for evidence on a study conducted in London that followed a group of ten year olds into early adulthood. The service costs were calculated for each of these young people between the ages of ten and twenty-seven, and summarised as Annex 4 to the Green Paper. They demonstrate that ten-year olds with antisocial behaviour that is sufficient to justify a diagnosis of conduct disorder (which is the most common mental health problem among children) have costs over the next 17 years that are ten times as large as the costs of services used by ten-year olds with no behavioural or emotional problems. Most of these costs are incurred in the criminal justice system. Crime costs are also an important consideration when looking at the social impact of addictions.

60. The EPSILON multi-country study of people with schizophrenia, funded by the Commission, demonstrated how service systems and availability varied greatly between five study sites. A high proportion of in-patient care was used in the Danish site compared to the English, Italian, Spanish and Dutch sites, but there were many more beds available for use. In contrast, the Spanish site had relatively few inpatient beds and the overall budgetary contribution of inpatient care was therefore lower.[23] The ERGOS multi-country study of services used by people with schizophrenia also found marked differences in treatment patterns of treatments across Europe; for example, family therapy was rarely used in France, Portugal or the Netherlands, but frequently provided in Italy and Spain.[24]

Impacts on the wider society and economy

61. The extent to which the consequences of mental health problems fall outside the health and social care sectors will obviously depend on how those and neighbouring sectors are organised and configured: different boundaries are drawn in different European countries between health, social services, education, housing and other service sectors. But however these services are organised, people with mental health problems often have needs for help from a number of different areas. Education, housing, criminal justice, youth

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[22] Adelina Comas-Herrera et al. (2007) Cognitive impairment in older people: the implications for future demand for long-term care services and their costs, *International Journal of Geriatric Psychiatry*, forthcoming.

[23] Martin Knapp et al. (2002) Comparing patterns and costs of schizophrenia care in five European countries: the EPSILON study, *Acta Psychiatrica Scandinavica*.

[24] Viviane Kovess et al. (2005) Professional team's choices of intervention towards problems and needs of patients suffering from schizophrenia across six European countries, *European Psychiatry*.

justice, social security and other sectors could all be called upon to make inputs. These various services could be provided by the state, by private sector bodies, or by voluntary organisations. Patterns of provision vary from country to country. In central and eastern Europe, for instance, the public sector has historically dominated service provision; the almost complete absence of civil society structures for many years has left many voluntary sector activities rather weak.

62. These multiple impacts are hard to factor into decision-making. According to Mr David McDaid and colleagues at the London School of Economics, there was a need to promote better coordination between the different parts of government and communities. They offered the example of child and adolescent mental health, where there was a need to coordinate schools, general medical services, social care, social welfare, criminal justice, and housing services with specialist mental health services. Better coordination would promote better identification of and responses to emotional and behavioural problems in childhood and adolescence (pp 10–12). A major challenge was "silo budgeting" under which resources located in specific agencies or budgets could not easily be shifted, indeed might be rigorously protected. One of the problems in increasingly performance-reviewed health and social care systems was that service professionals might find it hard to take decisions that were in the interests of somebody else's budget (including the service user's) if it could only be achieved at a cost to their own agency's resources.

63. The British media, probably more so than their counterparts elsewhere in the EU, give much coverage to the public risks associated with certain mental health problems[25]. Whether it thereby stokes exaggerated public fears and stigma is a moot point (see chapter 6), but there is clearly a need to be aware of the real and perceived impact of mental health problems on the wider society. Helping service users to maintain contact with services and to take their medications, and thereby to lessen the rates of deliberate self-harm, suicide and violent criminal acts is a key policy aim in all countries.

64. Another societal and economic impact is linked to the inability of people with mental health problems to work, either because of their capabilities at a time when they are ill, or because of the reactions from employers and others who discriminate against people with a history of mental health problems (see chapter 6). The economic consequences can be substantial. To give an example, the Health and Safety Executive in the UK has estimated that between 5 and 6 million days are lost per annum because of depression. Another calculation is that the cost of depression in terms of lost working days (and hence the loss to national productivity) was 23 times larger than the treatment costs falling to the NHS.[26] The Green Paper notes that mental health problems are the leading cause of early retirement in many European countries.

65. These negative employment effects associated with depression are obviously most immediately felt by people with the condition, but clearly also have an impact on employers and the economy more generally through reduced productivity, lower tax revenues and higher social security payments. In the

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[25] Mind. *Counting the cost*

[26] Christine Thomas and Stephen Morris (2003) "Cost of depression among adults in England in 2000" *British Journal of Psychiatry*.

UK, recent figures from the Department of Work and Pensions show that 40 per cent of the 2.7 million people claiming incapacity benefit in the UK in 2006 are described in official statistics as unable to work because of mental illness.

66. Just as the service implications of mental health problems can persist over many years, so too can the wider economic consequences. Evidence from a number of studies in the UK has shown that children with emotional or behavioural problems are much less likely than their peers to be in employment as adults, and that if they are, then their salaries are generally lower than those earned by their peers.[27] In other words, the societal consequences persist, as do the social exclusion disadvantages of young people who have already endured the distressing symptoms of mental health problems at an early age.

Summary of impacts

67. A document submitted to us by the International Longevity Centre UK (ILC),[28] cited a number of reports in which the economic cost of mental ill health had been assessed. Among these was the Policy Brief of the European Observatory on Health Systems and Policies[29] which conservatively estimated that the economic costs—for the 15 countries that were members of the European Union (EU) before 1 May 2004—were at least 3–4% of gross national product. Of this total, the report stated that most of the quantifiable costs occurred outside the health sector, being due to lost employment, absenteeism, poor performance within the workplace and premature retirement. Typically, they accounted for between 60% and 80% of the total economic impact/consequences of major mental health problems. Other important consequences, such as stigmatisation, social exclusion and fundamental abuses of human rights were rarely included in economic analyses—because they were not measurable in cost terms—but should not be ignored.

68. Mind quoted a report[30] that in England in 2002/03 the total economic and social costs of mental ill health were £77 billion. This was broken down in the report into the following categories:

- £12.5 billion health and social care costs;
- £23 billion in output losses;
- £41.8 billion in "human costs" (calculated by assigning a monetary value to the human suffering, pain, disability and disease associated with mental health).

69. The evidence we received has supported the statement in the Green Paper that:

> "There is no health without mental health. For citizens, mental health is a resource which enables them to realise their intellectual and emotional

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[27] Andrew Healey et al. (2004) Adult labour market implications of antisocial behaviour in childhood and adolescence: findings from a UK longitudinal study, *Applied Economics*.

[28] *Moving to social integration of people with severe mental illness: from policy to practice*

[29] David McDaid et al. (2005) "*Mental health III—Funding mental health in Europe*", European Observatory on Health Systems and Policies, which includes the following passage.

[30] *The future of mental health: a vision for 2015 Sainsbury Centre for Mental Health (2003)*

> potential and to find and fulfil their roles in social, school and working life. For societies, good mental health of citizens contributes to prosperity, solidarity and social justice. In contrast, mental ill health imposes manifold costs, losses and burdens on citizens and societal systems."

70. **We urge a wider public recognition of the considerable body of evidence which indicates the substantial social and economic impact of mental health problems. Our view is that the heavy responsibilities carried by the families and other carers of people with mental health problems are too often overlooked, and that better recognition and support of carers is essential. We recommend that the Commission encourages EU Member States to take steps to address these issues, coordinating action as necessary across many different parts of government and society.**

CHAPTER 4: THE ADDED VALUE OF AN EU MENTAL HEALTH STRATEGY

What an EU strategy would set out to achieve

71. The Green Paper proposes[31] that the priorities of an EU strategy could be:

    (a) Promote the mental health of all;

    (b) Address mental ill health through preventive action;

    (c) Improve the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity; and

    (d) Develop a mental health information, research and knowledge system for the EU.

72. In pursuit of these priorities the Green Paper identifies[32] a number of initiatives for action:

    (a) Promoting mental health and addressing mental ill health through preventive action;

    (b) Promoting the social inclusion of mentally ill or disabled people and protecting their fundamental rights and dignity;

    (c) Improving information and knowledge on mental health in the EU;

    (d) Launching an EU-Platform on Mental Health;

    (e) Developing an interface between policy and research on mental health.

73. The Commission Green Paper states[33] that the legal basis for EU action on mental health is provided by the EU's Public Health Programme 2003–2008. This is based on Article 152 of the Treaty establishing the European Community which states that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care." The Community has an awareness-raising and co-ordination role in addition to the obligation to ensure a high level of human health protection in the definition and implementation of all Community policies and activities.

74. In relation to the aims set out in the Green Paper on the issue of EU competence in this area, Ms Rosie Winterton MP, Minister of State for Health Services, stated that "… legislation is not generally considered to be something that we would want to be particularly tied to at a European level because we do want to make sure that we have the ability to decide our health systems, particularly because of the uniqueness of the National Health Service." On the other hand, she added, "The platform for exchange of ideas will act … as a kind of stimulus for people to be able to go back and say, 'This is what is available, how can we look to copy these?'" (Q 248).

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[31] op. cit. p. 80

[32] op. cit. ps. 8–13

[33] op. cit. p. 6

75. In responding to the Commission Green Paper, the Government took the view that the priorities identified were sufficiently broadly defined in order to allow for local variations in emphasis; and that the actions identified arose naturally from those priorities (pp 30–34).

76. Mr Jurgen Scheftlein (EU Directorate General for Health and Consumer Protection) reassured us that the Commission's work in developing a strategy was within the scope of areas in which it had competence to act, in particular (Q 2):

- promotion and prevention;
- supporting vulnerable groups;
- information and research; and
- addressing discrimination and stigma.

77. Mr Scheftlein also emphasised that the issues relating to mental health cover many different areas within the Commission's competence including: health; employment; social affairs; equal opportunities; and research and information. The Green Paper was intended to stimulate a consensus among EU Member States about how the Commission's actions in these areas could best contribute to the WHO Declaration's objectives (Q 2).

78. Mr Scheftlein anticipated further that the Commission's involvement in a mental health strategy would have the role of helping to develop agreement about the importance of positive mental health programmes among stakeholders in the fields of education, employment and the general community (Q 18). He expected it would include mechanisms for collecting and making available information, for stimulating understanding of the issues, for sharing information and for encouraging the development of a consensus about best practice (Q 34). A similar view was expressed by the Royal College of Psychiatrists who supported the plan for a single integrated and coordinated strategy as set out in the Green Paper, stating that this should avoid the risk of separate, independently generated projects giving incoherent coverage of the issues (pp 161–164).

79. Mr Scheftlein explained that the EU's role in taking forward the strategy would be to bring together people from a number of relevant backgrounds in order to share information and best practice. Participants would be invited from: the economic world; the health profession; the social field; and from civil society. Representatives of the WHO would certainly be involved, in partnership, but the Commission would be the "owner" of this platform or forum process. The Commission wished to a launch this approach, in 2007, to replace the former working party on mental health. He saw this as the principal Commission structure for the implementation of an EU strategy on mental health (Q 26).

80. Dr Matt Muijen (Regional Adviser for Mental Health at the European Region of the World Health Organization) confirmed that the Commission had made great efforts to involve the WHO in the development of the ideas set out in the Green Paper (Q 198).

81. Mr Scheftlein explained that most of the areas of activity in the strategy proposed were outside the mandate for legislative action of the Commission. It might focus on such activities as producing recommendations (in the sense of encouragement), promoting the exchange of good practice and helping to develop better technical and statistical bases of information. He suggested

that a platform would have value as a means of improving understanding and of developing a consensus around these issues (QQ 28–31).

82. Mr Scheftlein's view was that the Open Method of Consultation (OMC) was not an instrument that would be used either as part of the mental health strategy to gather information and exchange best practice, or in the policy context generally. His view was that, while OMC was an effective tool, it required a lot of resource investment, so that the "looser" approach of the platform would be preferable (Q 24). He explained that the platform approach would allow for the involvement of other relevant areas of the Commission than health, for example DG Employment. He envisaged that meetings could take place once or twice a year and could be used to monitor progress in implementing elements of the WHO Helsinki Declaration (Q 27).

83. A number of witnesses lent their support to the view that the Commission's platform process should, and probably would, encourage cross-Directorate discussion and collaboration within the European Commission, just as cross-ministry collaboration was essential to the successful prosecution of good mental health policy and practice within Member States. Officials from the Department of Health commented that, by bringing in non-governmental representatives, the platform would help to ensure a focus on the needs of real people (Q 79). Mr John Bowis MEP took a similar view of the advantages of involving non-governmental organisations in discussions, but added that it was insufficient just to share good practice. His view was that the platform discussions needed to generate plans for further action (Q 115).

84. Mr McDaid (London School of Economics) commented that the value of an EU Platform on Mental Health would depend a lot on whether or not there were good links between those working on the platform and those people who actually influence policy in Member States. He thought it important that all stakeholders should take part and that, where necessary, practical difficulties relating to the funding of attendance expenses should be addressed in order to facilitate good attendance (Q 71).

85. Asked about the suggestions in paragraph 6.2 of the Green Paper[34] that possible initiatives within the EU strategy might relate to social inclusion and also the Fundamental Rights Agency,[35] Mr Scheftlein replied that, on social inclusion, the Commission would not wish to take action separately from that already being taken forward by DG Employment. The contribution of the strategy could be to stimulate work with DG Employment to add a greater dimension to the Commission's existing social inclusion work relating to mental health issues (Q 33).

86. Mr Scheftlein explained that the idea put forward in the Green Paper was that the Fundamental Rights Agency might be a place for the collection of information about conditions in psychiatric institutions across the EU. He did not envisage the development of legally binding, or even harmonised, minimum standards on human rights in health care. He did, however, envisage that good guidelines might be developed for health promotion and quality management in mental health institutions (Q 33). We return to the question of minimum standards or guidelines in chapter 9.

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[34] op. cit. ps. 11-12

[35] Established by Council Regulation (EC) No. 168/2007 of 15 February 2007 establishing a European Union Agency for Fundamental Rights [2007] OJ L53/1.

87. Mr Scheftlein agreed: in summary, he envisaged action at the Community level taking place in the fields of:

- stimulating understanding which would result in action among practitioners;
- providing and collecting data;
- raising awareness on the basis of new data; and
- exchanging best practice.

He hoped that the functions of consensus building and monitoring actions could also form part of the implementation of the strategy (Q 34).

88. The Commission's summary of responses to its Green Paper was published on 19 December 2006.[36] Some 237 responses were received, of which the majority supported the development of a comprehensive mental health strategy. Respondents advised that the emphasis be put on mental health promotion and prevention, as well as on enhancing the situation of those with mental health problems through reducing stigma and discrimination.

89. Differing views were expressed by witnesses about whether the proposed platform approach would give sufficient opportunity for mental health service users and carers to participate in discussion about the development of policy and practice. Broadly speaking, however, there was support for the view that the proposed mode of working should provide an opportunity for service users and carers to be involved. Mrs Alexandra Burner from Rethink commented to us that she felt that the EU platform that was proposed would be a useful mechanism for giving service users and carers a voice within Europe (Q 159). She took the view that it would provide an important single point of access to information about service users and carers, and to information from service users and carers as well (Q 167).

90. Dr Marcus Roberts, from Mind, also supported the proposed platform approach and added that, although there was a lot more to learn in the UK and there was a long way still to go on user involvement, the UK could play a part in sharing good practice across the EU relating to the involvement of service users and carers in mental health issues, largely because the work of organisations like Mind and Rethink was quite well developed in this area (Q 167).

91. **We recognise that the question of EU competence regarding mental health matters is complex, given that mental health impacts upon a range of policy areas. We recommend that careful consideration be given to this matter before the adoption of any measures at EU level.**

92. **Our view is, however, that the platform or forum approach set out by the Commission should be supported because of its inclusiveness, transparency, engagement with service users and other relevant stakeholders. This could add value by co-ordinating Member States' actions and by assisting in the exchange of best practice across the EU. We emphasise that the wide-ranging impacts of many mental health problems make it imperative that there is collaboration**

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[36] See Responses to the Commission Green paper—
http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mentalgp_report.pdf

between different parts of the Commission, just as there needs to be cross-ministry collaboration within Member States.

How the EU's role differs from that of the WHO

93. In relation to the interaction between the roles of the WHO and of the Commission in the field of mental health, Mr Scheftlein explained that, following the Helsinki Conference, the WHO, the Council of Europe and the Commission were meeting regularly to coordinate their work and to work in partnership (Q 6). In broad terms, the WHO had the role of advising Member States on issues of health care and treatment, the Council of Europe worked on human rights aspects and the Commission's role focused on information collection and provision, and the development of a consensus on policies for the promotion of understanding about mental health and for the prevention of mental ill-health (Q 9).

94. The Government's view (pp 30–34) was that an EU mental health strategy would have potential for added value in the areas of:

- creating a framework for information exchange;
- increasing coherence of action across different policy sectors; and
- opening a platform for involving stakeholders, including patient and civil society organisations.

The EU strategy should have the aim of providing practical support to Member States for implementing the WHO Helsinki Mental Health Action Plan.

95. Professor Thornicroft (Consultant psychiatrist at the South London and Maudsley NHS Trust) supported the need for European Commission involvement in the field of mental health, which he thought would complement rather than duplicate the role of the WHO. He put forward two main reasons. First, that the WHO European Region had a much wider coverage of countries than the EU—53 as against 27—and that its focus was necessarily on the most deprived and underdeveloped countries, many of them in central Asia. Second, that the WHO's resources were limited so that the number of staff in its mental health office was small and it did not have the capacity needed (Q 40). Dr Matt Muijen, who welcomed the Commission's role in formulating a strategy for mental health in Europe, identified a third reason why the Commission's and the WHO's roles in this area were complementary rather than overlapping. The WHO had a broader health mandate than the EU, and could provide technical support to countries as they sought to develop their health systems and services (Q 198, pp 86–87).

96. Mr McDaid (Mental health policy analyst at the London School of Economics) agreed: the proposed Commission role was complementary to that of the WHO. In addition to the points made by Professor Thornicroft, he noted that the remit of the Commission across a number of policy areas added a dimension not provided by the WHO. Examples where the WHO could not have a locus but the Commission could were (Q 41):

- ways and means of integrating individuals back into the community (following mental health problems);
- the promotion of good health in the workplace;

- the protection of the health of vulnerable people returning to the workplace;
- access to housing, discrimination, education; and
- support for carers.

The Minister also saw the benefits of complementary WHO and Commission roles in this area (Q 226).

97. **We conclude that, given the wide impact of mental health problems on many aspects of an individual's life and on many different service-providing and other sectors, the Commission's areas of competence and interest in relation to a mental health strategy would complement the specific expertise of the WHO. Moreover, we recognise that because mental health is not just a medical issue, but also a social issue and economic issue, it is important that the strategic agenda is not seen as solely the preserve of health ministries, nor that the international agenda is solely the preserve of the WHO.**

98. **Our view is that, for promoting better mental health and delivering better services, there is an important role for the EU, with its breadth of competence and interests, alongside the more specialised roles of the WHO and the legislative and policy-making responsibilities of national governments.**

CHAPTER 5: HUMAN RIGHTS ISSUES

Human rights issues in the mental health field

99. A fundamental concern expressed by many of our witnesses was that, in most EU countries, people with mental health problems (or at least mental health service users—the two groups are not the same) do not enjoy the same rights and opportunities as other people, including in relation to exercising choice about key aspects of their lives.

100. The WHO Helsinki Declaration explains that Resolutions of the European Union, recommendations of the Council of Europe and WHO resolutions dating back to 1975 recognise the damaging association between mental health problems and social marginalisation. It cites a number of international conventions concerning the protection of human rights and dignity of persons with mental disorder.

101. Professor Thornicroft provided helpful information on the human rights issues (pp 22–27). He explained that the primary source of international human rights within the United Nations was the Universal Declaration of Human Rights (UDHR), which relates to civil, political economic and social rights. Economic, social and cultural rights, such as the right to the highest attainable standard of physical and mental health, were described in a second binding treaty, the International Covenant on Economic, Social and Cultural Rights (ICESCR).

102. A United Nations document[37] sets out the basic rights and freedoms of people with mental illness that must be secured if states are to be in full compliance with the ICESCR. These principles apply to all people with mental illness, and to all people admitted to psychiatric facilities, whether or not they are diagnosed as having a mental illness. They provide criteria for the determination of mental illness, protection of confidentiality, standards of care, the rights of people in mental health facilities and the provision of resources.

103. In addition to these agreements under the auspices of the UN, 46 Member States of the Council of Europe are bound or guided by a series of human rights arrangements, including the 1950 European Convention on Human Rights and Fundamental Freedoms.

