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CONTENTS

	<i>Paragraph</i>	<i>Page</i>
FOREWORD—What this Report is about		6
Chapter 1: Setting the Scene	1	7
The purpose of our Inquiry	1	7
The human and economic costs of mental ill health	3	7
The WHO Helsinki Declaration and Action Plan	10	9
The European Commission Green Paper	12	9
The conduct of our Inquiry	15	10
Chapter 2: Defining mental well-being and mental health problems	19	11
The concept of mental well-being	19	11
The extent of mental health problems	25	12
Learning or intellectual disability	34	14
Chapter 3: The social and economic impact of mental health problems	40	16
Impacts on individuals	41	16
Impacts on families	50	18
Impacts on the health and social care system	57	19
Impacts on the wider society and economy	61	20
Summary of impacts	67	22
Chapter 4: The added value of an EU mental health strategy	71	24
What an EU strategy would set out to achieve	71	24
How the EU's role differs from that of the WHO	93	28
Chapter 5: Human rights issues	99	30
Human rights issues in the mental health field	99	30
Deinstitutionalisation	110	31
Compulsory treatment	124	34
Community care	129	35
Table 1: Human rights legislation of relevance to mental health issues		38
Table 2: Four aspects of mental health where human rights legislation is of relevance		39
Chapter 6: Social exclusion, stigma and discrimination	141	40
Social exclusion—the challenge	142	40
Social exclusion—need for action	156	43
Stigma and discrimination	164	44
Action to tackle negative attitudes and discrimination	169	45
Employment problems	187	48
Action to address employment problems	191	49
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		52
Chapter 7: Promotion and prevention	206	54
Mental health promotion and prevention	207	54

Examples of good practice	219	56
Sharing good practice	233	58
Chapter 8: Mental health issues for population subgroups	237	59
Children and adolescents	239	59
Older people	251	61
Ethnicity	264	64
Women	278	66
Chapter 9: Setting minimum standards or promoting principles	281	68
Variations	281	68
Minimum standards or guiding principles?	289	69
Sharing good practice	298	71
Chapter 10: Information needs	303	72
Statistics on mental health systems	308	72
Information on policy and practice	321	75
Research	325	76
Sharing good practice	331	77
Chapter 11: Conclusions and recommendations	337	79
Chapter 1—Setting the scene	337	79
The WHO Helsinki Declaration and Action Plan	337	79
The conduct of our Inquiry	338	79
Chapter 2—Defining mental well-being and mental health problems	339	79
The extent of mental health problems	339	79
Learning or intellectual disability	340	79
Chapter 3—The social and economic impact of mental health problems	341	79
Summary of impacts	341	79
Chapter 4—The added value of an EU mental health strategy	342	79
What an EU strategy would set out to achieve	342	79
How the EU’s role differs from that of the WHO	344	80
Chapter 5—Human rights issues	346	80
Deinstitutionalisation	346	80
Compulsory treatment	348	80
Community care	349	80
Chapter 6—Social exclusion, stigma and discrimination	351	81
Social exclusion—need for action	351	81
Action to tackle negative attitudes and discrimination	354	81
Action to address employment problems	357	82
Chapter 7—Promotion and prevention	360	82
Mental health promotion and prevention	360	82
Examples of good practice	362	82
Sharing good practice	363	82
Chapter 8—Mental health issues for population subgroups	364	83
Children and adolescents	364	83
Older people	365	83
Ethnicity	366	83

Women	368	83
Chapter 9—Setting minimum standards or promoting principles	369	83
Sharing good practice	369	83
Chapter 10—Information needs	372	84
Statistics on mental health systems	372	84
Information on policy and practice	374	84
Research	375	84
Sharing good practice	376	84
Appendix 1: Sub-Committee G (Social Policy and Consumer Affairs)		85
Appendix 2: List of Witnesses		86
Appendix 3: Call for Evidence		88
Appendix 4: WHO Mental Health Action Plan for Europe Facing the Challenges, Building Solutions		90
Appendix 5: Recent Reports		101

NOTE: References in the text of the Report are as follows:

(Q) refers to a question in the oral evidence

(p) refers to a page of written evidence

The Report of the Committee is published in Volume I (HL Paper 73-I) and the Evidence is published in Volume II (HL Paper 73-II)

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.

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

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 Declaration⁵ 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

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.**

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 estimates¹¹ 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

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 health¹² (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.

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

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 Sheet¹⁴ 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

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 than 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

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

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 Unit¹⁹ 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 Council²¹ relating to 28 European countries (all of Western Europe and eight Eastern

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 direct 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

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 problems²⁵. 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

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 Policies²⁹ 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 report³⁰ 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

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 McDauid 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 proposes³¹ 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 identifies³² 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 states³³ 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).

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 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 Paper³⁴ 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.

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 Schefflein 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**

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 document³⁷ 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

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 homes³⁹. 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.

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

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 position⁴² 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

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

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 or Degrading Treatment or 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	<p>Relevance of Human Rights</p> <p>(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)</p>
Addressing the barriers to social exclusion	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 Paper⁴⁴ 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

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 Paper⁴⁶ 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 Curran⁴⁷ review the limited progress with the promotion of social inclusion. They find that, to date, there has been no

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 Paper⁴⁸ 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

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 health (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

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).

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 employment⁵¹ 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

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

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

