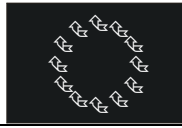


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DRAFT REPORT

on improving the mental health of the population. Towards a strategy on
mental health for the European Union
(2006/2058(INI))

Committee on the Environment, Public Health and Food Safety

Rapporteur: John Bowis

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MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

on improving the mental health of the population. Towards a strategy on mental health for the European Union (2006/2058(INI))

The European Parliament,

- having regard to the Green Paper from the Commission - "Improving the mental health of the population. Towards a strategy on mental health for the European Union" (COM(2005)0484),
 - having regard to Articles 2, 13 and 152 of the EC Treaty,
 - having regard to the Charter on Fundamental Rights,
 - having regard to the Council Resolution of 18 November 1999 on "The Promotion of Mental Health" (2000/C 86/01),
 - having regard to the declaration of the WHO European Ministerial Conference of 15 January 2005 on facing the challenges of mental health in Europe and building solutions,
 - having regard to Rule 45 of its Rules of Procedure,
 - having regard to the report of the Committee on the Environment, Public Health and Food Safety and the opinions of the Committee on Employment and Social Affairs and of the Committee on Women's Rights and Gender Equality (A6-0000/2006),
- A. whereas one in four people in Europe experience at least one significant episode of mental ill health during their lives, and during the course of any one year 18.4 million people in the European Union aged between 18 and 65 are estimated to suffer from major depression,
- B. whereas economic costs to society of mental ill health are enormous, with some estimates putting them at between 3% and 4% of GDP in the Member States of the European Union,
- C. whereas some 58 000 European Union citizens commit suicide each year, more than the annual deaths from road traffic accidents or HIV/AIDS, and whereas ten times this number attempt suicide,
- D. whereas in some European countries up to 85% of the money devoted to mental health is spent on maintaining large institutions,
- E. whereas a lack of understanding and investment in mental health promotion has contributed to deteriorating health and disabilities among individuals and societal problems,

- F. whereas approximately 40% of all prisoners have some form of mental disorder and whereas they are up to seven times more likely to commit suicide than people in the community, and whereas inappropriate imprisonment can worsen the disorder and prevent rehabilitation,
 - G. whereas throughout the European Union not enough attention or resources have been given to the mental health of children and young people,
 - H. whereas longevity means increasing numbers of people in their later years living with neurodegenerative diseases,
 - I. whereas in most European Union countries there has been a move from long-term institutionalised care, both for people with chronic and severe disorders and for those with learning disabilities, towards supported community living, but whereas this has been without proper planning and resourcing of community services,
1. Welcomes the Commission's commitment to mental health promotion; calls for greater priority for this in health policies and believes this should be mainstreamed into the policies of all Commission Directorates and all Member State ministries;
 2. Believes that good mental health is a prerequisite for a healthy economic performance in the EU;
 3. Believes that any future proposal by the Commission should involve partnership and consultation with those who have experienced mental health problems, their carers and advocacy NGOs;
 4. Further believes that different actions will be needed to achieve the three aims of mental health promotion, mental health improvement and mental disorder prevention;
 5. Stresses the need for careful use of terms such as "Mental Ill Health", "Mental Health Disorders", "Severe Mental Illness" and "Personality Disorder";
 6. Calls for people with learning difficulties to be included within any future strategy, as they face similar issues as people with mental disorders, including social exclusion, institutionalisation, abuse of human rights, stigma and lack of support for themselves and their carers;
 7. Welcomes the Commission's highlighting of children, employees, older people and disadvantaged members of society as key target groups, but would extend this to include, for example, those with long-term and terminal illnesses, prisoners, ethnic and other minority groups, rough sleepers and the range of mental health and care issues of specific reference to women;
 8. Acknowledges that men and women may have different mental health needs, and that more research is needed particularly into the link between compulsory inpatient care and self-harm among women;