104. The EU has a supportive framework for human rights issues; and Article 6 of the EU Treaty and the Charter of Fundamental Rights affirm rights. The Fundamental Rights Agency, established in February 2007, may also provide assistance and expertise to raise awareness of the Charter. The Green Paper envisages a mental health strategy that fully recognises human rights.

105. The Open Society Mental Health Initiative hoped that that the Green Paper's suggestion to identify, through the consultation process, best practice for protecting the rights of people with mental health problems would generate a range of activities that could address stigma and discrimination and promote social inclusion (pp 155–159). Mr John Bowis MEP (Q 127) also made the point that the "wholly unnecessary" added burden of stigma

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[37] Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Care Adopted by UN General Assembly resolution 46/119 of 17 December 1991

experienced by people with mental health problems had to be tackled as a human rights abuse, giving people better legal protections in terms of access to work, to play, and to services.

106. Ms Camilla Parker (a legal and policy consultant working on the field of mental health disability and human rights) emphasised that people with mental health problems were governed by international human rights legislation that covered the rights to, among other things, liberty, freedom from torture, work, education and good health. But there were particular human rights issues that applied to people with mental health problems because of the risk that they might be denied some of their basic rights (Q 170). Table 1 printed at the end of this chapter, which Ms Parker provided, summarises the relevant human rights instruments.

107. Ms Parker argued that human rights were integral to the mental health strategy that the European Commission had proposed. The Commission should accordingly recognise that all activities described within its Strategy needed to be planned and implemented within the human rights context. These activities should enhance respect for the individual, promote equality and social inclusion, and help to ensure that people with mental health problems were able to participate in the planning and implementation of mental health policies.

108. She urged that the European Commission and national governments should look at human rights in four areas, introducing and enforcing legislation to: address barriers to social inclusion (particularly in relation to stigma, discrimination, guardianship, and the rights of people who may lack capacity), provide community-based care, clarify the circumstances in which care and treatment can be compulsorily required, and safeguard the rights for people living in institutions (Q 170). Table 2, printed at the end of this chapter, also provided by Ms Parker, sets out a summary of human rights in these four areas.

109. A similar argument was made by the Mental Disability Advocacy Center (MDAC), an international non-governmental organisation, based in Hungary, that promotes and protects the rights of people with mental health problems and intellectual disabilities across central and Eastern Europe (pp 134–140). The MDAC view was that it was not possible to achieve the broad European aims of social justice, non-discrimination and socio-economic development without addressing the underlying rights of individuals. Positive and pro-active measures were needed to ensure that people with mental health problems enjoyed equal rights to other European citizens. This led MDAC to urge the Commission to make a commitment to a disability-specific directive. They also drew attention to the fundamental rights situation of people with mental health problems in Bulgaria and Rumania.

Deinstitutionalisation

110. Human rights violations have been reported across Europe, and are especially visible in the psychiatric institutions, dispensaries and (institutionally organised) social care homes that remain the mainstay of mental health systems in some countries, including many in Central and Eastern Europe. Individuals admitted to such institutions generally still have little chance of returning to the community. There are well-documented accounts of individuals being kept in “caged beds”, chemical restraints,

solitary confinement, physical and sexual abuse, overcrowding, electro-convulsive therapy without anaesthesia or muscle relaxants in contravention of international guidelines. The Open Society Mental Health Initiative (MHI) suggested that children and adults with mental disabilities, who were isolated in institutions regardless of their age, sex, or type of disability, were often subjected to the most severe forms of cruel, inhuman and degrading treatment and other human rights violations. They recognised that there were pockets of high quality community-based services in Central and Eastern Europe, but "tens of thousands of people with mental disabilities are still living in institutions" (pp 155–159).

111. Not surprisingly, closing the institutions is part of the Commission's proposed strategy: "The deinstitutionalisation of mental health services and the establishment of services in primary care, community centres and general hospitals, in line with patient and family needs, can support social inclusion. Large mental hospitals or asylums can easily contribute to stigma. Within reforms of psychiatric services, many countries are moving away from the provision of mental health services through large psychiatric institutions (in some new Member States, such institutions still account for a large share of the mental health services infrastructure) towards community-based services. This goes hand in hand with instructing patients and their families as well as the staff in active participation and empowerment strategies".[38]

112. Reliance on institutional services varies considerably across Europe, with the UK among those countries that have successfully reduced the number of beds in psychiatric hospitals. The asylums may have had their uses in other times, but they embody and reinforce only negative attitudes about people with mental health problems, and sometimes still smack of the kind of social control and abuse inherited from former Soviet systems (pp 118–120). They also eat up a high proportion of total expenditure on mental health in many countries: in Lithuania it has been estimated that around 70 per cent of the mental health budget is used to maintain psychiatric hospitals and institution-like social care homes[39]. A fear sometimes expressed by even very enlightened mental health professionals in central and eastern Europe is that closing a large and expensive hospital might not mean that the resources thereby saved are made available for the development of community-based mental health services: released funds could instead "leak away" to other parts of the health system or economy.

113. It has gradually been recognised that community-based services are more effective in promoting quality of life and are also not necessarily more expensive. Care in community settings is generally preferred by service users. Most fundamentally, community-based services make it easier to promote and protect basic human rights.

114. Two of the leading mental health advocacy bodies in the mental health field in central and Eastern Europe, the Mental Disability Advocacy Center (MDAC) and the Open Society Mental Health Initiative (MHI) were critical of what they saw as the ambiguous position of the Commission on deinstitutionalisation.

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[38] op. cit. p. 11

[39] Richard Saltman and Vaida Bankauskaite (2006) Conceptualizing decentralization in European health systems: a functional perspective, *Health Economics, Policy and Law*.

115. The MDAC noted that institutions were not defined merely by their size: "an institution is any place in which people do not have, or are not allowed to exercise control over their lives and their day-to-day decisions. Conditions of care are very poor". The MDAC referred to the ample evidence that large institutions were no longer acceptable because they did not meet modern European standards of core fundamental rights, but that there remained a lack of political will to close the institutions and establish community-based services. They advocated more EU-funded research on the experiences (successes, limitations, failings) of Member States that had already established community-based care systems; that the Commission should set a timeframe for institutional closure and monitor progress, and that there should be examination of mental health systems as part of the accession process into the EU.

116. The MDAC also argued that the Green Paper appeared to support the continued existence of institutions and long-term social care homes, clearly counter to the community-based approach already endorsed by the EU in the Helsinki Declaration of 2005. It was important to distinguish between the large long-stay, social care homes in some Central and Eastern European countries, where provision was of a dreadfully low standard and human rights abuses were all too common, and the social care facilities that accommodated many thousands of people in countries such as the UK where standards were much higher (pp 134–140).

117. The Open Society Mental Health Initiative (MHI) stressed the need for deinstitutionalisation. They too were concerned that the Green Paper was not unequivocal in its condemnation of institutions. The MHI wanted greater emphasis in the Commission's strategy on the need to ensure that Member States commit to, and implement, a policy of closing all institutions. They therefore also criticised the Green Paper for failing to mention the poor quality social care homes and orphanages that continued to accommodate large numbers of people in some countries. Unless comprehensive community-based services were developed, the social exclusion of people with mental health problems would be perpetuated. The MHI also argued that membership in, or candidacy for membership of, the EU should be based in part on the state of mental health policies and services. The existence of institutions was anathema to the concept of a civil and open society in which the rights of all citizens were respected (pp 134–140).

118. MHI welcomed the reference to deinstitutionalisation in the Green Paper, but criticised the Commission for failing to make clear that the unjustified segregation of people with mental health problems in long-stay institutions was unacceptable and a major violation of human rights. They also criticised the Commission for failing to recognise that many people were accommodated in smaller but no less institutional settings, such as poor quality social care homes for elderly people and orphanages for children and young people with mental disabilities. A further criticism was levelled at the apparent promotion of the improvement of long-term care facilities, since, they argued, people with mental health problems and disabilities did not need long-term care, with the exception of some forensic patients.

119. The four aspects on which the Commission proposes to focus its strategy are: mental health promotion; preventative action; improving quality of life through social inclusion and protection of rights; and developing better information, research and knowledge systems. MHI suggested that

deinstitutionalisation should be an additional focus area: it was a crucial step towards addressing these other areas. Policy and practice needed to emphasise the development of comprehensive community-based services so as to enable resources to be shifted away from long-stay institutions.

120. Hospital-based services still have important therapeutic roles to play, but as part of a community-centred approach to meeting needs—the so-called "balanced care approach" (see the section on "Community care" below).

121. A new challenge in some countries that have made good progress with the closure of the asylums could be the growth of "reinstitutionalisation", where people with mental health problems who, in the past, might have found themselves in the old asylums, could now be accommodated for long periods in prisons, secure forensic units or care homes.[40]

122. **We support the Commission's view set out in the Green Paper that there is a need to move "away from the provision of mental health services through large psychiatric institutions … towards community-based services", but warn against the dangers of inadequately planned and insufficiently resourced community-based alternatives.**

123. **We also take the view that there is a need to recognise better that smaller care settings can be highly institutional in the way they treat individuals with mental health problems. Member States and accession countries should move away from institutionally organised services that deny residents their basic human rights and subject them to poor and often appalling conditions of care.**

Compulsory treatment

124. As we have seen, mental health service users do not have the same rights and opportunities as other people, including in relation to exercising choice and assuming control of their lives. Policy makers face the substantial challenge of balancing the need to keep vulnerable people in touch with services (for their own protection and for the protection of others) against the danger of over-controlling their lives. Individuals should have an obligation to turn up for treatment and to take their medication. However, some people with mental health problems lack insight into their condition, some will have previously been subjected to compulsion and may therefore be suspicious of the motives of the people treating them, and some may quite rationally choose not to take medications that have awful side effects.

125. A survey of compulsory admission arrangements across the (then) 15 EU Member States in 2002 found considerable variation in legal regulations, routine procedural arrangements and numbers.[41] Compulsory admissions as a percentage of all psychiatric admissions to hospital varied between 3.2% in Portugal and 30% in Sweden (with the UK having a rate of 13.5%), while expressed as the rate per 10,000 population, the range extended from 0.6 in Portugal to 21.8 in Finland (with the UK rate being 9.3 per 10,000). National legal traditions, structures and quality standards of general health

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[40] Stefan Priebe et al. (2005) Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries, *British Medical Journal*.

[41] Hans-Joachim Salize et al. (2002) Piloting a minimum set of mental health indicators for Europe: *Europe Population*.

care provision were seen as the main determining factors in explaining this variation.

126. The Commission's position[42] is that the compulsory placement of patients in psychiatric institutions and involuntary treatment severely affects their rights. Such placement should only be applied as a last resort, where less restrictive alternatives have failed. It should also be proportionate, appropriate, and for the purposes of treatment rather than detention.

127. Legislation has an obvious role to play. It can ensure, for example, that compulsory treatment or detention is used only as a last resort, and can build in safeguards such as access to an independent periodic review for people who are involuntarily treated or admitted to inpatient or other services. Legislation should also address the issue of community protection. Ms Camilla Parker's view was that mental health legislation must ensure that the decisions on the circumstances in which people might be subject to voluntary admission and/or compulsory treatment should be made within a human rights context and should respect individuals' rights (Q 170).

128. **Again, we support the view set out in the Green Paper that the compulsory placement of individuals in institutions should be proportionate, appropriate, and for the purposes of treatment rather than mere incarceration. Compulsory treatment should only be applied as a last resort, where other alternatives have failed.**

Community care

129. As has often been said, it is relatively easy to close an institution but much harder to replace it with community-based arrangements that deliver high quality services of the kind that people actually want to use. As we have seen, community care tends to be preferred to hospital-dominated approaches on the grounds of human rights, relative effectiveness and social inclusion, and is strongly preferred by most service users.

130. Today, a "balanced care" approach is often recommended: front-line services should be based in the community, but hospitals and other "congregate care" settings would play important roles as specialist providers. Under such an approach people would still be admitted to in-patient psychiatric care, but hospital stays should be as brief as possible, and should be offered in integrated facilities rather than in specialised, isolated locations. As the Christian Council on Ageing noted, "No-one likes to be in an institution, including those with dementia or severe mental illness, but some aspects of the institutions were beneficial. A sheltered environment with easy access to recreation and useful activity may be the most satisfactory way of preserving the rights and dignity of some individuals. This does not have to be in an 'institution' but does need to alleviate isolation fear and anxiety. Support should not mean disempowerment" (pp 112–113). Their clear message was that some people would sometimes need a place of "asylum" in the proper sense of the word.

131. When all of the costs of delivering a comprehensive community care system are taken into account, including the costs that fall to non-health care agencies as well as those that fall to families, community-based mental health care may not be less costly than hospital provision. A worry often expressed

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[42] op. cit. p. 11

is that policy makers will make untested assumptions of lower cost and then under-fund community provision, for example not investing sufficiently in after care support or crisis services. There is also the worry, alluded to earlier, that any resources released by closing an institution would not be "protected" for the mental health sector. Ring-fencing funds for mental health can also have disadvantages, but in countries that have still to make the transition away from care dominated by asylums, adequate and (in the short-term at least) protected community mental health budgets are needed.

132. Another worry is that staff are not always recruited and trained, nor appropriate community facilities in place, before the process of hospital closure commences. The rapid decanting of people out of long-stay institutions into under-prepared and under-resourced support systems in what are often very hostile communities is a recipe for disaster. Even when services are apparently in place, people with mental health problems may not use them because they do not want to, or because they do not appreciate the benefits of doing so, or because they feel stigmatised, or because health care and other staff in "ordinary" community services discriminate against them.

133. A well-planned community-based approach to mental health care will involve a range of public and other bodies. Perhaps more than any other health issue, mental health requires a concerted, coordinated, multi-sectoral approach to both policy development and implementation on the ground. Multiple responsibilities mean multiple budgets, which in turn can easily erect barriers in the way of appropriate systems of treatment and support. As the locus of care shifts from hospital to community so too must the balance of funding. Indeed, because of the organisational structure of care systems in many countries, and the diverse funding streams employed, the balance of funding often needs also to shift from a system that is dominated by medical services to one that represents a greater mixture of services and budgets, drawing on social care, education, social housing and other community resources. A major challenge across the EU is to ensure that the right structures or incentives are in place to mobilise resources from a range of service-providing and other bodies in order to meet the multiple needs of people with mental health problems.

134. The Green Paper recognises these challenges stating that: "… although medical interventions play a central role in tackling challenges, they alone cannot address and change social determinants. Therefore, in line with the WHO strategy, a comprehensive approach is needed, covering the provision of treatment and care for individuals, but also action for the whole population in order to promote mental health, to prevent mental ill health and to address the challenges associated with stigma and human rights. Such an approach should involve many actors, including health and non-health policy sectors and stakeholders whose decisions impact on the mental health of the population. Patient organisations and civil society should play a prominent role in building solutions".[43]

135. The Open Society Mental Health Initiative (MHI) welcomed the Green Paper's comprehensive approach, but wanted to see this approach reflected more clearly in the suggested areas of action. They particularly drew attention to the need for social welfare reform for the development of

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[43] op. cit. p. 5

community-based services, and to involve service users in decision-making (pp 155–159).

136. The Northern Ireland Association for Mental Health (pp 148–155) similarly argued for a cross-sectoral approach and partnership working, rather than "silo-dominated" modes of operation. They also urged the Commission to take social capital into account, i.e. the collection of "networks, norms, and social trust that facilitated coordination and cooperation for mutual benefit". The Royal College of Psychiatrists (pp 161–164) agreed that added value would flow most readily from initiatives that were based on, or encouraged, inter-agency and inter-state collaboration. Mind (pp 54–60) wanted the Commission to ensure that its strategy to improve mental well-being was not isolated from wider EU policy relating to risk factors such as poverty, social exclusion, work-related stress, racial injustice, and drug and alcohol misuse.

137. Arguing that the whole can be greater than the sum of the parts, Mind (pp 54–60) had welcomed earlier EU initiatives on mental health but noted that they had been restricted to specific initiatives in separate policy areas. They would complement each other more effectively if part of a coherent, strategic whole. The example they gave was of initiatives to reduce the stigma of mental illness which have to battle against government policies, or at least government rhetoric, that portrayed people with mental health problems as a threat to public safety. They saw this as happening currently in England and Wales in the debate over reform of the 1983 Mental Health Act.

138. Ms Rosie Winterton MP, Minister for Health Services, described to us the efforts made within the National Framework for Mental Health to improve community-based mental health care. Some 700 community health teams had now been set up in England to support people with mental ill health in the community, including getting help at an early stage with both early intervention and crisis resolution (Q 224). Dr Matt Muijen took the view that a great deal had been achieved with community care in England. He saw the provision of specialist services at local level as a most impressive achievement equalling anything elsewhere in the world, with the possible exception of Australia. He did, however, mention the negative side of the NHS system of centralised funding which could mean that insufficiently good access was available in England in some cases for treatment of conditions such as depression, which needs a short, sharp intervention by a therapist on a one-to-one basis (Q 197).

139. **Good community care requires coordinated responses from a range of public and other bodies, the challenges of which should never be under-estimated.**

140. We recognise that the consensus among organisations in the UK, representing both service providers and service users, is that front-line services for the treatment of mental health problems should primarily be based in the community, but that hospitals still need to play an important role as specialist providers. Our view is that Member States should pursue a balanced care approach, using specialist hospital services within a system of care and treatment that is primarily community-based, and that promotes integration, inclusion and choice for the individual and appropriate protection for the community.

TABLE 1
Human rights legislation of relevance to mental health issues

Instrument	Overview
Universal Declaration of Human Rights, 1948	Range of civil & political rights and economic, social and cultural rights, such as: right to life and liberty, the right to marry and found a family, the right to work and the right to an adequate standard of living.
UN International Covenant on Civil & Political Rights, 1966	Includes rights such as the right to life; right to liberty; right to marry and found a family; right to take part in the conduct of public affairs; right to vote.
UN International Covenant on Economic, Social & Cultural Rights, 1966	Includes the right to work, right of everyone to achieve the highest attainable standard of physical and mental health.
UN Convention on the Rights of the Child 1989	Includes the right to education, respect for the views of the child and recognises that all disabled children: “should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community.” (Article 23)
UN Draft Convention on the Rights of Persons with Disabilities (not adopted yet)	“Persons with disabilities” includes “those who have a long-term physical, mental, intellectual or sensory impairments …” General principles include: “Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons.”
UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities 1990	Seek to ensure that all disabled people “as members of their societies, may exercise the same rights and obligations as others.”
UN Principles for the Protection of Mental Illness 1991	Sets out guidance on areas such as procedures for involuntary admission and standards of care.
European Convention on Human Rights 1950	Includes rights such as the right to liberty, right to private and family life and the right to marry and found a family.
European Social Charter 1961 (Revised Charter 1996)	Includes right to work, the right to a fair remuneration, right to vocational training and the right to protection of health.
European Convention on the Prevention of Torture and Inhuman of Degrading Treatment of Punishment, 1987	Establishes the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which, through inspection visits, examines “the treatment of all categories of persons deprived of their liberty by a public authority, including persons with mental health problems”. The CPT has published a report in which it draws together its views on the manner in which persons deprived of their liberty ought to be treated (referred to as the CPT Standards).
European Union Charter of Fundamental Freedoms, 2000	Range of civil, political, economic and social rights such as right to life and right to education. The Union recognises and respects the right of persons with disabilities to ensure their independence, social and occupational integration and participation in the life of the community.’ (Article 26)
Council of Europe Rec (2004)10	Guidelines to protect the human rights & dignity of persons with mental disorder.

Table supplied by Ms Camilla Parker—Legal and policy consultant

TABLE 2

Four aspects of mental health where human rights legislation is of relevance

Key areas	Relevance of Human Rights (Key Principles: Protection against discrimination, the promotion of equality and social inclusion, promoting personal autonomy and independence (respect, choice and control); least restrictive alternative/proportionality, provision of care on the basis of individual needs, participation in policy development)
Addressing the barriers to social exclusion	• Requires the introduction of anti-discrimination legislation • In some cases States are required to take positive action to address the causes of discrimination and "to reduce structural disadvantages and to give appropriate preferential treatment … in order to achieve the objectives of full participation and equality within society for all [disabled people]." • "The Union recognises and respects the right of persons with disabilities to ensure their independence, social and occupational integration and participation in the life of the community." (European Union Charter of Fundamental Freedoms (EU Charter))
Providing community-based care	• UN Mental Illness Principles: right to be treated and cared for in the community (as far as possible) • UN Special Rapporteur on the Right to Health: the right to community integration is derived from the right to health and other human rights; "States should take steps to ensure a full package of community-based mental health care and support conducive to health, dignity and inclusion". • Development of positive obligations under the European Convention on Human Rights (ECHR) • Recognition of "the equal right of all persons with disabilities to live in the community …" (UN Draft Convention on the Rights of Persons with Disabilities (UN draft CRPD))
Regulating detention and compulsory treatment	• Protection from arbitrary detention: requirement of minimum conditions to be met for detention to be lawful and for an independent review of the decision to detain. • Least restrictive alternative: Detention is only justified where other less severe measures have been considered and found to be insufficient to safeguard the individual or public interest, which might require that the person be detained (Witold Litwa v Poland (ECHR, 2000)). • Right to privacy: is a wide-ranging right including issues relating to compulsory treatment. • Involuntary placement and involuntary treatment should be a last resort Rec(2004)10
Safeguarding the rights of those receiving in-patient care	• Adequate living conditions (right to privacy, freedom from torture, inhuman & degrading treatment) • Adequate provision of care and treatment (right to health, freedom from torture, inhuman and degrading treatment) • Protection from harm (right to life, freedom from torture, inhuman and degrading treatment) • Contact with family and friends (right to family life) • Need for independent monitoring (Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT))

Table supplied by Ms Camilla Parker—Legal and policy consultant

CHAPTER 6: SOCIAL EXCLUSION, STIGMA AND DISCRIMINATION

141. The Green Paper[44] states that, despite improved treatment options and positive developments in psychiatric care, people with mental health problems still experience social exclusion, stigmatisation, discrimination, or their fundamental rights and dignity are not respected. Many of our witnesses reinforced this point. With the exception of sexually transmitted diseases, no other health problem appears to attract the same public response. Ignorance, stigma and discrimination are commonplace. These issues are obviously closely linked to the denial of basic human rights, as discussed in the previous chapter. There are also close links to promotion and prevention, which we discuss in Chapter 7.

Social exclusion—the challenge

142. The term "social exclusion" was initially used as a simile for poverty, but has grown to acquire a wider interpretation. It would now encompass unemployment, poor quality housing or homelessness, limited social networks, and restricted participation in social, economic and political life.

143. The 2004 report from the Government's Social Exclusion Unit clearly set out the connections between mental health problems and social exclusion. It suggested that there were five main reasons why mental health problems too often led to and reinforced social exclusion, stigma and discrimination: low expectations of what people with mental health problems can achieve; lack of clear responsibility for promoting vocational and social outcomes; lack of ongoing support to enable them to work; and barriers to engaging in the community.[45]

144. Some or all of these same dimensions were identified in evidence submitted to us (for example: pp 120–123; pp 60–63; pp 140–144). Mind strongly advocated a strategy that addressed the deprivation and marginalisation experienced by people with mental health problems as essential within the European Union's broader commitment to solidarity, community and social justice (pp 54–60).

145. Rethink emphasised the need to focus on social cohesion, dependent in turn on the fulfilment of individual human rights and social inclusion as a citizen, as well as community acceptance of individual difference. They warned that some groups were more vulnerable than others, identifying: women who were single parents or who experienced domestic violence; Black, Asian and other ethnic minority groups; the homeless; and unemployed people (pp 60–63). The NHS Confederation (pp 144–145) also emphasised the centrality of social cohesion.

146. As noted in Chapter 3, people with mental health problems experience above-average mortality rates. If an early death is the ultimate form of social exclusion, then denial of basic human rights is not far behind. The summary of evidence on rights in Chapter 5 shows that a large number of people with mental health problems in many European countries are still denied some of the most basic rights generally enjoyed by the rest of the population. Most fundamentally, those people who spend large parts of their lives incarcerated

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[44] op. cit. p. 5

[45] Mental Health and Social Exclusion—Social Exclusion Unit Report, ODPM 2004

in asylums or other institutions, separated from the normal opportunities to socialise, to work, to travel, to have personal relationships and to live in a family, are among the most socially excluded people in Europe today.

147. As we also described in the previous chapter, many organisations and individuals called for the Commission to put greater emphasis on deinstitutionalisation. The Open Society Mental Health Initiative thought there was insufficient emphasis in the Green Paper on the need to ensure that all Member States both commit to, and implement, policies to eliminate to the extent possible the practice of holding people with mental health problems in institutions (deinstitutionalisation). This meant not only closing the large dehumanising institutions but also (and indeed ahead of closure) developing comprehensive community-based services. They took the view that to segregate people, bar them from access to education and employment or deny them the right to choose where and how they lived and with whom they associated, solely on the basis of a mental disability label was unacceptable. The nature of institutions was, in itself, dehumanizing; and the existence of institutions was anathema to the concept of a civil and open society in which the rights of all citizens were respected (pp 155–159).

148. The Mental Disability Advocacy Center (MDAC) in Hungary also criticised the Green Paper for failing to give an unequivocal commitment to the closure of all institutional services. Their interpretation of the Green Paper's encouragement to Member States to assess "how the Structural Funds can be better used to improve long-term care facilities and health infrastructure in the field of mental health" was that it supported the existence of institutions and long-term social care homes. It should be noted that the MDAC employs the latter term in the way it has been used in discussions of large, substandard facilities run by social welfare agencies in many central and Eastern European countries—see the discussion of this terminology in Chapter 5 of this report. Instead, the MDAC wanted structural funds to be used to create good community-based services orientated towards recovery, self-help, integration and crisis management (pp 134–140).

149. Ms Camilla Parker (a legal and policy consultant working on the field of mental health disability and human rights) argued that, if the Commission and national governments were to be serious about promoting mental health, then they needed to tackle the extreme social exclusion of people placed in institutions for years on end, sometimes for life. The first step in a European-wide strategy, she argued, had to be to close the long-stay institutions and build good community-based alternatives (Q 173).

150. However, as the NHS Confederation stated, people with mental health problems suffer from community isolation even after deinstitutionalisation. They suggested that to receive treatment and care in the community guaranteed very little (pp 144–145). The European Public Health Alliance wanted the Commission's strategy to encourage better access to social housing and greater efforts to help homeless people with mental health problems to be "socially reinserted" (pp 115–117).

151. The Minister also called for better access to supported housing, especially for those people who have been living in institutions for many years (Q 234). At the same time, she argued, there was a need to try to tackle the stigma and discrimination that many people faced from an uninformed general public when placements in the community were being considered. This would not be easy. As the NHS Confederation remarked, there was public concern

about risk, and it was a reality that many criminal offenders had diagnosable mental health problems. Whether public perceptions of the size of the risk were accurate was another matter (pp 144–145). We discuss below the role of the media in the portrayal of mental health problems.

152. Some people with mental health problems—indeed it would appear to be a growing number—are in prison. The Mental Disability Advocacy Center suggested that prisoners and people in (long-stay, institutional) social care homes with mental health problems were vulnerable to abuse and mistreatment (pp 134–140). Mind wanted people in prison to be added to the Green Paper's list of marginalised groups that should be targeted in the strategy. They cited the Social Exclusion Unit's estimate in 2002 that 72 per cent of male prisoners and 70 per cent of female prisoners suffered from two or more mental disorders, proportions that were 14 and 35 times, respectively, the levels found in the general population (pp 54–60).

153. Although most of our evidence referred to the social exclusion experienced by people as a result of their mental health problems, the case was also made that social exclusion could itself be a risk factor for poor health, including mental health. Mind drew our attention to Annex 7 of the Green Paper which summarised material from the World Health Organization identifying key risk factors. These included:

- exposure to drugs and alcohol;
- displacement, isolation and alienation;
- lack of education, transport and housing;
- neighbourhood disorganisation;
- peer rejection;
- poor social circumstances;
- poor nutrition;
- poverty;
- racial injustice and discrimination;
- social disadvantage;
- urbanisation;
- violence and delinquency;
- war;
- work stress; and
- unemployment.

Mind was therefore concerned that a "medical model of mental health"—which they saw as still dominant in many countries—would obscure the social causes and contexts of mental distress (pp 54–60).

154. Rethink noted the close link between unemployment and mental health problems, and referred to the Social Exclusion Unit report that social isolation was an important risk factor for deteriorating mental health and suicide; and that two-thirds of men under the age of 35 with mental health problems who died in the UK by suicide were unemployed (pp 60–63).

155. Dr Marcus Roberts from Mind returned to this theme. He found it interesting that the Commission should have become more concerned about mental health problems as awareness has grown about their social and economic causes. He said that the EU did not have competence in the mental health field as such, but that once the social and economic causes and consequences were recognised, then it would become a matter of great interest and relevance. The EU might then want to approach other policy areas in ways that were "mental health-proofed", i.e. checking legislation and reports for their likely impact on mental well-being. He suggested that the EU might go further. When investing in measures to tackle, for example, social exclusion or employment, some proportion of resources might be specifically identified for projects that promote better mental health (Q 141).

Social exclusion—need for action

156. Department of Health officials described to us the national, cross-departmental social inclusion programme that was part of the wider approach to mental health, built upon the work of the Social Exclusion Unit that we quoted earlier in this chapter. Government departments and delivery agencies, working with local authorities and different tiers of the NHS, were endeavouring to coordinate initiatives in the areas of housing, employment, welfare benefits as well as health and social care, with particular targets including homeless people, offenders, asylum seekers and other marginalised groups (Q 96).

157. The Green Paper[46] in contrast, does not go into any detail when discussing action to combat social exclusion, except for the recommendation—welcomed by many of our witnesses—that through the consultation process it would be hoped to identify best practice for promoting the social inclusion and protecting the rights of people with mental health problems.

158. The Mental Disability Advocacy Center was critical of the Commission's proposals for action, which, they said, were weak and needed to become more concrete and tangible. They were also critical of the top-down approach, and suggested that the achievement of long-term impact required guidance "on all levels" (pp 134–140).

159. The Mental Health Foundation wanted an EU mental health strategy to cover discrimination, employment, mental health promotion and access to fundamental rights such as decent housing and education (pp 140–144). The International Longevity Centre also supported a European strategy that sought to improve both the health and social inclusion of people with mental health problems. They pointed to the critical role played by patient/family engagement in advancing social inclusion and human rights. This led them to recommend the joint training of patients, family members, professionals and policymakers in advancing social inclusion and in countering stigma and discrimination. The EC-supported LEONARDO programme and other initiatives offered an example of such an approach (pp 120–123).

160. Liz Sayce and Claire Curran[47] review the limited progress with the promotion of social inclusion. They find that, to date, there has been no

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[46] op. cit. p. 12

[47] Page 34 of their chapter "Tackling social exclusion across Europe" in *Mental Health Policy and Practice across Europe* (edited by Martin Knapp et al., Open University Press, 2007)

national or European initiative strong enough to make a significant system-wide impact on rates of exclusion faced by people with mental health problems or psychiatric disabilities. As they point out, this is despite an EU Directive on employment in 2000 that required governments to outlaw discrimination on grounds including disability, and a promised but not yet delivered Directive on disability discrimination.

161. **We conclude that social exclusion is itself a risk factor for poor health, including mental health problems. We think therefore that action to address the mental health needs of the population should recognise the social causes and contexts of mental distress. We strongly support the Commission's proposals to address this social exclusion.**

162. **We recognise that the Government has arguably done more than most Member States to recognise the problem of social exclusion of people with mental health problems, and has taken a number of initiatives to address the problem. Nevertheless, there is still a long way to go, and we recommend that the Commission should support concerted efforts by Member States and others to counter the social exclusion of people with mental health problems, who experience disadvantage in many areas, including housing, employment, access to services, income and participation.**

163. **We accept that a particularly difficult challenge is the number of people with mental health problems who are in prison, where their mental health needs may not get recognised or appropriately treated. We recommend that the Commission should encourage Member States urgently to examine the services available to recognise and to treat those with mental health problems in prisons.**

Stigma and discrimination

164. Professor Graham Thornicroft of King's College London, Institute of Psychiatry, suggested an agenda for mental health policy. His starting point was the widespread discrimination experienced by people with mental health problems "at home, at work, in personal life, in social activities, in healthcare, and in the media". He made the distinction between ignorance (the problem of knowledge), prejudice (the problem of attitudes) and discrimination (the problem of behaviour). Stigma stemmed from these three: from the widespread misunderstanding of mental health; from the fear, anxiety and avoidance of the general public and of people with mental health problems ("self-stigma" because they anticipated rejection and discrimination); and from the evidence that discrimination blighted the lives of many people (pp 22–27).

165. In its Green Paper[48] the Commission recognised these problems, stating that people with mental health problems met fear and prejudice from others, often based on misconceptions. They also recognised that stigma increased personal suffering and social exclusion, and could impede access to housing and employment.

166. Dr Marcus Roberts of Mind noted the high costs of stigma: "...it is stigma that keeps people out of work, it is stigma that stops them approaching services when they need help, and it is stigma that keeps people isolated

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[48] op. cit. p. 11

because they do not integrate into their community, and therefore it perpetuates in a vicious circle [the] wider causes of mental health" (Q 149).

167. Many others reiterated these concerns to us. Rethink reported how the stigma surrounding mental health problems could prevent people from forming close personal relationships, which compounded their isolation, adding to the vicious cycle that connects social exclusion and mental heath (pp 60–63). One of the recommendations they suggested was education to improve public awareness of mental health. The King's Fund commented that stigma was a major barrier to recovery (pp 124–127); but the Royal College of Psychiatrists suggested that stigmatising attitudes—or at least "negative attitudes or indifference"—were often displayed by health care staff (pp 161–164).

168. The Open Society argued that tackling stigma was essential if Member States were to make progress in pursuing the first three priorities identified by the Green Paper, i.e. promoting mental health; preventative action; and improving quality of life through social inclusion and protection of rights and dignity (pp 155–159).

Action to tackle negative attitudes and discrimination

169. Professor Thornicroft helpfully set out a number of suggested actions to counter the negative attitudes and stigma experienced by people with mental health problems. He distinguished action to support individuals and their families, action to support people with mental health problems at their place of work, actions needed at the local level, and actions needed at the national level. In Table 3, at the end of this chapter, we detail the actions suggested by Professor Thornicroft. He also described action to support service user advocacy groups (pp 22–27).

170. Among Professor Thornicroft's recommendations were a number of specific actions that should be taken at international level. He noted the standards set out by the World Health Organization as a guide to countries that were producing for the first time or revising their mental health laws. These covered areas such as involuntary treatment, restraint, privacy and seclusion. At European level, action should be taken to enforce anti-discrimination laws in relation to employment (see the next section of this chapter). European health ministers should also ensure that they implement the Mental Health Declaration and Action Plan to which they gave their assent following the 2005 Helsinki discussions. The priorities set out there included the need to foster awareness of mental health problems, and the commitment to tackle stigma, discrimination and inequality.

171. Others drew our attention to the need for the Commission and national governments to recognise that a number of pieces of legislation already existed that should guard against stigma and discrimination. The Mental Health Foundation made this point, and referred specifically to the Disability Discrimination Act in the UK that stated that people should not be discriminated against on the grounds of disability, including disability stemming from poor mental health. Enforcement of anti-discrimination legislation was clearly to be encouraged, but would be unlikely to be sufficient unless backed up by other initiatives (pp 140–144).

172. Mind and Rethink also referred to existing legislation, and wanted mental health to be "mainstreamed" as a core disability rights issue. However, they

warned that language was important and that it might not be helpful simply to assimilate mental health within disability as it could confuse the issue (QQ 143–146).

173. The NHS London EU Unit urged the Commission to promote "one-stop shops" to provide information about, and assistance with, mental well-being in non-stigmatising settings, and to encourage Member States to share best practice examples of how to challenge stigma and discrimination (pp 145–148). The Scottish Association for Mental Health recommended that other countries learn from the award-winning "See me" anti-stigma campaign in Scotland, which was showing early signs of success. Mind and Rethink noted that this campaign was funded by the Scottish Executive from revenue raised through a tobacco levy in Scotland. They applauded this link (Q 148).

174. In England, the Department of Health has established *Shift*, a national anti-stigma and discrimination programme launched in 2004. Shift is a communications-driven programme that works with the media, schools, private and public organizations to reduce stigma and discrimination. Shift endorsed the key priorities of the Green Paper, which corresponded to the key objectives of the National Social Inclusion Programme (NSIP) which built on the Social Exclusion Unit report. The NSIP worked across government departments to influence policy and raise awareness of the non-health needs of people with mental health problems, and also worked with partners in the health field to promote better social inclusion. Shift recommended that mental health needs should be addressed within broader EU strategic policy objectives. The illustration they offered was in relation to employer practice that can have a large impact on the mental health of employees (p 171).

175. However, Mind and Rethink lamented the small budget allocated to Shift: £873,000. This was, they said, about one twentieth the size of the budget for the successful anti-stigma campaign in New Zealand, which had significantly changed attitudes. Expenditure per head of population on their anti-discrimination work in New Zealand was 34 pence, compared to 13 pence in Scotland and just 1.44 pence in England. The New Zealand campaign was also long-term (funded for five years) whereas Shift was funded from year to year, and delivered by a coalition of voluntary organisations (QQ 146–149).

176. Referring to the European Parliament's response to the Green Paper,[49] Mr John Bowis MEP identified defeating stigma as the most important of the specific areas of action set out in the document (Q 112). Stigma was a wholly unnecessary added burden to an illness which had to be tackled as a human rights abuse. Individuals need legal protection in access to work, leisure and services, and the public needed to be educated to get a better understanding of mental health problems, which would—he argued—improve tolerance. He also argued that better coordination between agencies (health, social work, housing, employment service, social security) would help to defeat stigma (Q 127).

177. The Mental Health Foundation identified the central role played by the media in influencing public perceptions of mental illness, but lamented the way the media generally reinforced negative misperceptions (pp 140–144). Whether the media could ever be persuaded to challenge stigma was an open

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[49] European Parliament resolution on Green Paper 2006/2058(INI)—adopted 6/9/2006

question. Department of Health officials referred to the "discriminatory attitudes" of the media (Q 94). The Samaritans organisation was critical of the Green Paper's failure "to engage the need for media to be engaged both as a group to influence and a channel to utilise". They explained that the Samaritans themselves produced media guidelines on the representation of suicide and monitor media output in an attempt to encourage "positive, non-stigmatising and alternative messages on the portrayal of mental ill health and suicide" (pp 164–167).

178. The Minister (Q 224) also identified the need to try to work with the media to alter how they portrayed mental health problems. She pointed to some of the successes achieved by the Shift programme (Q 237), suggesting that work with the media had been "quite successful", and that some of the campaigns by the BBC, targeted at young people, had also been effective. Work with employers, mentioned in Shift's own submission to the Inquiry, was encouraging.

179. Mr John Bowis MEP (Q 112) referred to some of the high profile cases involving people with mental health problems that had attracted a lot of media coverage. He was concerned that every such incident gets reported three times by the media—once when the incident occurred, a second time when there was a court case, and a third time when the conclusions of any formal inquiry were published. This could mislead the public into thinking there were three separate incidents. He referred to the tabloid headlines that generated letters to Members of Parliament and to local councillors from "frightened or worried constituents". More needed to be done, he argued, to undermine the widespread ignorance about mental health.

180. A number of witnesses argued that one way to change attitudes, break down stigma and counter discrimination was to help people with mental health problems to be empowered in ways which help to address their problems. Professor Thornicroft noted that "empowerment" had been described as the opposite of "self-stigmatisation". He made a number of recommendations to help to empower people with mental health problems, including: participation in formulating care plans and crisis plans; using therapy to reverse negative self-stigma; collecting consumer satisfaction ratings of services; creating user-led and user-run services; developing peer support worker roles in mainstream services; advocating for employers to give positive credit for experience of mental health problems; and participating in research on treatment and care (pp 22–27).

181. Rethink called efforts to support the greater involvement of mental health service users by giving them the correct medication, adequate support in accessing services, and reducing barriers to accessing services, not only in mental health services but all services, particularly housing and education. The voices of service users and carers needed to be heard. They argued that enabling participation, and maintaining involvement, in society helped people with mental ill health to remain active citizens (pp 60–63).

182. The International Longevity Centre (pp 120–123) and the London NHS EU Unit (pp 145–148) saw empowerment and social integration as being at the heart of initiatives to improve the health and quality of life of people with mental health problems. Mind (pp 54–60) urged the Commission to ensure that any efforts to promote mental health included a substantial input from those who had experienced mental distress.

183. Department of Health officials emphasised the difficulties of tackling stigma and discrimination, and hence the value of learning from the experiences of other countries. They referred to a small and growing body of expertise on what worked, but considered that this did need nurturing and helping by contacts. They also reinforced what others had said, that defeating stigma required action from a range of sectors and was not exclusively a health sector responsibility. They mentioned the launch by Ministers of the Action on Stigma campaign on World Mental Health Day in October 2005, which sought to engage major employers in fighting stigma. The campaign had started with NHS employers, to "get our own house in order first" (Q 94).