9. Calls for a multi-disciplinary and multi-agency response to tackling complex mental ill health situations, such as how best to support children with behavioural problems or eating disorders, or whose parents suffer from mental ill health (or are kept in long-term institutions);
10. Calls for employers to introduce "Mental Health at Work" policies as a necessary part of their health and safety at work responsibility, and that these should be published and monitored within existing health and safety legislation;
11. Believes Member States should work together to find and implement effective strategies to reduce suicide, particularly among young people and other at risk groups;
12. Sees one of the greatest challenges in mental health as being the ageing of Europe's population and urges that more emphasis is given to the prevention and care of neurodegenerative diseases;
13. Stresses that people with mental disorders should be treated and cared for with dignity and humanity; that there should be a clear understanding as to their rights to be or not to be treated; that they should be empowered wherever possible to participate in decisions about their own treatment and consulted collectively on services; that, when prescribed medicines, they should have the fewest possible side effects; believes that compulsory inpatient care should be used only as a last resort;
14. Calls for the defeat of stigma to be at the heart of any future strategy, as the stigma attached to mental ill health leads to rejection by society in every field from employment to family, and from community to health professionals;
15. Emphasises the need to reform mental health services so that they are based on high-quality community care at home or in sheltered accommodation with access to proper health and social care; with regular monitoring and assessment; with respite care for people with mental health problems and their carers; with a one-stop-shop approach to accessing health, social, housing, training, transport, benefits and other services; stresses that this should be backed up by a range of inpatient services for acute, chronic or secure needs but always with independent monitoring of anyone who receives compulsory inpatient care;
16. Believes that dual diagnosis of people with mental health and addiction problems should normally lead to concurrent treatment;
17. Stresses that mental and physical aspects of health are interlinked;
18. Supports the Commission's comments on deinstitutionalisation, as long-term stay in mental health institutions can lead to reinforcement of stigma and social exclusion, but acknowledges that greater efforts must be made to convince the public of the effectiveness of community care of people with severe mental or learning disorders;
19. Suggests the Commission identify sites and examples of good practice and disseminates details of these to all Member States, these "Demonstration Sites" being comparable to WHO sites under their "Nations for Mental Health" programme;

20. Believes that the term "treatment" should include both the use of medication and other forms of therapies, either of which, or a combination of the two, may be the most suitable treatment in any given case;
21. Further believes that in addition to treatment, an appropriate social environment and community support are required to prevent mental health problems and improve and promote mental wellbeing;
22. Urges the Commission to support continuing reforms in any Member State that previously practised the abuse of psychiatry, over use of medication or incarceration, or inhumane practices such as caged beds or excessive use of seclusion rooms;
23. Calls for more research into the development of more effective drugs with fewer side effects, into determinants of mental disorders and suicide and into outcome measurements for investment in mental health promotion;
24. Believes further that more research is needed into stigma and ways to counter it; the experience of individual service users and their carers; working relations between different services and professions; and cross-border provision;
25. Believes that mental health services should receive funding that is proportionate to the cost of mental disorders to individuals, health and social care services, and society as a whole if they are to be effective and command public confidence;
26. Recognises the valuable contribution that informal carers make to supporting people with mental health problems, and equally recognises that many of them will have their own care needs, and will need support if they are to continue providing care;
27. Calls for a "Mental Health Coordinating and Monitoring Group" to be established by the Commission to collect information on mental health practice and promotion in the EU;
28. Urges the EU and ACP countries to work closely on investing in good mental health through development and Cotonou Policies;
29. Instructs its President to forward this resolution to the Council, the Commission, the Member States, the ACP countries and WHO Europe.

EXPLANATORY STATEMENT

‘Wir haben in diesen letzten Wochen unsere Sprachlosigkeit ueberwunden und sind jetzt dabei, den aufrechten Gang zu erlernen.’
(‘In these last weeks we have found our voice again and have learned once more to walk with our head held high.’)

- Stefan Heym - November 1989 Alexanderplatz, East Berlin

Stefan Heym’s November 1989 words to the vast crowd of East Berliners who had come together to oust a cruel regime should be our guide as we overturn, and reform elements of mental health practice in Europe, which can so often be resource-inadequate and unthinkingly cruel. We need to bring mental health to standards of care, treatment, therapy, rehabilitation and patient involvement, that we would expect of the best physical health systems. We can warmly welcome and endorse this Green Paper on Mental Health. We now look for swift and comprehensive proposals to translate the good words into effective legislative and codifying action.