184. **We are persuaded that to improve public understanding of mental health problems would help to counter the negative attitudes that are often expressed. To achieve this, we recommend that efforts should be continued and reinforced to raise public awareness as to the extent, causes, characteristics and impact of mental health problems (sometimes called improvements to "mental health literacy").**

185. **While we recognise that different approaches might work best in different countries, we believe that Member States should be encouraged to make a commitment to tackling stigma and discrimination and to promoting the social integration of people with mental health problems. Member States should also be encouraged to work towards a code of good practice and to share examples of successful initiatives.**

186. **Our view is that mental health problems should be recognised as coming within the scope of anti-discrimination legislation relating to disability and that, to the extent that such legislation exists already, it should be enforced and its impact should be monitored. Member States that do not have such legislation should be encouraged to introduce it.**

Employment problems

187. While most people with mental health problems, even severe problems, want to work, employment rates can be extremely low, as we saw in Chapter 3. But a Healthcare Commission survey in 2004 of 27,000 mental health service users in England found that a third had not received any help with finding work.[50] Loss of employment can equate to severely reduced income, as well as losses to social networks, pension and other entitlements. Work is also a normalising experience, allowing people to participate more fully in society and can promote self-esteem and quality of life. In short, it considerably enhances the chances of social inclusion.

188. Mr John Bowis MEP as we noted earlier, cited the defeat of stigma as the most pressing issue for a mental health strategy (Q 112). Another key priority he identified was the need to educate employers and the trades unions about the importance of mental health in the workplace. The welfare of people at work, he noted, had been a very direct responsibility of the EU since the Treaty of Rome. While accident prevention at work had received a lot of attention, the mental health needs of the workforce had been neglected (QQ 112, 130).

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[50] Healthcare Commission (2004) *Patient Survey Report 2004—Mental Health*, Healthcare Commission.

189. Many other witnesses also emphasised the central role played by discrimination in employment. The London NHS EU unit noted that stigma, discrimination and exclusion from employment affect economic prosperity (pp 145–148). The NHS Confederation urged national governments to make commitments to raise employment rates of people with mental health problems, similarly pointing to the compelling business case for increased labour market participation. The Confederation saw this as instrumental to efforts to tackle discrimination and "the myths of mental illness" (pp 144–145).

190. Mind saw stigma as a barrier to employment for people with experience of mental health problems. Lack of flexibility among employers was also an issue. Mind referred to the Social Exclusion Unit report on mental health and social exclusion, which found that fewer than four in ten employers would consider employing someone with a history of mental health problems, compared to more than six in ten for physical disability. They referred also to the more recent survey by the Chartered Institute of Personnel and Development that found that more than 60 per cent of employers disregarded applications from people with drug or alcohol problems, criminal records, and a history of mental health problems or incapacity. Half the employers surveyed said that nothing would persuade them to recruit from these "core jobless" groups. Despite these reports indicating the need for improvement in the attitudes of employers in the UK to mental health issues, Mind worryingly thought that employers' attitudes to mental health were probably more progressive in the UK than in some other EU countries (pp 54–60).

Action to address employment problems

191. A number of appropriate actions were identified by witnesses. West Sussex County Council described how they were endeavouring to encourage more progressive attitudes and approaches by employers. One approach they were using was to train employers to have a better understanding of the challenges of employing people who experienced mental health problems (pp 174–176).

192. Professor Thornicroft recommended a number of actions to support people at work (see Table 3 at the end of this chapter). Just as workplace modifications were made for people with physical disabilities, so it was necessary to make "reasonable adjustment" (as the Disability Discrimination Act requires) for people with mental health-related disabilities. Among the examples he offered were the following measures: flexibility in work hours so that people could attend appointments for treatment, or could work when they were not impaired by their medication; more gradual induction phases for people returning to work after a prolonged absence or for people with some cognitive impairment; reallocation of marginal job functions which caused an individual anxiety; and efforts to raise disability awareness among all employees to reduce stigma (pp 22–27).

193. This point was also made by Ms Camilla Parker. She noted that people often interpreted the "reasonable accommodation" requirement of the European Directive on employment[51] simply to mean making buildings accessible to people with physical disabilities, but it needed to be extended to include the more challenging task of flexibility for people with mental

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[51] We understand this to be a reference to Article 5 of Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation [2000] OJ L 303/16.

health problems. She wanted the Commission to use its proposed platform to engage with employers and with individuals—improving awareness of obligations and rights—so as to encourage better working practices (QQ 185–186).

194. Both the Minister (Q 224) and Department of Health officials (Q 94) referred to the Government's *Health, Work and Wellbeing* strategy on which the Department for Work and Pensions, the Health and Safety Executive and the Department of Health were collaborating. The aim was to get employers to play their part in acknowledging and dealing with mental health problems in the workplace, while ensuring that people did not feel excluded or that they have to leave work.

195. The Minister also described the work done with employers as part of the Shift campaign, encouraging greater openness about mental health. She cited the efforts of big employers such as Royal Mail and BT to share their experiences of how they have dealt with those issues, and particularly how they had taken responsibility to adapt working environments. She referred, also, to "changing the culture", partly through the Pathways to Work projects that were trying to help people with mental health problems back into the workforce—"to maximise everyone's potential and skills and keep them at work"—and partly through exploration of a code of practice for employers, that would aim to develop a healthier workplace. At this stage, the Government was working with voluntary guidance and was monitoring how much progress could be made in that way (Q 238).

196. Ms Winterton MP also drew attention to the guidance issued to employers in October 2005, some of it voluntary and some of it reminding them of their obligations under the Disability Discrimination Act (p 107).

197. At a European level, Professor Thornicroft noted that anti-discrimination laws were now mandatory under the EU's Article 13 Directive,[52] making it illegal to discriminate in the workplace on grounds that include disability. Member State governments had also to enforce these laws. He suggested that it would be timely to share experience on how successful such laws had been in reducing discrimination against people with mental health problems. This could provide a basis for identifying the need for further or amended legislation (pp 22–27).

198. The Mental Health Foundation also wanted employers and employees to be made aware of their duties and rights under European and national legislation. They suggested that "If Member States' laws were inadequate in this regard, they should be encouraged and supported to introduce legislation". The Foundation suggested that the European Commission might lead by example by implementing positive and proactive employment initiatives for its own staff with experience of mental health problems (pp 140–144).

199. Dr Matt Muijen (Regional Adviser for Mental Health at the European Region of the World Health Organisation) warned against the risk, if mental health problems were singled out for special attention in a legal framework, that employers might seek to avoid employing people with mental illness

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[52] We understand this to be a reference to Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation [2000] OJ L 303/16.

altogether. Including mental health within mainstream disability would help to avert this danger (Q 212). He did not support legislation that would require employers to employ a certain percentage of people with mental health problems, as he saw this as unenforceable. Instead he suggested that incentives to employers would be more helpful for example giving subsidies or tax breaks for good practice. It was important to support people in the workplace, including support for people wanting to get back to work (Q 219).

200. Dr Marcus Roberts from Mind (Q 150) floated the idea of a European Directive or similar instrument that would require businesses above a certain size to have proper mental health policies. He referred to the UK Access to Work scheme which provided funding to employers to make workplace adjustments to help people with disabilities, including mental health problems, thus removing the financial barrier. Applications were made by individuals. For small businesses it could be hard to introduce flexibility, and it might be that government needed to provide compensatory funding. He also supported social enterprise models as good vehicles for reintegrating people into work.

201. Mr Paul Corry from Rethink (Q 150) agreed that there were particular issues for small employers. He wanted to stress, however, that people with mental health problems, when they were actually in work, had higher productivity rates than the general workforce because their motivation was higher.

202. Not everyone will be able to work, even with better flexibility and other reasonable adjustments. As Mind suggested, people who were not able to get into paid employment should be encouraged to get involved with voluntary work because of the many benefits that could follow. Mind felt that these kinds of projects made a vital contribution to the well-being and social inclusion of people with mental health problems, and that it was important that they were properly funded as part of a comprehensive European mental health strategy (pp 54–60).

203. **We recognise that a key area of exclusion and stigma is employment, and that disadvantage in employment has major economic and social consequences. We recommend that the Commission should encourage Member States to work with employers to help them to recognise the economic benefits of mental health promotion/prevention, and to agree a code of practice.**

204. **We understand why small businesses might find it economically difficult to put in place the flexible working arrangements that can help people with mental health problems. We urge Member States to seek practical means of helping small businesses to comply both with the legislation and with any voluntary codes of practice.**

205. **We recommend also that the European Commission should consider introducing a "reporting obligation" for Member States to monitor how employers are performing in relation to the employment of people with mental health problems.**

TABLE 3

Suggestions by Professor Thornicroft (Consultant psychiatrist at the South London and Maudsley NHS Trust) for actions needed to form a strategy for mental health

Action to support individuals and their families

Action	By
Develop new ways to offer diagnoses	Mental health staff
Have information packages for family members that explain causes, nature and treatments of different types of mental illness	Mental health staff, consumer and families
Actively provide factual information against popular myths	Mental health staff
Develop and rehearse accounts of mental illness experiences which do not alienate other people	Mental health staff and consumer groups

Actions needed at the local level

Action	By
Introduction of supported work schemes	Mental health services with specialist independent sector providers
Psychological treatments to improve cognition, self-esteem and confident	Mental health and general health services
Health and social care explicitly give credit to applicants with a history of mental illness when hiring staff	Health and social care agencies
Provision of reasonable adjustments/accommodations at work	Mental health providers engaging with employers and business confederations
Inform employers of their legal obligations under disability laws	Employers' confederations
Deliver and evaluate the widespread implementation of targeted interventions with targeted groups including school children, police and healthcare staff	Education, police and health commissioning and providing authorities
Provide accurate data on mental illness recovery rates to mental health practitioners	Professional training and accreditation organisations
Implementation of measures to support care plans negotiated between staff and consumers	Mental health provider organisations and consumer groups

Actions needed at the national level

Action	By
Use a social model of disability that refers to human rights, social inclusion and citizenship	Governments and non governmental organisations (NGOs) to change core concepts
Apply the anti-discrimination laws to give parity to people with physical and mental disabilities	Parliament and government
Inform all employers of their legal obligations under these laws	Employment ministry or equivalent
Interpret anti-discrimination laws in relation to mental illness	Judiciary and legal profession
Establish service user speakers' bureaux to offer content to news stories and features on mental illness	NGOs and other national level service user groups
Provide and evaluate media watch response units to press for balanced coverage	Statutory funding for NGOs to provide media watch teams
Share between countries the experience of disability discrimination acts	Legislators, lawyers, advocates and consumer groups
Understand and implement international legal obligations under binding declarations and covenants	NGOs to communicate legal obligations of all stakeholders, and health and social care inspection agencies to audit how far these obligations are respected in practice
Audit compliance with codes of good practice in providing insurance	Associations of Insurers with Service User organisations and mental health NGOs
Providing economic incentives rather than disincentives to disabled people ready to return to work	Employment Ministries to introduce new and flexible arrangements for disabled people to work with no risk to their income
Change law to allow people with a history of mental illness to serve on juries with a presumption of competence	Justice Ministries to amend the law relating to jury service

Taken from evidence submitted by Professor Graham Thornicroft (Consultant psychiatrist at the South London and Maudsley NHS Trust)

CHAPTER 7: PROMOTION AND PREVENTION

206. Clearly, central concerns of any mental health care system should be how to prevent the emergence of mental health problems in the first place, and how to promote better mental well-being (better quality of life) of individuals and families affected by illness. Among other things, this could be taken to argue that health systems look beyond "merely" alleviating symptoms or reducing the probability of relapse, and instead encourage services and therapies that are more holistic and more ambitious in their aims.

Mental health promotion and prevention

207. Mental health promotion and prevention are not the same thing. The aim of mental health promotion is to protect, support and sustain emotional and social well-being. This can be achieved by creating the right conditions (individual, social and environmental) for good psychological and psycho-physiological functioning, and so enhance mental health. Consequently, mental health promotion initiatives are generally directed at whole populations rather than at people who already have or are recovering from mental health problems.

208. Prevention initiatives, in contrast, endeavour to tackle the risk factors associated with mental health problems, and also to enhance the protective factors. The primary aim is to prevent mental health problems from emerging. Associated aims are to shorten the duration of an episode of illness, to reduce the risk of a relapse, and to reduce the impacts that mental health problems have on the individual, their family and the wider society. As Chapter 3 described, these impacts are many and wide-ranging.

209. Although the concepts are different, prevention and promotion initiatives can overlap. Eva Jané-Llopis and Peter Anderson,[53] of the WHO European Region office, referred to the recommendations of the 2005 WHO Declaration and Action Plan (see Appendix 4). They suggested an integrated approach that not only used the health system to promote better mental health, but also involved linked action across other social policy areas. This could mean working to: reduce economic insecurity for individuals and their families; improve social cohesion; and provide better access to education, introduce labour market policies that promote better health and improve housing and urban planning. This had been called a "public health" approach to mental health. Such a broad approach to promotion and prevention had been seen by many as necessary to address the complex causes of mental health problems.

210. Social scientists, policy makers and international institutions agree that for people to build networks of personal, community and work-related contacts (social capital) may help to reduce the number of people newly developing mental health problems and the overall number of people in the population with these problems. The Department of Health has explicitly cited the development of social capital as an important feature of mental health promotion, something that was also given emphasis in the Social Exclusion Unit's 2004 report on the links between mental health and social inclusion.

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[53] A policy framework for the promotion of mental health and the prevention of mental disorders, in Knapp M, McDaid D, Mossialos E, Thornicroft G (eds) *Mental Health Policy and Practice across Europe*, (2007) Open University Press, pp. 188–214).

Their report recommended actions such as developing social networks, but there is still little hard evidence as to whether such actions lead to any improvements.[54]

211. Most EU governments have given relatively limited attention to policies that can promote population well-being and individual mental health. The Commission, working with the WHO and national governments, could encourage more and better public mental health initiatives. An obvious starting point would be to set up structures to share examples of good practice (i.e. initiatives of proven effectiveness). This means that mental health decision makers need to engage with groups such as teachers, social workers, employers, trades unions, local community groups and faith-based organizations.

212. **We believe that a "public health" approach for addressing the promotion and prevention of mental health issues is to be encouraged, recognising the multiple influences on the mental health of populations, from outside as well as from within the mental health system as conventionally defined.**

213. Dr Matt Muijen referred to the distinction made in the WHO Helsinki Declaration between "mental wellbeing" to cover positive mental health, and "mental health problems" to cover negative mental health (Q 205). The importance of this distinction was that prevention can refer to different groups of people and problems. It was important, he argued, not to cluster together a whole group of disorders and a whole group of people who had nothing in common. People with relatively minor anxiety states and people with very major forms of schizophrenia need very different interventions and have different outcomes. Prevention was particularly relevant for stress-related disorders, anxiety and depression. Dr Muijen also noted how there was widespread support for prevention but it was very often secondary to other forms of government action.

214. The Green Paper's emphasis on promotion and prevention stems partly from work by the WHO which we have summarised above.[55] "Promotion of mental health and prevention of mental ill health address individual, family, community and social determinants of mental health, by strengthening protective factors (e.g., resilience) and reducing risk factors. Schools and workplaces, where people spend large parts of their time, are crucial settings for action".

215. Witnesses described several examples of successful mental health promotion and prevention initiatives, both local and national, short-term and long-term, drawn from the UK and elsewhere, and targeting the general public, policy makers, informal carers, employers or others. Some of these examples are noted below. They included initiatives in childhood and old age. The case studies submitted are exactly the sort of thing that would be disseminated in an evidence-sharing exercise of the kind envisaged for the Commission's platform approach.

216. However, it is hard to judge the robustness of the supporting material. For example, economic savings are often cited, as are better social outcomes, but as Dr Muijen noted, the evidence for high level prevention strategies was not very strong because they were non-specific and of high cost (Q 205).

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[54] *Mental Health and social exclusion.* Social Exclusion Unit Report, June 2004

[55] op. cit. p.8

217. He also commented that, with respect to the newer countries in the EU, although they lacked basic structures and services in mental health, there was evidence of micro-initiatives in prevention and promotion and of mental health. But again, carefully evaluated national activities were scarce (Q 210).

218. **We recommend that the Commission encourage national governments to investigate ways to provide early identification and early intervention services. At the European level, we support the Commission's proposal for a platform approach that would help to bring together different Commission Directorates and encourage parallel efforts in Member States.**

Examples of good practice

219. Examples and case studies provided to us cover a variety of activities and initiatives. Dr Muijen referred to posters on buses in France that said "Your neighbour may suffer from mental illness", but he was not sure whether this was helpful or not. He was positive about activities in Greece where famous singers and other "champions" of mental well-being were involved. He referred also to initiatives in Finland, the Netherlands and Scotland, but effective evaluation had not taken place (Q 210).

220. Mr Scheftlein, Mr Bowis and Ms Parker, among others, emphasised that efforts to counter stigma would help to encourage people to refer themselves or their relative for treatment at the early signs of a mental health problem, rather than allowing the problem to develop into something more serious that was not only much more distressing but might also require more drastic (and more costly) service responses. Similarly, improving "mental health literacy" among the general public ought to improve early recognition of symptoms, and so should have preventive benefits (QQ 13, 112, 182).

221. The Mental Health Foundation argued that investment in early detection and early intervention services appeared (from UK evidence in one or two areas) to pay dividends in terms of health, quality of life and cost-effectiveness. They also referred to whole-school approaches to mental health promotion, aiming to reduce bullying in schools, providing universal support to parents and mechanisms to monitor progress on promoting children's mental health. The Foundation advocated less reliance on medication and more attention to be paid to identifying effective ways of building resilience (pp 140–144).

222. Mind told us that in Estonia, an attempt was made to encourage local communities to be more welcoming of people with mental health problems by screening the film *A Beautiful Mind* (Q 161). The International Longevity Centre UK sent us information that in Denmark, the Danish Mental Health Fund had experimented with a "Happy Bus", providing full educational facilities, including internet access. A mobile unit went around the community and targeted children and young adults. They described "Mindfull", a project promoted by STAKES, the Finnish National research and development centre for welfare and health, which demonstrated the power of good information in raising awareness and understanding of severe mental health problems and their treatment (pp 120–123).

223. A number of witnesses described how programmes such as *Mind out for Mental Health*, *Shift* (in England) and *See Me* (in Scotland) provide examples that are making a positive impact. The Minister, Ms Rosie Winterton MP, pointed to some of the real successes in the five-year Shift programme. She

thought a lot of the work with the media had been quite successful and some of the BBC campaigns targeted at young people had been effective (Q 237).

224. Action is also needed outside the mental health system. Among the areas mentioned were: urban improvements; housing; employment opportunities; skill development; physical activity; investment in social capital; and healthy workplaces. The European Public Health Alliance pointed out the link between good nutrition, physical activity and mental health (pp 115–117). Mind informed us that there was growing empirical evidence that participation in physical activities, such as walking and conservation work, could have substantial mental health benefits (pp 54–60).

225. The encouraging work undertaken by big employers like Royal Mail and BT to give advice to managers to be more open about mental health issues was also mentioned by the Minister. Such initiatives could help to reduce the embarrassment and counter the stigma associated with mental health problems. These companies had sought to create environments that positively influenced the mental health of their employees. The Minister questioned whether major national campaigns were as effective as smaller efforts to tackle what was happening to people in their everyday lives, particularly in the workplace. She drew attention also to workplace mental health promotion efforts in Spain and France (Q 237).

226. Mr Jurgen Scheftlein (Q 19) referred to "corporate social responsibility", which he saw as an avenue for spreading information about good practice and involving companies in mental health promotion. Mr Muijen explained that there was technical evidence that certain ways of working and the workplace atmosphere can be directly inimical to mental well-being (Q 207). Mr McDaid told us that the Boeing Company's long-standing programme on promoting mental as well as physical health has apparently shown some good outcomes (Q 66).

227. Mr Jurgen Scheftlein described how the European Alliance against Depression (EAAD) had sponsored the establishment of regional networks of information-sharing among different sections of the community—media, teachers, priests, police and doctors. This had apparently resulted in some pilot projects reporting a 25% reduction in suicides and suicide attempts. Effective promotion and prevention campaigns did make people understand and helped them to seek medical care (Q 13).

228. The Citizens Advice Bureaux report published in April 2004, *Out of the Picture*, highlighted problems resulting from an interaction between debt and mental illness. This motivated the International Longevity Centre to produce a film and training materials entitled *Money Worries* to improve the advice and support offered by finance providers to those with mental health difficulties and debt problems (pp 120–123).

229. Evidence from Mr McDaid and colleagues from the London School of Economics noted the use of parent training programmes and interventions for the early identification of mental health problems in schools, as well as bereavement counselling and social activities to reduce isolation and the risk of depression in older age (pp 10–12).

230. Rethink told us that informal carers often needed better information, communication and support and that it had been reported that informed, involved and supported carers had a better experience and were more effective carers than those who were uninvolved and without access to support and information. Targeting informed carers in such a manner significantly reduced

the risk of developing depression and suicidal tendencies (pp 60–63). The International Longevity Centre described an example of this approach in Poland, where priests working with carers in innovative partnerships had been able to reduce the number of suicides. The ILC gave details of a number of training programmes for carers across Europe (pp 120–123).

231. Promoting public understanding of mental health problems would help to change the way the public perceive those affected by such problems, particularly if the policy aim is to integrate people in the community. For example, Mr John Bowis MEP described the case of a woman who was concerned about her mentally ill neighbour living alone, but then felt reassured because of information campaigns and knowledge that she could approach relevant agencies to seek out help for her neighbour in times of need (Q 127).

232. **We have been impressed by the many examples of good practice in mental health promotion and prevention, both in the community and in the workplace, that have been drawn to our attention in this inquiry. We support the Commission's proposals to encourage Member States and employers to learn from such examples and to recognise the benefits of adopting such an approach.**

Sharing good practice

233. It was not possible for us to judge whether initiatives based on the examples of good practice described to us would indeed prevent mental health problems from emerging, delay onset of symptoms or improve quality of life for individuals, families and communities. It would be important, however, for the Commission and national governments to encourage the sharing of experience that was, as far as this can be ascertained, of proven benefit. As Mr Scheftlein remarked, the European Commission was funding the Mental Health Economics European Network which was currently gathering evidence on mental health promotion and prevention from 32 countries, looking especially at early childhood interventions and the workplace (Q 19).

234. Department of Health officials noted that there was a very helpful publication that accompanied the Green Paper, *Country Stories*, that collected stories about successful activities around promoting mental health from different Member States. Mrs Tyson, one of the DH officials, argued that the UK should be carrying out its own mental health promotion and prevention activities to tackle the particular problems that arose in the particular context of this country. She expected other Member States to have the same view. In the same way as other witnesses, she referred to the difficulty of identifying whether a mental health promotion initiative had indeed been effective (Q 88).

235. Consequently, Mrs Tyson noted that the Department of Health was alive to the possibility that input from an EU strategy might help with the UK's own national promotion and prevention agenda. This might be by raising the profile of mental health issues and the actions that people could take in their everyday lives to preserve and promote their own mental health. It might be through the sharing of good practice (Q 88).

236. **We support the Commission's proposal for sharing good practice across the EU, and indeed more broadly, and we believe it would be helpful for the Commission and/or the WHO to take responsibility for the collation of these examples, with the help of national governments. Those examples should be of proven effectiveness.**

CHAPTER 8: MENTAL HEALTH ISSUES FOR POPULATION SUBGROUPS

237. The Green Paper is concerned with mental health problems across the full age span, but focuses almost all of its attention on working age adults. Some subgroups within the working age population warrant particular attention, and there is also a need to ensure that the needs of children and adolescents and of older people are not overlooked. In our view, four groups need to be considered in a little more detail:

- Children and adolescents
- Older people
- Black and minority ethnic groups
- Women

238. For each of these groups all of the issues discussed earlier in this report have relevance: stigma; discrimination; the need for preventive and promotion strategies; the advantages of community-based care systems; and the difficulties of working across agency boundaries to establish collaborative working. But there appear to be additional issues for these four groups.

Children and adolescents

239. In its Green Paper, the Commission draws attention to issues of mental health concerning younger people. They suggest that, as mental health is strongly determined during the first years of life, promoting mental health in children and adolescents is an investment for the future. The view is taken that teaching parenting skills can improve child development; and that attention to these issues in schools can increase social competencies, improve resilience, and reduce bullying, anxiety and depressive symptoms.

240. Among those expressing concern about the under-recognition of the mental health needs of children and adolescents, and the consequent under-provision of services, Ms Camilla Parker (Q 187) suggested to us that one in ten children developed mental health problems, and that the proportion was much higher among young people in care or in custody. Turning Point (pp 172–173) supported a strategy that encompassed people of all ages, giving particular mention to children; and the King’s Fund (pp 124–127) noted how mental health resources in Europe were concentrated on working-age adults with enduring mental health needs, and wanted the EU strategy to emphasise the need to support children and older people among whom numbers of mental health problems were increasing.

241. This under-recognition arises partly because it can be difficult to determine when emotional or behavioural characteristics warrant specialist attention. Partly it is because few professionals with “generic” training are sufficiently skilled to identify these needs, and in many countries there are shortages of trained specialists. Partly, too, there is limited availability of evidence on what works for children and adolescents, and treatments (such as medications) which have been tested and found to be effective for adults may not have been tested specifically for children. An added difficulty is the complexity of working across agencies in support of children and adolescents with mental health problems. Yet because of the strong threads of continuity in respect of emotional or behavioural problems running from childhood into

adolescence and into at least early and mid adulthood, the need for concerted mental health promotion and prevention efforts should be obvious, as should the need for earlier recognition and treatment.

242. West Sussex County Council (pp 174–176) expressed the Council's commitment to enabling children and young people to enjoy good physical and emotional health, to encourage them to choose healthy lifestyles, and to the eradication of health inequalities. These ends would be best served, they argued, by shifting the focus from treatment of established health problems towards prevention.

243. The Open Society (pp 155–159) referred to the Bamford Report on Mental Health Promotion which identified as one of three key domains for action the need for better preventive efforts among children and adolescents. The NHS Confederation (pp 144–145) wanted to see identification and prevention of problems before adulthood as the cornerstone of service change across EU Member States.

244. Among the promotion and prevention initiatives cited were "whole-school" approaches, reduction of bullying within schools, provision of universal support to parenting, and mechanisms to monitor progress on promoting children's mental health (pp 140–144). The Foundation also wanted to see less reliance on medication and further research into identifying effective ways of building resilience among children and young people. The Royal College of Psychiatrists recommended schools programmes, parental support and attention to city planning. Targeted interventions in school and community settings were supported by the European Public Health Alliance (pp 115–117).

245. The Minister, Ms Rosie Winterton MP, commended some of the campaigns by the BBC targeted at young people as effective (Q 237). West Sussex County Council expressed the view to us that there was a need for advice to be provided to parents and children about physical activity, diet and nutrition in order to reduce obesity, which was linked to mental distress and exclusion (pp 174–176).

246. A linked theme was the need for earlier identification of problems and needs. Mr Paul Corry of Rethink (Q 157) commented favourably on the UK's investment in early intervention services, supporting 15 to 18 year-olds before they develop serious mental health problems, when contrasted to the treatment of some children in countries such as Romania. But Ms Camilla Parker (Q 192) was critical of the arrangements in the UK, noting that too often, things were left until they reached crisis point, with the situation being worse for children and young people than for adults. She saw a major gap during the period of transition from child and adolescent services to adult services, with a lot of young people finding themselves ineligible for adult mental health services. According to the Mental Health Foundation, early intervention would significantly reduce the human and economic costs of mental health problems across the life course (pp 140–144).

247. The European Public Health Alliance saw education as the key to alleviate the burden of mental health problems, particularly when children and young people were integrated in regular education and vocational training schemes (pp 115–117). When mental health problems did develop, however, it was pointed out by the Mental Health Foundation that specialist services would

be needed (pp 140–144); and West Sussex County advocated good partnership working (pp 174–176).

248. Ms Camilla Parker took the view that young people with mental health problems should not be placed in prison environments, on the grounds of human rights and welfare. She said, however, that this practice persisted in the UK and across much of Europe (Q 188). The Open Society Mental Health Initiative's evidence was that in parts of Central and Eastern Europe the need for improvement was more basic. Many children and young people with mental disabilities were accommodated in large orphanages, often because there was no community-based support for parents (pp 155–159). There were also many young people in prisons and young offender institutions whose emotional and behavioural needs were not being met.

249. In Chapter 6 we noted the enduring stigma attached to mental health problems and the discrimination that can result for many people. These experiences are as relevant for children and adolescents as for anyone else. A mental health service user from the UK quoted by Rethink, (pp 60–63) argued—"Please, we have to work in schools with young children to make them understand that mental illness is nothing to be ashamed about, that it is a serious medical issue, and they should be taught about mental illnesses throughout their schooling". Similarly, the Open Society Mental Health Initiative wanted to see efforts to raise awareness in schools as part of a broader initiative on disability issues (pp 155–159).

250. **We recognise that to address the mental health needs of children and adolescents requires specialist attention, separate from the action needed in the case of adults. We note also that, for this action to be effective, especially good collaborative working by education, health, social services and other agencies is essential. We recommend, therefore, that the Commission encourage Member States to put in place, for children and adolescents with emotional and behavioural problems, proven preventive and treatment strategies with effective structures and incentives.**

Older people

251. In the Green Paper,[56] the Commission recognises that an ageing EU-population, with its associated mental health consequences, calls for effective action. It is argued that old age brings many sources of stress that may increase mental ill health, such as decreasing functional capacity and social isolation. Late-life depression and age-related neuro-psychiatric conditions, such as dementia, increased the burden of mental disorders. Support interventions have been shown to improve mental well being in older populations.

252. As for children, however, the Commission goes on to say relatively little about the mental health issues affecting this population group. The Government's response to the Green Paper commented that most of the discussion and recommendations in the document were focused on younger adults (pp 30–34).

253. A number of particular issues surface regularly in discussions of older people with mental health needs. One issue is the obvious one that the ageing of

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[56] op. cit. p. 9

Europe's population means that there will be growing numbers of older people and hence growing numbers of people with dementia and other mental health needs associated with ageing. This was a point made by the King's Fund (pp 124–127), the International Longevity Centre (pp 120–123) and Age Concern (pp 108–110). Breakthroughs in medicine and investment in public health meant that more people were living to quite an advanced age, when the risk of dementia was especially high. Age Concern pointed out that those numbers were projected to increase rapidly over coming decades. Moreover, more people with illnesses such as schizophrenia were surviving into old age and, unlike such people in decades gone by, these people were unlikely to be spending their lives accommodated out of sight in the back wards of forgotten asylums (pp 108–110).

254. A second concern is the under-recognition of needs; many old people do not have their mental health problems identified or treated. Depression seems to be particularly overlooked. The evidence from Age Concern noted that depression is the most common mental health problem among older people, affecting up to one in four people aged 65 and over at any point in time. Suicide rates were high among older people. Depression was especially prevalent (and largely untreated) in care homes and among older people receiving social care support in their own homes (pp 108–110).

255. The Medical Ethics Alliance (an association of world faith organisations and individuals who share a common ethos as stated in the Hippocratic Oath) drew attention to the unmet faith needs of older people. Those who could not attend places of worship should receive visits in their own homes, and religious services should be arranged in care homes (pp 130–132).

256. A further need identified by witnesses concerned protection. There was no reference in the Green Paper to the issue of the abuse of older people. The Government response to the Green Paper referred to the *No Secrets* guidance launched in the UK in 2000, aimed at improving support and protection for adults who were vulnerable to abuse (pp 30–34).

257. Care professionals (social and health care) may be too ready simply to label these needs as part of the normal and inevitable process of ageing, and not to refer on for assessment or treatment. This suggests a need for better training so that care staff can recognise and respond to mental health needs. Age Concern emphasised that most older people enjoyed good mental health and made significant contributions to the economy and to society (pp 108–110).

258. Age Concern went on to suggest that, as an issue, mental health in later life had fallen into a gap between mental health policy and ageing policy. They took the view that mental health policy tended to focus on younger people and adults "of working age" (meaning—on the basis of the present State Pension age in the UK—16 to 59 for women and 16 to 64 for men); and that ageing policy tended to focus on physical health. They thought that a life course perspective on ageing and mental health should be adopted, giving priority to mental health promotion and the prevention of mental illness (pp 108–110). In support of this approach, Mr McDaid and others suggested that the European Commission should facilitate better recognition of the psychological challenges faced by older people (pp 10–12).

259. In many, perhaps most, EU countries today, therefore, older people with mental health problems face many disadvantages. Because their mental health needs are not recognised, older people do not get the same access as

younger people to appropriate treatments and services. Rethink referred to this ageist discrimination against older people with mental health needs. Even though the UK was sometimes seen as fortunate in having a specialist psychogeriatric service—whereas many other EU Member States have less skilled, generic provision—the written evidence from Rethink included a quote from a service user: "Older people get a very poor deal in the statutory mental health sector" (pp 60–63).

260. Mental health promotion among older people warrants much more attention. Age Concern pointed out how age discrimination could lead to mental health problems, as could barriers to participation in public and private life, isolation and loneliness, poor physical health and poverty (including anxieties about future financial insecurity) (pp 108–110). The Christian Council on Ageing also urged more attention to be paid to mental health promotion for older people which, they said, often took a back seat in provision, and to support interventions that were all too often rather neglected in this age group (pp 112–113). The Minister pointed out that the National Service Framework for older people[57] included emphasis on the promotion of good mental health (Q 229).

261. The Government response to the Green Paper (pp 30–34) drew attention to *Everybody's Business*, published by the Department of Health in 2005, which outlined a comprehensive older people's mental health strategy and identified the promotion of good mental health for older people as a cross-cutting issue. Among the "essential prerequisites" for ensuing good mental health for older people, the Government response listed access to advocacy and specialist advice, lifelong learning, volunteering, transport, finance and benefits, housing and safety and environment, health, social care and social activities. The Government response also made reference to the Social Exclusion Unit report, *Making Life Better for Older People,* which set out an economic case for preventative services and activities in relation to older people.

262. More generally, Age Concern wanted the Commission to ensure that its Strategy was "age-proofed" and did not discriminate against older people, either directly (by giving little attention to their needs) or indirectly (by negative images of ageing). They called for the Commission to develop parts of the Green Paper further by (pp 108–110) by:

- acknowledging the costs to society of mental health problems in later life;
- identifying a setting for action for older people (just as the school and workplace are the identified settings for younger groups);
- recognising that suicide rates are high among older people; by ensuring that statistical descriptions include people aged 65 and over; and
- eliminating age-discriminatory language (e.g. the distinction between "the working population" and "older people", since many older people still work).

263. **We recognise that there is a growing number of older people in the EU and that to address their mental health needs requires especially good collaborative working by health, social services and other agencies. We recommend, therefore, that the Commission encourage national governments to pay more attention to the identification,**

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[57] Department of Health National Service Framework for Older People: published 27 March 2001

prevention and treatment of mental health problems experienced by older people, including those who may already be using social or other health care services. Among other things, this should include encouraging staff training so as to improve the recognition of mental health problems experienced by older people.

Ethnicity

264. EU Member States have had very different migration patterns and hence have diverse populations and especially rather different ethnic mixes. Consequently, the policy and practice issues in relation to mental health and ethnicity also tend to vary between countries. The issue is a major one in the UK because of the accumulating evidence that people from black and minority ethnic communities are relatively disadvantaged in the care and treatment they receive from the mental health system. The independent report into the death of David Bennett after being restrained in an NHS clinic identified "institutional racism" in the Health Authority.[58] Since then, increasing attention has been paid to the implications of culture and faith when designing systems to identify and treat needs.

265. Mind cited the 2003 report by the National Institute for Mental Health for England on race equality and mental health. That report had concluded that black and ethnic minority people were more likely to experience problems accessing mental health services. They were more likely also:

- to express lower satisfaction with those services;
- to have a greater likelihood of being transferred to medium and high secure facilities;
- to have higher rates of voluntary admission hospital but to be less satisfied with hospital care;
- to stay for longer in hospital;
- to be readmitted to hospital more frequently and to be more likely to get coercive treatment; and
- to be less likely to access talking treatments (i.e. treatments that provide an opportunity to explore issues with a trained professional such as a psychologist) (pp 54–60).

A number of other witnesses made similar points about unequal patterns of experience and discrimination, for example Ms Camilla Parker (Q 187) and Ms Rosie Winterton (Q 224).

266. The NHS Confederation (pp 144–145) urged the European Commission to look at this issue of differential service use by ethnic group, arguing that there was much to learn about improving access for black and minority ethnic users across the European Union. But although there is not enough understanding of this area in the UK, it is possible that we have a more credible platform of acceptance of ethnic minorities in society generally and also a better record on disability (broadly defined) and ethnicity than in many other countries. Obviously, there are no grounds for complacency, but we think it possible that experiences and practices in the UK with these

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[58] Report under HSG(94)27 by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority: published December 2003

population sub-groups in the UK could serve as useful guides for other mental health systems.

267. The Mental Disability Advocacy Center suggested that other groups such as Roma, migrants and asylum seekers, who already suffered from discrimination, could be at even greater risk if they suffered mental health problems. These groups should perhaps be separated for the purposes of formulating a mental health strategy at European level and in the policy responses of national governments. Migration itself could be a very stressful experience (pp 134–140).

268. There are known to be differences in the incidence and prevalence of mental health problems across ethnic groups. There are a number of possible reasons for these differences, including social deprivation and associated stressors (including different feelings of isolation and exclusion from employment, quality housing, social networks and education), affordability of preventive action which could affect resilience, cultural acceptability of symptoms, levels of awareness and insight (perhaps linked partly to language), different thresholds of shame or stigma, and genetic risk factors. See the evidence from: Rethink (pp 60–63); Kent County Council (pp 123–124); the Open Society (pp 155–159); and Dr Matt Muijen (Q 213).

269. Mr Paul Corry from Rethink noted that all the available information suggested that the occurrence of new cases of mental illness and the overall number of people with such problems were much higher in "second generation" groups in society. It did not matter where their first generation came from—Africa, Caribbean, Eastern Europe, Ireland or faith communities—there was no doubt, he argued, that the second generation experienced significantly higher rates of severe mental health problems. He did not think that the reasons for these higher rates of illness were fully understood, but suggested that it may be linked to the tensions and stresses of living in two cultures, although other factors were likely to be playing a part. He stated the view that, as population movements across Europe increased, particularly as people moved in search of employment, it would be very important for those groups who settled that services were in place for their children (Q 164).

270. This last point about migration patterns was one to which a number of witnesses referred during the course of the Inquiry, linked in part, but not exclusively related, to refugees and asylum seekers. The King's Fund (pp 124–127) suggested that the stigma of having a mental health problem might be compounded by the stigma of being from an ethnic minority. Mr David McDaid and colleagues from the London School of Economics (pp 10–12) noted the challenges posed by the mental health needs of people displaced through conflict, persecution or economic migration. Mind argued that refugees and asylum seekers were exceptionally vulnerable to developing mental health problems, because of past experiences, but also because of current experiences of abuse, exclusion and marginalisation (pp 54–60).

271. The Samaritans commented that many of the migrant workers now based in the UK came from new accession countries with high rates of suicide which, combined with a lack of normal support networks as a result of migration, could be a source of additional stress. The Samaritans themselves advertised and offered their services in a variety of languages (pp 164–167).

272. The Royal College of Psychiatrists urged the Commission to ensure that its Strategy targeted migrants as a vulnerable group (pp 161–164). More broadly, a number of organisations gave emphasis to the added value of European-level action, given that, by definition, migration and its consequences had an international dimension. Turning Point saw the mental health of migrants and asylum seekers as an issue with a scope beyond individual countries (pp 172–173). The NHS London EU unit wanted the European Commission to encourage information sharing about cultural attitudes to mental health problems to support effective and culturally sensitive help for migrants and others from minority ethnic groups (pp 145–148).

273. Dr Marcus Roberts of Mind wanted the Commission to go further. He advocated that the Commission should provide financial and other support to help countries developing culturally appropriate services in the necessary range of languages (Q 164). The Mental Health Research Network wanted to see support for research on cultural issues in any European mental health strategy (p 174).

274. Whether or not the initiative should come from the Commission or from national governments, there is a strong need for culturally appropriate mental health services. The Minister gave examples of what had been done in England, such as the Delivering Race Equality programme, which issued guidance about promoting mental health for people from black and minority ethnic communities (Q 224).

275. In the Green Paper,[59] the Commission recognises that migrants and other marginalised groups are at increased risk for mental ill health, but they do not discuss the issue further. Nor do they discuss either the specific need for a better understanding of the complex links between ethnicity and mental health, or the need for culturally appropriate service responses. Perhaps this lack of attention arose because these topics appear to have been debated much less in the EU generally than in the UK. Possibly also, as Mr Bowis MEP suggested to us (Q 123), there is a better understanding of these issues in this country than in most other EU Member States. However, with rapidly increasing rates of migration, this will surely become a growing challenge more widely across the EU.

276. **We anticipate that, as migration patterns change, so will the ethnic diversity of Europe's populations. Our view is that more attention needs to be paid to the mental health needs of people from minority ethnic groups, both established populations and migrants, and including refugees and asylum seekers.**

277. **We draw attention also to the pressing need to develop culturally appropriate mental health services.**

Women

278. The European Parliament has expressed concern about the limited attention given to gender in the Green Paper, and particularly that the needs of women were overlooked.[60] Mr Bowis MEP summarised for us some of the concerns expressed in that paper. One concern was the high rate of pre- and post-natal depression, linked to evidence that if society could promote good mental

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[59] op. cit. p. 9

[60] European Parliament resolution on Green Paper 2006/2058(INI)—adopted 6/9/2006

health among mothers then their children were less likely to grow up with difficulties themselves. Asian women had very specific health problems, including mental health problems, which needed to be understood better (Q 123).

279. The Mental Disability Advocacy Center referred to research that showed that men and women had significantly different experiences in mental health systems, with women being more vulnerable to discrimination and abuse (pp 134–140). Rethink drew attention to the psychological vulnerability of women who were single parents or who experienced domestic violence (pp 60–63). The European Public Health Alliance (pp 115–117) and Mind (pp 54–60) both advocated gender-sensitivity when designing and reforming mental health services.

280. **We recommend that differences in the prevalence and impact of mental health problems between men and women should be recognised in the European Commission's mental health strategy, and in the design of mental health systems in Member States.**

CHAPTER 9: SETTING MINIMUM STANDARDS OR PROMOTING PRINCIPLES

Variations

281. As earlier chapters of this Report relate, it was made very clear to us at many points during our inquiry that there are wide variations in mental health policy, practice and experience across the EU.

282. Annex 6 of the Green Paper itself illustrates that funding for mental health (as a proportion of total health expenditure) varies markedly between Member States. It is difficult to be sure, however, that reported funding indicates the same thing from one country to another. There are differences in accounting methods, and indeed in what constitutes a mental health service, but the variation is nevertheless substantial. This implies that there are cross-country variations in staffing levels, availability of therapies, what is provided in community care systems, and investments in new services.

283. This suggests, in turn, that different Member States vary in their ability to alleviate the symptoms and to address the needs of people with mental health problems, and hence in their ability to promote quality of life. But even in the higher spending countries of Europe—and the UK is one of the Member States that for some years has devoted a relatively high proportion of its health budget to mental health services—it became clear during the inquiry that large numbers of people with mental health problems are not getting any, or adequate, treatment or support.

284. There are also marked differences in relation to attitudes to mental health problems, among the general public, employers, politicians and other key decision makers in health and related systems. Patterns of discrimination, although hard to substantiate, would therefore be likely to show differences between, as well as within, countries. The emphasis given to promotion and prevention is also not the same across Europe. There are even countries in Europe without an explicit mental health policy framework, other countries where the policy has not been revised for decades, and some where agreed policies are simply disregarded. At a finer level of detail, and despite the high suicide rates in some countries, there are still few national strategies for suicide prevention.

285. Most obviously and, as some witnesses suggested, also most shockingly, there are enormous differences between countries in their intentions to close poor quality institutions and to replace them with well-resourced community-based models of care. Good residential provision has an important place in community-oriented systems of care. Indeed, more fundamentally, there are enormous differences in the degree of protection afforded to individual rights of vulnerable and marginalised people.

286. In this inquiry we did not set out to document the differences between Member States, something that would be a substantial research project in its own right and which the Commission might want to consider supporting in the future (see Chapter 10). Some of the reasons for those variations should be appreciated.

287. One source of variation is a country's underlying commitment of resources to health care in general. A society's attitudes to mental illness will then have a bearing on what proportion is allocated to mental health services. Similarly,

these attitudes could influence the level of investment in social housing, criminal justice diversion schemes, support for employers offering workplace mental well-being programmes, respite for carers of people with dementia, and other "non-health" inputs to a mental health system broadly defined.

288. Some, perhaps much, of the observed variation in funding, patterns of services and levels of activity between Member States is legitimate and entirely appropriate, but one of the concerns that led the Commission to set out to develop a European strategy for mental health, and to publish its Green Paper, was that at least part of the variation was neither appropriate nor acceptable in the 21st Century. As we have summarised in previous chapters, many of the individuals and organisations submitting evidence to or appearing as witnesses before the Sub-Committee shared that concern.

Minimum standards or guiding principles?

289. Our witnesses suggested two principal means of addressing these inter-country differences; in particular to help eradicate unacceptable policies and practices:

(a) a set of minimum standards that each Member State would be required to achieve; and

(b) a set of guiding principles which each Member State would be asked to agree.

Under a), the Commission's role would be to regulate; under b), the role would be to advise, guide and occasionally to monitor.

290. Mr Jurgen Scheftlein of the Commission explained the thinking behind the drafting of the Green Paper. One idea was to use a vehicle such as the Fundamental Rights Agency as a means to collect information about conditions in institutions for people with mental health problems in all Member States (and not just new Member States) on the premise that there could be a need for action across the whole of Europe. He was unsure whether Member States would be ready to accept such an approach. He was equally unsure about whether it made sense to set minimum standards on human rights in mental health care. His preference was to encourage the emergence of harmonised but not legally binding standards (Q 33).

291. Officials from the Department of Health indicated to us their broad support for the principles set out in the Green Paper, which were of course very similar to those in the WHO Helsinki Declaration, and not antagonistic to the standards set out in the 1999 National Service Framework for Mental Health in England. The feeling was that Member States might feel that they know their local situation best, but that they would and should be willing to learn from good practice examples from elsewhere. Mr Fowles, one of the DH officials, commented that it was difficult to come up with a one-size-fits-all solution (QQ 75, 92).

292. Mr John Bowis MEP told us that he could see some arguments for favouring an approach based on minimum standards in some areas, and certainly, as he said, in the areas of employment law and human rights. He suggested that there were plenty of examples of good practice across Europe, and the challenge was to find them and share them. Overall, Mr Bowis favoured describing, rather than prescribing, good practice in order to put pressure to raise standards on Member States via their citizens, their media and their

professionals who have come to learn what was possible and what had been achieved in other Member States (Q 113).

293. Mind and Rethink gave some support for minimum standards. Dr Marcus Roberts of Mind suggested that the EU could play a role in ensuring that certain minimum standards were upheld, against the background of Europe's long-term commitment to human rights. He also argued that the Commission could ensure that mental health policy was based on evidence and that it could be a bastion and informer of evidence-based practice. He illustrated the point by questioning the principles underlying the proposals in the Mental Health Bill[61] (Q 158).

294. Ms Camilla Parker (a legal and policy consultant working in the field of mental health disability and human rights) saw the attractions of minimum standards, but warned of the danger that countries that had already achieved higher standards might feel that they did not need to try quite so hard to progress (QQ 173–174). In Table 2, reproduced following chapter 5, Ms Parker set out some of the human rights principles that she suggested might be adopted as guiding principles to provide an alternative approach to setting minimum standards.

295. Dr Matt Muijen (Regional Adviser for the European Region of the WHO) also expressed reservations about minimum standards. He was unsure how these could be phrased in such a way as to have meaning, and how they could be monitored or enforced. His preference would be for a system based on both minimum standards and guiding principles (QQ 200–201). Dr Muijen discussed the National Service Framework for mental health services in England, one of the strengths of which was that it was based on principles reinforced by standards, but not minimum standards. He recommended that well-meaning principles needed to be followed by quite hard-hitting policies and legislation supported by funding. Neither the EU nor the WHO has a mandate to set binding principles or standards, so that any initiative would at best be advisory. He was worried that principles could refer to attractive ideas about human rights and other aspects of care, but must not be seen as a substitute for the real thing. A second worry was that principles could have different interpretations in different countries, so that they should perhaps be translated into quite specific statements of what was required. He did not oppose principles, but on their own he felt they could be worthy but meaningless (QQ 200–201).

296. The Minister, Ms Rosie Winterton MP, did not feel that setting minimum standards would be particularly helpful. She supported the general approach to health service matters within the EU, which was to try to keep responsibility with individual Member States, not least because of the substantial differences between them. She argued that mental health provision in the UK was already at quite a high standard, and she was not sure that European legislation would necessarily alter the standard of provision already available in the UK (QQ 247–248).

297. We find it helpful to recall that the mental health spectrum is wide, and there is a need to make some distinctions. For people with severe, enduring and highly distressing symptoms, institutional care remains the mainstay of provision in some countries. Some arguments were made to us that to set

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[61] A Bill to "Amend the Mental Health Act 1983 and the Mental Capacity Act 2005 in relation to mentally disordered persons; and for connected purposes".

minimum standards might be a helpful way to convey the strength of feeling about the inappropriateness of such provision, particularly during negotiations with candidate Member States. However, the diversity of circumstances and provision across countries to which we have just referred, especially with regard to the identification and treatment of less severe mental health problems, was seen by many witnesses as probably ruling out the use of minimum standards.

Sharing good practice

298. The processes through which changes might be achieved in Europe's mental health systems were discussed by witnesses at various points during the inquiry. Framework directives, minimum standards, principles and other mechanisms were discussed. There was universal agreement that the sharing of experiences, both good and bad, would provide very valuable material to inform efforts to improve the identification and treatment of mental health problems.

299. This approach was advocated by the Commission itself in the Green Paper.[62] They recognise that there are significant inequalities between (and also within) Member States' so that, given the diversity between Member States, it is not possible to draw simple conclusions or to propose uniform solutions. They take the view, however, that there is scope for exchange and cooperation between Member States and for opportunities for them to learn from each other.[63]

300. **We recognise the diversity of circumstances and provision across Member States, especially with regard to the identification and treatment of less severe mental health problems and we do not, therefore, support the imposition of minimum standards for mental health provision across the European Union.**

301. **We do, however, support the development of a set of principles to guide mental health policy and practice in Member States. These principles could cover the locus of care (and particularly the use of institutional services), compulsory treatment, access to evidence-based treatments, protection of human rights, efforts to combat negative attitudes, stigma and discrimination, and structures to empower individuals.**

302. **We recommend that the European Commission and the World Health Organization draw up, in consultation with national governments, a set of such principles. We also recommend that the Commission and the WHO introduce mechanisms designed to facilitate the effective operation of these principles.**

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[62] op. cit. p. 6

[63] op. cit. p. 7

CHAPTER 10: INFORMATION NEEDS

303. One of the four proposed aims of the EU mental health strategy is the development of a mental health information, research and knowledge system. In the Green Paper the Commission note that mental health is poorly covered by existing health monitoring systems. They suggest that major efforts are needed to harmonise existing national and international indicators on mental health and disability in populations in order to create a comparable dataset across the EU. They also state that more data are required on the social, demographic and economic determinants of mental health, as well as on promotion and preventive infrastructures, activities and resources.[64]

304. We agree with the Commission's identification of these key information issues. Better statistical indicators would assist comparison between countries and the monitoring of progress towards either minimum standards or guiding principles, and whether the comparisons or advisory activities or monitoring were carried out by the Commission, the World Health Organization, national governments and/or others. Of course, service users, families, their advocates, taxpayers and others might also wish to know how well a mental health system is functioning.

305. In addition, there are relevant aspects of a mental health system that cannot easily or sensibly be summarised by statistical indicators, such as public attitudes, the extent to which service users are empowered in choosing their care arrangements, how well legislative structures protect human rights, whether the various agencies with roles to play are collaborating fruitfully in the promotion of better mental health and the treatment of those problems that emerge, and whether the right incentives are in place to encourage better access to care.

306. Encouraging more and better research in the mental health field could support the quest for reliable and useful statistical indicators on needs, resources, activities and achievements. Research could also help to illuminate any or all those areas mentioned in the previous paragraph, including in circumstances where comparisons are made across countries. Research that actively involved service users and family members would be more likely to engage with the people most affected by mental health problems whilst ensuring that experiential data are drawn upon.

307. In the final part of our Inquiry, we focused on these three areas: statistics; other information; and research. Each is addressed below. The points arising take us back to the theme running through this Report: the benefits of sharing of experiences between and within countries, and especially the sharing of examples of best practice.

Statistics on mental health systems

308. In principle, it would be possible to contemplate a wide range of statistics on aspects of a mental health system, covering such areas as the prevalence of different mental health problems, the incidence of new cases, the needs of individuals with those problems, and the needs of their families. There could be statistics that measure the levels and patterns of expenditure by health

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[64] op. cit. p. 12

care and other relevant agencies, and on how those expenditures are allocated. Indicators might also cover the availability of services, the volumes of services delivered and patterns of use, the pharmacological treatments that are licensed and those that are reimbursed or provided with public health care systems. At the level of the individual service user or family, statistics could measure the combinations ("packages") of care that are used and perhaps also give some indication of the consequences of care for health status, functioning, employment and quality of life.

309. The costs of providing those care packages could be measured, and the proportions of total cost falling to the health system, to social care agencies and to other budgets could also be recorded. Costs carried by individuals and families could be measured. There could be statistics on various aspects of social inclusion—for example, the extent to which people with mental health problems are in employment, or actively participating in other aspects of normal life. There could be indicators that record how many people are accommodated in different types of setting, and how many are compulsorily treated.

310. It is not difficult to think of many uses to which any such statistics could be put. But anyone drawing up a list of desirable indicators needs to recognise the difficulties both of obtaining many of these measures, and then of interpreting them. For example, what constitutes a "mental health service" is not consistently agreed across the EU. Consequently, cross-country variations in indicators of service levels, contact rates, expenditure and cost could in part reflect differences in definition. Measuring the outcomes for individual service users is famously difficult, and no mental health system in the EU, indeed worldwide, has developed any satisfactory routine outcome measures. The measure most frequently available is the suicide rate, which is undoubtedly important, but only a small percentage of people with mental health problems could realistically be seen as a suicide risk. Moreover, many people who commit suicide have had no prior contact with mental health services.

311. Mr Scheftlein explained to us that the Commission had developed some mental health indicators, including the European Community Health Indicators, but that in many cases there were problems in getting the data. He hoped that, by giving mental health greater visibility, it would be easier to collect the necessary information. He also hoped that the European Statistical Office (Eurostat) could be involved in developing more survey-based information in the future, that there would be more psychological indicators in the European household survey, and that the EU's Labour Force Survey could include more mental health indicators. Mr Scheftlein also referred to the ongoing work of the WHO, particularly its Mental Health Atlas, which provided an inventory of the resources invested in mental health and some indicators of service patterns organisation. However, given the Commission's particular interest and focus on promotion and prevention, the challenges of obtaining good indicators should not be underestimated (QQ 9, 23).

312. Mr McDaid told us that his view was that, while there was much data relating to mental health problems available in the UK in part originating from the Department of Health and the Office for National Statistics (ONS), the available data for other some European countries were very limited. He added that he did not think it possible for the EU to try to impose a common

system of data collection using the same standard for all countries. But he did see a role for Eurostat in trying to increase the amount of mental health information that was collected; and for there to be arrangements for the sharing of good practice relating to data collection and measurement methods (QQ 53–54).

313. Asked to be more specific about the particular types of data he saw as most important, Mr McDaid mentioned: information about the utilisation of services; access to services; the availability of services; and the incidence and prevalence of poor mental health across Europe (Q 55). He referred to some useful indicators on the prevalence of mental health problems and costs across European countries that have been produced recently by the European Brain Council and also by the Mental Health Economics European Network, both of which initiatives were drawn upon by the Commission in preparing the Green Paper. Both initiatives also illustrated the difficulties of obtaining usable data from all countries (QQ 53, 63).

314. A further point made by Mr McDaid was that, in relation to the collection and interpretation of statistics, there was a need for better communication within the Commission, and between the Commission and the research community. Professor Graham Thornicroft thought that "there is a lot of information collected within Europe, but much of it is not very informative". A lot of the available information related to inputs (such as expenditure) or processes (such as bed numbers), but there was relatively little on the extent to which services were being delivered in ways that were acceptable to the individuals they were intended to benefit, or on the extent to which individuals' needs were being met (Q 56).

315. Professor Priebe reinforced the point about the desirability of improved data. His view was that anyone who has tried to put data from different countries together would have found the experience much more difficult than anticipated. He suggested that reliable information on simple parameters such as the provision of different types of services, let alone more sophisticated indicators, could be extremely difficult to obtain, and that comparisons were further complicated by different definitions and connotations (pp 159–161).

316. A similar point was made to us by Mr John Bowis MEP. His worry in relation to statistics was that "different Member States calculated in a different numerical language as well as linguistic"; and he wanted more research to be done to develop comparable data. There was also a widespread need, he suggested, to develop better measures for outcomes, particularly for mental health promotion, suicide prevention and anti-stigma efforts (Q 133).

317. Mrs Kathryn Tyson, of the Department of Health, told us that she expected that, just as the state of mental health care varied considerably across Member States, so also did the state of information about the performance of service systems and the general state of population mental health. She referred to the Mental Health Minimum Data Set (MDS),[65] which was quite a comprehensive tool although not yet as widely implemented and used as they would hope. She explained that, where the MDS was fully implemented, it provided a rich source of data including information about:

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[65] See—http://www.ic.nhs.uk/datasets/datasets/mentalhealth

what services were doing; how they were helping people; and how many people were being helped (Q 84).

318. Mrs Alexandra Burner of Rethink described how statistical information was increasingly available from Eurostat and the WHO, but that the type of information available remained quite limited. She particularly lamented the lack of service user and carer involvement in the processes of information design and collection. This was another reason for welcoming the platform approach proposed by the Commission, because this would help to give service users and carers a voice within Europe (Q 159).

319. **We recognise the inherent difficulties of obtaining consistently defined, reliable and meaningful indicators for some key dimensions of a mental health system, such as the outcomes of treatment and care for individuals and families. Nevertheless, if the ultimate performance of a mental health system is to be assessed and monitored, such indicators will be needed. We welcome the Commission's quest to develop better statistical indicators of how national mental health systems are funded, how they function and how they perform.**

320. **We recommend that the Commission encourage Member States to invest in better statistical reporting on mental health problems and the systems of services set up to respond to them. These indicators should relate not only to health care, but also range over relevant aspects of social care, housing, education, criminal justice, social security and other fields.**

Information on policy and practice

321. Some of the issues raised during the course of our inquiry do not lend themselves to simple statistical summary. Some examples are:

- public attitudes about mental health (even though attitude surveys can generate some useful indicators);
- experiences of stigma;
- detailed aspects of national or local mental health policies;
- eligibility criteria for treatment;
- types of funding system for health or other care and the incentives they create;
- the extent to which individuals are empowered to take decisions or take control in mental health systems; and
- protection or denial of various human rights.

322. There is nevertheless a need to ensure that information is available on these aspects of mental health policy, practice and context. Mr David McDaid, and colleagues from the London School of Economics, drew upon the recently published book, *Mental Health Policy and Practice across Europe*, to discuss the information needs for a European mental health strategy. They suggested the intelligence-gathering role within an EU strategy would not only be a question of the regular collection of comparable data across Europe. Information was needed, relating both to the health sector and more widely, about services, structures and national and regional strategies in the field of mental health. The current lack of information across Europe about

public attitudes to mental health and the pervasiveness of stigma might also usefully be addressed in an EU context (pp 10–12).

323. Mr Jurgen Scheftlein described to us the need for information to be available that ranged beyond the mental health system narrowly defined. He wanted to encourage the involvement in a mental health strategy of many parts of society, including businesses, schools and others in what he referred to as the public health approach. This in turn would require national governments to have information, and statistical data if appropriate, about these various other sectors and how they could contribute to mental health prevention and promotion efforts. This would also contribute to consensus building, and also, he hoped, help to convince these other actors of the need to invest in better mental health (QQ 17–18).

324. **We recognise that some highly relevant aspects of mental health systems cannot easily be described with statistical indicators. Nevertheless, we recommend that the Commission should seek to collect comparable information on aspects of policy, practice and experience to underpin national and European strategies to improve the mental health of the population.**

Research

325. Research, whether funded by national governments, the EC or other bodies, provides one way to generate the statistical and other information needed to underpin, monitor and evaluate mental health policies and practices.

326. Mr Bowis explained to us that the EU had ensured that mental health research was a key part of the sixth and seventh Framework Programmes being taken forward by the part of the European Commission responsible for research (Directorate General—Research). That mental health had a stronger position in the research programmes than ever before, was welcome. He also referred to the work of the European Health Observatory and the publications it produced on each country in the EU and elsewhere, describing health systems in quite some detail. As the book describing each country's health system came to be revised, so the amount of attention given to mental health problems and their treatment grew. This facilitated objective comparisons across countries (QQ 133–135).

327. Mr McDaid and colleagues suggested that an EU strategy could have a role in helping to strengthen weaker parts of the evidence base. This was often in areas where research funding was difficult to obtain. Funding might be through the EU's Research Framework Programme, but also through individual Commission Directorates. Among the areas where research was needed, they suggested, were workplace mental health promotion strategies and strategies to help people with mental health problems return to work (pp 10–12).

328. Other evidence advocated the need for specific pieces of research work. Rethink argued that the Commission should undertake a broad piece of work on social inclusion and rights (pp 60–63). The Mental Disability Advocacy Center wanted the Commission to sponsor research on community care, in order to highlight the successes, limitations and failings of Member States' efforts to date. This would provide the basis for developing joint strategies to improve European mental health systems (pp 134–140).

329. The Royal College of Psychiatrists recommended shared research across countries on epidemiology and resourcing mechanisms. This would be designed to highlight variations in local prevalence, social deprivation and the distribution of services (pp 161–164).

330. **We draw attention to the need for more and better research to establish which circumstances, factors and actions lead to improved performance in mental health systems. This includes research on patterns of care, the utilisation of compulsory powers, quality of care, social inclusion and participation, discrimination, service user choice and empowerment, protection of human rights and effective forms of mental health promotion and prevention.**

Sharing good practice

331. The Commission's proposed approach for taking forward a mental health strategy envisages the use of a platform or its equivalent to promote cooperation and information exchange across the EU. There would be considerable advantage in using this approach to share information about the operation and performance of mental health systems across countries, highlighting evidence-based processes and practices that have demonstrated success in preventing the emergence of mental health problems or in promoting better quality of life for people with those problems.

332. The Department of Health's view was that the Commission's proposal for a relatively informal means of exchanging data would be helpful for Member States, allowing them to compare their policy targets and provision, and to learn from each other's approaches to performance monitoring and statistical collection. Given the considerable challenges of overcoming social exclusion, tackling stigma and discrimination and preventing mental health problems, Mrs Tyson said that the Department of Health would welcome all the help and learning that it could get. Consequently, she felt that any information sharing, good practice sharing, platform and facilitation that could be obtained, through the EU Strategy and from other places, would be extremely welcome. The small but growing body of evidence on what worked needed to be nurtured and disseminated. This should be a cross-governmental and cross-European initiative (Q 84).

333. Other witnesses strongly supported the proposals to share experiences. Mr Paul Corry described how Rethink hosted the annual general meeting of the European Federation of Associations of Families of People with Mental Illness (EUFAMI) two years ago, bringing together organisations from around Europe to share experiences. Dr Marcus Roberts of Mind described the work of Mental Health Europe, an umbrella organisation for voluntary sector provider and service user organisations, as an information hub. He also referred to a network called "Users, Ex-Users and Survivors of Psychiatry". Consequently, there might not be a need to set up a new platform but to invest in existing arrangements, although all were currently small and with limited funding bases. Sharing good practice on user involvement across the EU would have a number of benefits, as would an approach that encouraged proper service user involvement from the outset in all discussions of mental health policy and practice development (Q 140).

334. The top priority for the sharing of information and experience identified by Ms Camilla Parker was best practice in relation to the transition from institutional care to community-based services. The UK had made good

progress in this area, but had not yet got it right, and could learn from elsewhere. She also identified the need to gather good practice examples on the child and adolescent mental health, particularly on early intervention, and the transition between children and adolescent mental health services and adult mental health services (QQ 191–192).

335. The Minister, Ms Rosie Winterton MP, supported the Commission's proposal to exchange information and ideas through the platform approach. She singled out the usefulness for service users of sharing information about what happens in other countries, as this would help to empower them. She thought that the UK could learn from good prevention campaigns in other countries; and that visitors from elsewhere in Europe to the UK could learn from our experiences with community mental health services and practices designed to help people with mental health problems get back to work (Q 227).

336. **We see considerable advantage in the sharing of information and experience across Europe about the operation and performance of mental health systems across countries. This action could highlight evidence-based processes and practices that have demonstrated success in preventing the emergence of mental health problems, and in promoting better opportunity and quality of life for people with those problems.**

CHAPTER 11: CONCLUSIONS AND RECOMMENDATIONS

Chapter 1—Setting the scene

The WHO Helsinki Declaration and Action Plan

337. We support the Mental Health Action Plan agreed by European Health Ministers at the 2005 WHO Helsinki Conference.

The conduct of our Inquiry

338. We make this Report to the House for debate.

Chapter 2—Defining mental well-being and mental health problems

The extent of mental health problems

339. We welcome the recognition by the Commission of the considerable extent of mental health problems; and we recommend that action is taken to ensure that people with diagnosable and treatable problems get access to appropriate, evidence-based care.

Learning or intellectual disability

340. We consider that it is wrong to group together learning disability and mental health problems for the purposes of the programme of action for mental health envisaged in the Green Paper. The two conditions are clearly separate and, indeed, a person with a learning disability, just as any other person, may or may not suffer from a mental health problem. We recommend, however, that the Commission give serious consideration to launching an action programme to address concerns about people with learning disabilities in Europe, how they are supported and the lives they are able to lead.

Chapter 3—The social and economic impact of mental health problems

Summary of impacts

341. We urge a wider public recognition of the considerable body of evidence which indicates the substantial social and economic impact of mental health problems. Our view is that the heavy responsibilities carried by the families and other carers of people with mental health problems are too often overlooked, and that better recognition and support of carers is essential. We recommend that the Commission encourages EU Member States to take steps to address these issues, coordinating action as necessary across many different parts of government and society.

Chapter 4—The added value of an EU mental health strategy

What an EU strategy would set out to achieve

342. We recognise that the question of EU competence regarding mental health matters is complex, given that mental health impacts upon a range of policy areas. We recommend that careful consideration be given to this matter before the adoption of any measures at EU level.

343. Our view is, however, that the platform or forum approach set out by the Commission should be supported because of its inclusiveness,

transparency, engagement with service users and other relevant stakeholders. This could add value by co-ordinating Member States' actions and by assisting in the exchange of best practice across the EU. We emphasise that the wide-ranging impacts of many mental health problems make it imperative that there is collaboration between different parts of the Commission, just as there needs to be cross-ministry collaboration within Member States.

How the EU's role differs from that of the WHO

344. We conclude that, given the wide impact of mental health problems on many aspects of an individual's life and on many different service-providing and other sectors, the Commission's areas of competence and interest in relation to a mental health strategy would complement the specific expertise of the WHO. Moreover, we recognise that because mental health is not just a medical issue, but also a social issue and economic issue, it is important that the strategic agenda is not seen as solely the preserve of health ministries, nor that the international agenda is solely the preserve of the WHO.

345. Our view is that, for promoting better mental health and delivering better services, there is an important role for the EU, with its breadth of competence and interests, alongside the more specialised roles of the WHO and the legislative and policy-making responsibilities of national governments.

Chapter 5—Human rights issues

Deinstitutionalisation

346. We support the Commission's view set out in the Green Paper that there is a need to move "away from the provision of mental health services through large psychiatric institutions … towards community-based services", but warn against the dangers of inadequately planned and insufficiently resourced community-based alternatives.

347. We also take the view that there is a need to recognise better that smaller care settings can be highly institutional in the way they treat individuals with mental health problems. Member States and accession countries should move away from institutionally organised services that deny residents their basic human rights and subject them to poor and often appalling conditions of care.

Compulsory treatment

348. Again, we support the view set out in the Green Paper that the compulsory placement of individuals in institutions should be proportionate, appropriate, and for the purposes of treatment rather than mere incarceration. Compulsory treatment should only be applied as a last resort, where other alternatives have failed.

Community care

349. Good community care requires coordinated responses from a range of public and other bodies, the challenges of which should never be under-estimated.

350. We recognise that the consensus among organisations in the UK, representing both service providers and service users, is that front-line

services for the treatment of mental health problems should primarily be based in the community, but that hospitals still need to play an important role as specialist providers. Our view is that Member States should pursue a balanced care approach, using specialist hospital services within a system of care and treatment that is primarily community-based, and that promotes integration, inclusion and choice for the individual and appropriate protection for the community.

Chapter 6—Social exclusion, stigma and discrimination

Social exclusion—need for action

351. We conclude that social exclusion is itself a risk factor for poor health, including mental health problems. We think therefore that action to address the mental health needs of the population should recognise the social causes and contexts of mental distress. We strongly support the Commission's proposals to address this social exclusion.

352. We recognise that the Government has arguably done more than most Member States to recognise the problem of social exclusion of people with mental health problems, and has taken a number of initiatives to address the problem. Nevertheless, there is still a long way to go, and we recommend that the Commission should support concerted efforts by Member States and others to counter the social exclusion of people with mental health problems, who experience disadvantage in many areas, including housing, employment, access to services, income and participation.

353. We accept that a particularly difficult challenge is the number of people with mental health problems who are in prison, where their mental health needs may not get recognised or appropriately treated. We recommend that the Commission should encourage Member States urgently to examine the services available to recognise and to treat those with mental health problems in prisons.

Action to tackle negative attitudes and discrimination

354. We are persuaded that to improve public understanding of mental health problems would help to counter the negative attitudes that are often expressed. To achieve this, we recommend that efforts should be continued and reinforced to raise public awareness as to the extent, causes, characteristics and impact of mental health problems (sometimes called improvements to "mental health literacy").

355. While we recognise that different approaches might work best in different countries, we believe that Member States should be encouraged to make a commitment to tackling stigma and discrimination and to promoting the social integration of people with mental health problems. Member States should also be encouraged to work towards a code of good practice and to share examples of successful initiatives.

356. Our view is that mental health problems should be recognised as coming within the scope of anti-discrimination legislation relating to disability and that, to the extent that such legislation exists already, it should be enforced and its impact should be monitored. Member States that do not have such legislation should be encouraged to introduce it.

Action to address employment problems

357. We recognise that a key area of exclusion and stigma is employment, and that disadvantage in employment has major economic and social consequences. We recommend that the Commission should encourage Member States to work with employers to help them to recognise the economic benefits of mental health promotion/prevention, and to agree a code of practice.

358. We understand why small businesses might find it economically difficult to put in place the flexible working arrangements that can help people with mental health problems. We urge Member States to seek practical means of helping small businesses to comply both with the legislation and with any voluntary codes of practice.

359. We recommend also that the European Commission should consider introducing a "reporting obligation" for Member States to monitor how employers are performing in relation to the employment of people with mental health problems.

Chapter 7—Promotion and prevention

Mental health promotion and prevention

360. We believe that a "public health" approach for addressing the promotion and prevention of mental health issues is to be encouraged, recognising the multiple influences on the mental health of populations, from outside as well as from within the mental health system as conventionally defined.

361. We recommend that the Commission encourage national governments to investigate ways to provide early identification and early intervention services. At the European level, we support the Commission's proposal for a platform approach that would help to bring together different Commission Directorates and encourage parallel efforts in Member States.

Examples of good practice

362. We have been impressed by the many examples of good practice in mental health promotion and prevention, both in the community and in the workplace, that have been drawn to our attention in this inquiry. We support the Commission's proposals to encourage Member States and employers to learn from such examples and to recognise the benefits of adopting such an approach.

Sharing good practice

363. We support the Commission's proposal for sharing good practice across the EU, and indeed more broadly, and we believe it would be helpful for the Commission and/or the WHO to take responsibility for the collation of these examples, with the help of national governments. Those examples should be of proven effectiveness.

Chapter 8—Mental health issues for population subgroups

Children and adolescents

364. We recognise that to address the mental health needs of children and adolescents requires specialist attention, separate from the action needed in the case of adults. We note also that, for this action to be effective, especially good collaborative working by education, health, social services and other agencies is essential. We recommend, therefore, that the Commission encourage Member States to put in place, for children and adolescents with emotional and behavioural problems, proven preventive and treatment strategies with effective structures and incentives.

Older people

365. We recognise that there is a growing number of older people in the EU, and that to address their mental health needs requires especially good collaborative working by health, social services and other agencies. We recommend, therefore, that the Commission encourage national governments to pay more attention to the identification, prevention and treatment of mental health problems experienced by older people, including those who may already be using social or other health care services. Among other things, this should include encouraging staff training so as to improve the recognition of mental health problems experienced by older people

Ethnicity

366. We anticipate that, as migration patterns change, so will the ethnic diversity of Europe's populations. Our view is that more attention needs to be paid to the mental health needs of people from minority ethnic groups, both established populations and migrants, and including refugees and asylum seekers.

367. We draw attention also to the pressing need to develop culturally appropriate mental health services.

Women

368. We recommend that differences in the prevalence and impact of mental health problems between men and women should be recognised in the European Commission's mental health strategy, and in the design of mental health systems in Member States.

Chapter 9—Setting minimum standards or promoting principles

Sharing good practice

369. We recognise the diversity of circumstances and provision across Member States, especially with regard to the identification and treatment of less severe mental health problems and we do not, therefore, support the imposition of minimum standards for mental health provision across the European Union.

370. We do, however, support the development of a set of principles to guide mental health policy and practice in Member States. These principles could cover the locus of care (and particularly the use of institutional services), compulsory treatment, access to evidence-based treatments, protection of human rights, efforts to combat negative attitudes, stigma and discrimination, and structures to empower individuals.

371. We recommend that the European Commission and the World Health Organization draw up, in consultation with national governments, a set of such principles. We also recommend that the Commission and the WHO introduce mechanisms designed to facilitate the effective operation of these principles.

Chapter 10—Information needs

Statistics on mental health systems

372. We recognise the inherent difficulties of obtaining consistently defined, reliable and meaningful indicators for some key dimensions of a mental health system, such as the outcomes of treatment and care for individuals and families. Nevertheless, if the ultimate performance of a mental health system is to be assessed and monitored, such indicators will be needed. We welcome the Commission's quest to develop better statistical indicators of how national mental health systems are funded, how they function and how they perform.

373. We recommend that the Commission encourage Member States to invest in better statistical reporting on mental health problems and the systems of services set up to respond to them. These indicators should relate not only to health care, but also range over relevant aspects of social care, housing, education, criminal justice, social security and other fields.

Information on policy and practice

374. We recognise that some highly relevant aspects of mental health systems cannot easily be described with statistical indicators. Nevertheless, we recommend that the Commission should seek to collect comparable information on aspects of policy, practice and experience to underpin national and European strategies to improve the mental health of the population.

Research

375. We draw attention to the need for more and better research to establish which circumstances, factors and actions lead to improved performance in mental health systems. This includes research on patterns of care, the utilisation of compulsory powers, quality of care, social inclusion and participation, discrimination, service user choice and empowerment, protection of human rights and effective forms of mental health promotion and prevention.

Sharing good practice

376. We see considerable advantage in the sharing of information and experience across Europe about the operation and performance of mental health systems across countries. This action could highlight evidence-based processes and practices that have demonstrated success in preventing the emergence of mental health problems, and in promoting better opportunity and quality of life for people with those problems.

APPENDIX 1: SUB-COMMITTEE G (SOCIAL POLICY AND CONSUMER AFFAIRS)

The Members of the Sub-Committee which conducted this Inquiry were:

Lord Colwyn (up till November 2006)
Earl of Dundee
Baroness Gale
Baroness Greengross
Lord Harrison (up till November 2006)
Baroness Howarth of Breckland
Baroness Morgan of Huyton
Lord Moser
Baroness Neuberger
Baroness Thomas of Walliswood (Chairman)
Lord Trefgarne
Baroness Uddin (from November 2006)
Lord Wade of Chorlton (from November 2006)

Declarations of Interest

A full list of Members' interests can be found in the Register of Lords Interests:

http://www.publications.parliament.uk/pa/ld/ldreg.htm

APPENDIX 2: LIST OF WITNESSES

The following witnesses gave evidence. Those marked with * gave oral evidence and written evidence.

Age Concern
Professor Peter Bartlett, School of Law, University of Nottingham
* Mr John Bowis MEP
British Geriatrics Society
British Medical Association
Christian Council on Ageing
* Department of Health
Department of Health's Older People's Mental Health Programme Delivery Board
* Mr Jurgen Scheftlein, European Commission
European Public Health Alliance (EPHA)
Finance & Leasing Association
Professor Tamara Hervey, School of Law, University of Nottingham
International Longevity Centre UK
Kent County Council
King's Fund
Professor Martin Knapp
Law Reform Committee of the Bar Council of England and Wales
Marylebone Healing and Counselling Centre
* Mr David McDaid
Medical Ethics Alliance
Mencap
Mental Disability Advocacy Center (MDAC)
Mental Health Foundation
* Mind
Professor Elias Mossialos
NHS Confederation
NHS London EU Unit
Northern Ireland Association of Mental Health
Open Society Mental Health Initiative (MHI)
* Ms Camilla Parker
Professor Stefan Priebe
* Rethink
Royal College of Psychiatrists

Samaritans

SAMH

Professor Norman Sartorius

Shift and the Social Inclusion Programme

* Professor Graham Thornicroft

Turning Point

UK Mental Health Research Network

West Sussex County Council

Rt Hon Rosie Winterton MP, Minister of State for Health Services, Department of Health

* World Health Organization (WHO)

We would like to take the opportunity to thank all our witnesses for their submissions to our Inquiry.

APPENDIX 3: CALL FOR EVIDENCE

Sub-Committee G of the House of Lords European Select Committee is carrying out an Inquiry into the policy issues related to a Green Paper published by the European Commission on 18 October 2005 entitled: *Improving the mental health of the population: towards a strategy on mental health for the European Union* (Commission document 13442/05 reference COM (2005) 484 final). This document is available from the Commission website:

http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf

The Green Paper is a consultative document designed to launch a policy debate about the relevance of mental health for the EU, the need for a strategy at EU level and possible priorities. It acknowledges that, while some public health aspects of mental health would fall under Community competence, others would be within the exclusive competence of Member States.

The Commission point out in the Green Paper that:

- Mental ill health affects every fourth citizen of the EU and costs an estimated 3–4% of EU GDP, mainly through lost productivity, as well as causing many suicides.
- Mental disorders are a leading cause of early retirement and disability pensions.
- Mental ill health and conduct and behavioural disorders in childhood incur costs for the social, educational, criminal and justice systems.
- Further intangible costs concern how society treats mentally ill or disabled persons who still experience social exclusion, stigmatisation, discrimination or non-respect of their fundamental rights and dignity.

Against that background, the Commission state that mental health is an important issue for the European Community because of:

- the contribution that good mental health of the population can make to some of the EU's strategic policy objectives;
- the role of the Community to encourage and support cooperation between Member States and to address inequalities between them; and,
- the obligation for the Community to contribute to a high level of human health protection through all its policies and activities.

The Green Paper suggests that an EU strategy on mental health could add value by creating a framework for exchange and cooperation between Member States; helping to increase the coherence of actions in different policy sectors; and opening a platform for involving stakeholders, including patient and civil society organisations, in building solutions.

Among the options for action outlined by the Green Paper are:

- promoting mental health and addressing mental health though preventive action;
- promoting the social inclusion of mentally ill or disabled people and protecting their fundamental rights and dignity; and,
- improving information and knowledge on mental health in the EU.

The Commission is expected to issue proposals later this year, based on responses to the Green Paper, for consideration by Member States and the European Parliament.

In March of this year, the Sub-Committee invited views from interested parties for the Inquiry on:

- whether an EU strategy on mental health would be appropriate,
- if so, what elements it might contain; and,
- how it might complement and add value to the strategies of Member States and the activities of the World Health Organisation and other international bodies.

Because the start of this Inquiry was delayed, the Sub-Committee is offering a further opportunity for interested parties to submit a concise statement of written evidence to the Inquiry by Monday 2 October 2006 for consideration by the Sub-Committee on return from the Parliamentary Summer Recess.

APPENDIX 4: WHO MENTAL HEALTH ACTION PLAN FOR EUROPE FACING THE CHALLENGES, BUILDING SOLUTIONS

Facing the Challenges, Building Solutions

This Action Plan is endorsed in the Mental Health Declaration for Europe by ministers of health of the Member States in the WHO European Region. They support its implementation in accordance with each country's needs and resources.

The challenges over the next five to ten years are to develop, implement and evaluate policies and legislation that will deliver mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems. The priorities for the next decade are to:

i. foster awareness of the importance of mental well-being;

ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;

iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;

iv. address the need for a competent workforce, effective in all these areas;

v. recognize the experience and knowledge of service users and carers[66] as an important basis for planning and developing services.

This Action Plan proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries of the WHO European Region, requiring action in the 12 areas as set out below. Countries will reflect these policies in their own mental health strategies and plans, to determine what will be delivered over the next five and ten years.

1. Promote mental well-being for all

Challenge

Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies. Public mental health and lifestyles conducive to mental well-being are crucial to achieving this aim. Mental health promotion increases the quality of life and mental well-being of the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.

Actions to consider

i. Develop comprehensive strategies for mental health promotion within the context of mental health, public health and other public policies that address the promotion of mental health across the lifespan.

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[66] The term 'carer' is used here to describe a family member, friend or other informal care-giver.

ii. Adopt promotion of mental health as a long-term investment and develop education and information programmes with a long time frame.

iii. Develop and offer effective programmes for parenting support and education, starting during pregnancy.

iv. Develop and offer evidence-based programmes that foster skills, provide information and focus on resilience, emotional intelligence and psychosocial functioning in children and young people.

v. Improve access to healthy diets and physical activity for older people.

vi. Promote community-based multilevel interventions involving public awareness campaigns, primary care staff and community facilitators such as teachers, clergy and the media.

vii. Integrate mental health promotion components into existing generic health promotion and public health policies and programmes, such as those supported by WHO health promoting networks.

viii. Encourage the consumption of healthy products and reduce the intake of harmful products.

ix. Create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles.

x. Offer effective mental health promotion activities to groups at risk such as people with enduring mental or physical health problems and carers.

xi. Identify clear mechanisms for empowering the population to take responsibility for health promotion and disease prevention targets, for example by heightening public awareness of the importance of life choices.

2. Demonstrate the centrality of mental health

Challenge

Mental health is central to building a healthy, inclusive and productive society. Sound and integrated public policies, such as those on labour, urban planning and socioeconomic issues, also have a positive impact on mental health and reduce the risk of mental health problems. The mental health implications of all public policy, and particularly its potential impact on groups at risk, therefore need to be considered. Mental health policy requires intersectoral linkages and should incorporate multisectoral and multidisciplinary approaches.

Actions to consider

i. Make mental health an inseparable part of public health.

ii. Incorporate a mental health perspective and relevant actions into new and existing national policies and legislation.

iii. Include mental health in programmes dealing with occupational health and safety.

iv. Assess the potential impact of any new policy on the mental well-being of the population before its introduction and evaluate its results afterwards.

v. Give special consideration to the relative impact of policies on people already suffering from mental health problems and those at risk.

3. Tackle stigma and discrimination Challenge

Mental health policy development and implementation must not be jeopardized by the widespread stigma attached to mental health problems that leads to discrimination. In many instances, people with mental health problems suffer from a lack of equal opportunities because of such discrimination. Human rights and respect for people with mental health problems must be protected. Empowerment is a crucial step towards meeting these objectives, as it enhances integration and social inclusion. The lack of empowerment of service users' and carers' organizations and poor advocacy hinder the design and implementation of policies and activities that are sensitive to their needs and wishes. The exclusion experienced by mental health service users, whether in asylums and institutions or in the community, needs to be tackled in a variety of ways.

Actions to consider

i. Instigate activities to counter stigma and discrimination, emphasizing the ubiquity of mental health problems, their general good prognosis and treatability, and the fact that they are rarely associated with violence.

ii. Introduce or scrutinize disability rights legislation to ensure that it covers mental health equally and equitably.

iii. Develop and implement national, sectoral and enterprise policies to eliminate stigma and discrimination in employment practices associated with mental health problems.

iv. Stimulate community involvement in local mental health programmes by supporting initiatives of nongovernmental organizations.

v. Develop a coherent programme of policy and legislation to address stigma and discrimination, incorporating international and regional human rights standards.

vi. Establish constructive dialogue with the media and systematically provide them with information.

vii. Set standards for representation of users and their carers on committees and groups responsible for planning, delivery, review and inspection of mental health activities.

viii. Stimulate the creation and development of local and national nongovernmental and service user-run organizations representing people with mental health problems, their carers and the communities they live in.

ix. Encourage the integration of children and young people with mental health problems and disabilities in the regular educational and vocational training system.

x. Establish vocational training for people suffering from mental health problems and support the adaptation of workplaces and working practices to their special needs, with the aim of securing their entry into competitive employment.

4. Promote activities sensitive to vulnerable life stages Challenge

Infants, children and young people, and older people are particularly at risk from social, psychological, biological and environmental factors. Given their vulnerability and needs, young and older people should be a high priority for activities related to the promotion of mental health and the prevention and care of mental health problems. However, many countries have inadequate capacity in this area, and services and staff are often poorly prepared to deal with developmental and age-related problems. In particular, disorders in childhood can be important precursors of adult mental disorders. Supporting the mental health of children and adolescents should be seen as a strategic investment which creates many long-term benefits for individuals, societies and health systems.

Actions to consider

i. Ensure that policies on mental health include as priorities the mental health and well-being of children and adolescents and of older people.

ii. Incorporate the international rights of children and adolescents and of older people into mental health legislation.

iii. Involve young people and older people as much as possible in the decision-making process.

iv. Pay special attention to marginalized groups, including children and older people from migrant families.

v. Develop mental health services sensitive to the needs of young and older people, operated in close collaboration with families, schools, day-care centres, neighbours, extended families and friends.

vi. Promote the development of community centres for older people to increase social support and access to interventions.

vii. Ensure that age- and gender-sensitive mental health services are provided by both primary care and specialized health and social care services and operate as integrated networks.

viii. Restrict institutional approaches for the care of children and adolescents and older people that engender social exclusion and neglect.

i Improve the quality of dedicated mental health services by establishing or improving the capacity for specialized interventions and care in childhood and adolescence and old age, and by training and employing adequate numbers of specialists.

x. Improve coordination between organizations involved in alcohol and drugs programmes and children's and adolescents' health and mental health at national and international levels, as well as collaboration between their respective networks.

xi. Ensure parity of funding in relation to comparable health services.

5. Prevent mental health problems and suicide Challenge

People in many countries are exposed to harmful stress-inducing societal changes that affect social cohesion, safety and employment and lead to an increase in anxiety and depression, alcohol and other substance use disorders, violence and suicidal behaviour. The social precipitants of mental health problems are manifold and can range from individual causes of distress to issues that affect a whole community or society. They can be induced or reinforced in many different settings, including the home, educational facilities, the workplace and institutions. Marginalized and vulnerable groups, such as refugees and migrant populations, the unemployed, people in or leaving prisons, people with different sexual orientations, people with physical and sensorial disabilities and people already experiencing mental health problems, can be particularly at risk

Actions to consider

i. Increase awareness of the prevalence, symptoms and treatability of harmful stress, anxiety, depression and schizophrenia.

ii. Target groups at risk, offering prevention programmes for depression, anxiety, harmful stress, suicide and other risk areas, developed on the basis of their specific needs and sensitive to their background and culture.

iii. Establish self-help groups, telephone help-lines and websites to reduce suicide, particularly targeting high-risk groups.

iv. Establish policies that reduce the availability of the means to commit suicide.

v. Introduce routine assessment of the mental health of new mothers by obstetricians and health visitors and provide interventions where necessary.

vi. For families at risk, provide home-based educational interventions to help proactively to improve parenting skills, health behaviour and interaction between parents and children.

vii. Set up in partnership with other ministers evidence-based education programmes addressing suicide, depression, alcohol and other substance use disorders for young people at schools and universities and involve role models and young people in the making of campaigns.

viii. Support the implementation of community development programmes in high-risk areas and empower nongovernmental agencies, especially those representing marginalized groups.

ix. Ensure adequate professional support and services for people encountering major crises and violence, including war, natural disasters and terrorist attacks in order to prevent post-traumatic stress disorder.

x. Increase awareness among staff employed in health care and related sectors of their own attitudes and prejudices towards suicide and mental health problems.

xi. Monitor work-related mental health through the development of appropriate indicators and instruments.

xii. Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising.

xiii. Involve mainstream agencies responsible for employment, housing and education in the development and delivery of prevention programmes.

6. Ensure access to good primary care for mental health problems

Challenge

For many countries in the European Region, general practitioners (GPs) and other primary care staff are the initial and main source of help for common mental health problems. However, mental health problems often remain undetected in people attending GPs or primary care services and treatment is not always adequate when they are identified. Many people with mental health problems, particularly those who are vulnerable or marginalized, experience difficulties in accessing and remaining in contact with services. GPs and primary care services need to develop capacity and competence to detect and treat people with mental health problems in the community, supported as required as part of a network with specialist mental health services.

Actions to consider

i. Ensure that all people have good access to mental health services in primary health care settings.

ii. Develop primary care services with the capacity to detect and treat mental health problems, including depression, anxiety, stress-related disorders, substance misuse and psychotic disorders as appropriate by expanding the numbers and skills of primary care staff.

iii. Provide access to psychotropic medication and psychotherapeutic interventions in primary care settings for common as well as severe mental disorders, especially for individuals with long-term and stable mental disorders who are resident in the community.

iv. Encourage primary health care staff to take up mental health promotion and prevention activities, particularly targeting factors that determine or maintain ill-health.

v. Design and implement treatment and referral protocols in primary care, establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services.

vi. Create centres of competence and promote networks in each region which health professionals, service users, carers and the media can contact for advice.

vii. Provide and mainstream mental health care in other primary care services and in easily accessible settings such as community centres and general hospitals.

7. Offer effective care in community-based services for people with severe mental health problems

Challenge

Progress is being made across the Region in reforming mental health care. It is essential to acknowledge and support people's right to receive the most effective treatments and interventions while being exposed to the lowest possible risk, based on their individual wishes and needs and taking into account their culture, religion, gender and aspirations. Evidence and experience in many countries support the development of a network of community-based services including hospital beds. There is no place in the twenty-first century for inhumane and degrading treatment and care in large institutions: an increasing number of countries have closed many of their asylums and are now implementing effective community-based services. Special consideration should be given to the emotional, economic and educational needs of families and friends, who are often responsible for intensive support and care and often require support themselves.

Actions to consider

i. Empower service users and carers to access mental health and mainstream services and to take responsibility for their care in partnership with providers.

ii. Plan and implement specialist community-based services, accessible 24 hours a day, seven days a week, with multidisciplinary staff, to care for people with severe problems such as schizophrenia, bipolar disorder, severe depression or dementia.

iii. Provide crisis care, offering services where people live and work, preventing deterioration or hospital admission whenever possible, and only admitting people with very severe needs or those who are a risk to themselves or others.

iv. Offer comprehensive and effective treatments, psychotherapies and medications with as few side effects as possible in community settings, particularly for young people experiencing a first episode of mental health problems.

v. Guarantee access to necessary medicines for people with mental health problems at a cost that the health care system and the individual can afford, in order to achieve appropriate prescription and use of these medicines.

vi. Develop rehabilitation services that aim to optimize people's inclusion in society, while being sensitive to the impact of disabilities related to mental health problems.

vii. Offer services for people with mental health needs who are in non-specialist settings such as general hospitals or prisons.

viii. Offer carers and families assessment of their emotional and economic needs, and involvement in care programmes.

ix. Design programmes to develop the caring and coping skills and competencies of families and carers.

x. Scrutinize whether benefit programmes take account of the economic cost of caring.

xi. Plan and fund model programmes that can be used for dissemination.

xii. Identify and support leaders respected by their peers to spearhead innovation.

xiii. Develop guidelines for good practice and monitor their implementation.

xiv. Introduce legal rights for people subject to involuntary care to choose their independent advocate.

xv. Introduce or reinforce legislation or regulations protecting the standards of care, including the discontinuation of inhuman and degrading care and interventions.

xvi. Establish inspection to reinforce good practice and to stop neglect and abuse in mental health care.

8. Establish partnerships across sectors

Challenge

Essential services which in the past were routinely provided in large institutions or were not considered as relevant to the lives of people with mental health problems are nowadays often fragmented across many agencies. Poor partnership and lack of coordination between services run or funded by different agencies lead to poor care, suffering and inefficiencies. The responsibilities of different bodies for such a wide range of services need coordination and leadership up to and including government level. Service users and their carers need support in accessing and receiving services for issues such as benefits, housing, meals, employment and treatment for physical conditions, including substance misuse.

Actions to consider

i. Organize comprehensive preventive and care services around the needs of and in close cooperation with users.

ii. Create collaborative networks across services that are essential to the quality of life of users and carers, such as social welfare, labour, education, justice, transport and health.

iii. Give staff in mental health services responsibility for identifying and providing support for needs in daily living activities, either by direct action or through coordination with other services.

iv. Educate staff in other related services about the specific needs and rights of people with mental health problems and those at risk of developing mental health problems.

v. Identify and adjust financial and bureaucratic disincentives that obstruct collaboration, including at government level.

9. Create a sufficient and competent workforce

Challenge

Mental health reform demands new staff roles and responsibilities, requiring changes in values and attitudes, knowledge and skills. The working practices of many mental health care workers and staff in other sectors such as teachers, benefit officers, the clergy and volunteers need to be modernized in order to offer effective and efficient care. New training opportunities must respond to the need for expertise in all roles and tasks to be undertaken.

Actions to consider

i. Recognize the need for new staff roles and responsibilities across the specialist and generic workforce employed in the health service and other relevant areas such as social welfare and education.

ii. Include experience in community settings and multidisciplinary teamwork in the training of all mental health staff.

iii. Develop training in the recognition, prevention and treatment of mental health problems for all staff working in primary care.

iv. Plan and fund, in partnership with educational institutions, programmes that address the education and training needs of both existing and newly recruited staff.

v. Encourage the recruitment of new mental health workers and enhance the retention of existing workers.

vi. Ensure an equitable distribution of mental health workers across the population, particularly among people at risk, by developing incentives.

vii. Address the issue of lack of expertise in new technologies of present trainers, and support the planning of “train the trainers” programmes.

viii. Educate and train mental health staff about the interface between promotion, prevention and treatment.

ix. Educate the workforce across the public sector to recognize the impact of their policies and actions on the mental health of the population.

x. Create an expert workforce by designing and implementing adequate specialist mental health training for all staff working in mental health care.

xi. Develop specialist training streams for areas requiring high levels of expertise such as the care and treatment of children, older people and people suffering from a combination of mental health problems and substance use disorder (comorbidity).

10. Establish good mental health information

Challenge

In order to develop good policy and practice in countries and across the Region, information has to be available about the current state of mental health and mental health activities. The impact of any implementation of new initiatives should be monitored. The mental health status and the help-seeking behaviour of populations, specific groups and individuals should be measured in a manner that allows comparison across the WHO European Region. Indicators should be standardized and comparable locally, nationally and internationally in order to assist in the effective planning, implementation, monitoring and evaluation of an evidence-based strategy and action plan for mental health.

Actions to consider

i. Develop or strengthen a national surveillance system based on internationally standardized, harmonized and comparable indicators and data collection systems, to monitor progress towards local, national and international objectives of improved mental health and well-being.

ii. Develop new indicators and data collection methods for information not yet available, including indicators of mental health promotion, prevention, treatment and recovery.

iii. Support the carrying out of periodic population-based mental health surveys, using agreed methodology across the WHO European Region.

iv. Measure base rates of incidence and prevalence of key conditions, including risk factors, in the population and groups at risk.

v. Monitor existing mental health programmes, services and systems.

vi. Support the development of an integrated system of databases across the WHO European Region to include information on the status of mental health policies, strategies, implementation and delivery of evidence-based promotion, prevention, treatment, care and recovery.

vii. Support the dissemination of information on the impact of good policy and practice nationally and internationally.

11. Provide fair and adequate funding

Challenge

Resources dedicated to mental health are often inadequate and inequitable compared to those available to other parts of the public sector, and this is reflected in poor access, neglect and discrimination. In some health care systems, insurance coverage of access and rights to treatment discriminate severely against mental health problems. Within the mental health budget, resource allocation should be equitable and proportionate, i.e. offering greatest relative share and benefits to those in greatest need.

Actions to consider

i. Assess whether the proportion of the health budget allocated to mental health fairly reflects the needs and priority status of the people with needs.

ii. Ensure that people with the most severe problems and the poorest in society receive the largest relative benefits.

iii. Assess whether funding is allocated efficiently, taking into account societal benefits, including those generated by promotion, prevention and care.

iv. Evaluate whether coverage is comprehensive and fair in social and private insurance-based systems, on an equal level to that for other conditions, not excluding or discriminating against groups and particularly protecting the most vulnerable.

12. Evaluate effectiveness and generate new evidence

Challenge

Considerable progress is being made in research, but some strategies and interventions still lack the necessary evidence base, meaning that further investment is required. Furthermore, investment in dissemination is also required, since the existing evidence concerning effective new interventions and national and international examples of good practice are not known to many policy-makers, managers, practitioners and researchers. The European research community needs to collaborate to lay the foundations for evidence-based mental health activities. Major research priorities include mental health policy analyses, assessments of the impact of generic policies on mental health, evaluations of mental health promotion programmes, a stronger evidence base for prevention activities and new service models and mental health economics.

Actions to consider

i. Support national research strategies that identify, develop and implement best practice to address the needs of the population, including groups at risk.

ii. Evaluate the impact of mental health systems over time and apply experiences to the formulation of new priorities and the commissioning of the necessary research.

iii. Support research that facilitates the development of preventive programmes aimed at the whole population, including groups at risk. Research is needed on the implications of the interrelated nature of many mental, physical and social health problems for effective preventive programmes and policies.

iv. Promote research focused on estimating the health impacts of non-health sector policies, as there is a clear potential for positive mental health to be improved through such policies.

v. Bridge the knowledge gap between research and practice by facilitating collaboration and partnerships between researchers, policy-makers and practitioners in seminars and accessible publications.

vi. Ensure that research programmes include long-term evaluations of impact not only on mental health but also on physical health, as well as social and economic effects.

vii. Establish sustainable partnerships between practitioners and researchers for the implementation and evaluation of new or existing interventions.

viii. Invest in training in mental health research across academic disciplines, including anthropology, sociology, psychology, management studies and economics, and create incentives for long-term academic partnerships.

ix. Expand European collaboration in mental health research by enhancing networking between WHO's European collaborating centres and other centres with research activities in the field of prevention.

x. Invest in regional collaboration on information and dissemination in order to avoid the duplication of generally applicable research and ignorance of successful and relevant activities elsewhere.

Mental Health for Europe: Facing the Challenges

Milestones

Member States are committed, through the Mental Health Declaration for Europe and this Action Plan, to face the challenges by moving towards the following milestones. Between 2005 and 2010 they should:

- prepare policies and implement activities to counter stigma and discrimination and promote mental well-being, including in healthy schools and workplaces;
- scrutinize the mental health impact of public policy;
- include the prevention of mental health problems and suicide in national policies;
- develop specialist services capable of addressing the specific challenges of the young and older people, and gender-specific issues;
- prioritize services that target the mental health problems of marginalized and vulnerable groups, including problems of comorbidity, i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness;
- develop partnership for intersectoral working and address disincentives that hinder joint working;
- introduce human resource strategies to build up a sufficient and competent mental health workforce;
- define a set of indicators on the determinants and epidemiology of mental health and for the design and delivery of services in partnership with other Member States;
- confirm health funding, regulation and legislation that is equitable and inclusive of mental health;
- end inhumane and degrading treatment and care and enact human rights and mental health legislation to comply with the standards of United Nations conventions and international legislation;
- increase the level of social inclusion of people with mental health problems;
- ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities.

APPENDIX 5: RECENT REPORTS

Recent Reports from the Select Committee

Session 2006–07

Evidence from the Minister for Europe on the Outcome of the December European Council (4th Report, Session 2006–07, HL Paper 31)

Government Responses: Session 2004–05 (6th Report, Session 2006–07, HL Paper 38)

The Commission's 2007 Legislative and Work Programme (7th Report, Session 2006–07, HL Paper 42)

Evidence from the Ambassador of the Federal Republic of Germany on the German Presidency (10th Report, Session 2006–07, HL Paper 56)

Recent Reports prepared by Sub-Committee G (Social Policy and Consumer Affairs)

Proposal to Establish the European Institute of Technology: Interim Report (13th Report, Session 2006–07, HL Paper 69)

Cross Border Health Services in the European Union (8th Report, Session 2006–07, HL Paper 48)

Proposed European Institute for Gender Equality: Supplementary Report (51st Report, Session 2005–06, HL Paper 271)

Consumer Credit in the European Union: Harmonisation and Consumer Protection (36th Report, Session 2005–06, HL Paper 210-I and 210-II)