The mental health challenge is to transform systems, attitudes and opportunities. For the past forty years we have been emerging from a dark age of mental disorder practice. In some parts of our continent there has been the abuse of psychiatry; in others an internment concept of asylum, which too often soothed the public’s sensitivities with an “out of sight, out of mind” institutionalisation, while doing little to help patients recover and rehabilitate; in others an overdependence on medication; in many a reliance on prison rather than hospital; in none a real understanding of mental health promotion.

We like to think we have moved on from the human rights abuses of mentally ill patients. And in many ways we have. We still have debates about compulsory treatment; discharge or sectioning decisions are sometimes unsound; patient abuse is from time to time exposed in residential care; arguments abound on vexed and conflicting rights of patients, families and communities. But by and large we have fewer locks and bolts, more patient choice and consent, legal checks and balances to see the patient’s civil rights are not abused.

Yet we still live in the dark age in at least one respect – stigma. It is rampant in all our countries and stigma is a human rights abuse, unintentional, born out of fear base on ignorance, but just as damaging to the individual as any other form of abuse. Living with mental illness is tough enough, without the added burden and pain of rejection and stigmatisation.

In calling for the Commission to develop its Green Paper into a Framework for Mental Health we need to base such a policy on the facts about mental disorder and the Lisbon Agenda imperative for an increased recognition of the value of investment in mental wellbeing.

Underlying our policy are the facts:

- Mental disorders are the fastest growing health burden with unipolar depression the leading disorder.

- 450 million people in our world live with a neurological or mental disorder.
- 1 in 4 of us will be affected in our lifetime.
- 121 million of us have Depression – 3 in every 100 of us every year.
- 1 million people in our world commit suicide. 10 million try each year.
- Neuropsychiatric disorders are responsible for one third of disabilities, 15% of inpatient costs, nearly a quarter of drugs costs, half the caseload of social workers; and, in the United Kingdom alone, over 90 million days lost at work each year.
- People are living longer and, on the whole healthier, lives, but in their later years a growing number of them become frail of body and mind.
- Carers, of a child, an adult or an elderly relative, have not been helped to adapt to the new community care of people with mental health problems.
- Drug addiction and crime, drunkenness, accidents, absenteeism, vandalism, disruptive pupils, rough sleepers, and many of society's "problems" in fact link to mental health problems.

If we do not invest in the right range of services – in-patient, acute, long-stay, secure, medium secure, day-care, domiciliary care and the trained staff for each – we shall not cure, care for or rehabilitate those who are ill now. If we do not invest in a mentally healthy life for our citizens, then the graph will continue rapidly to climb, in numbers and in cost. If we do not invest in bringing understanding about mental health and mental disorders, then budgets will remain pitiful and stigma and prejudice will be rampant.

Patients and Service Users are steadily and rightly moving centre-stage. They will be better informed, be more involved in decisions affecting them and will use their new rights to bypass sluggish services and effect change. They need to be seen as partners in their own treatment plans but also in service planning. Health professionals need to do what the best do in most areas of healthcare - explain and consult before decisions are taken. Then the patient will not just respect their professional judgement but would also, perhaps, understand a little more what was wrong and be a little less apprehensive about what was being done to them. That is right in human rights terms; it also makes for better compliance with and outcome from the treatment and care programme.

There has been a steady move from remote institution care to community services. This has applied to people with long-term and sometimes severe disorders and people with learning disability. To be successful such services need adequate resources and multi-disciplinary teamwork. They also need to convince the public that such methods work for both patients and communities. Lurid media stories of patients being discharged and causing harm to themselves or others can undo years of work towards a more humane system and show how crucial proper checks and balances are. So can public uncertainty as to whether someone who may be behaving "oddly" in the street is being adequately supervised.

There are five key flaws in our mental health system:

- the inadequacy of community services;
- the failure to listen to service users and their carers;
- the inability or unwillingness of different agencies to work together;
- serious underfunding;
- and a policy for mental health promotion that is in most countries notable by its almost complete absence.

Someone with mental health problems needs a one-stop shop with one organisation ensuring contact, access to medical care, housing and other social care needs, income, legal services and rehabilitation. In other words, a single purchasing agency for all the person's needs and a trusted friend who knew his or her way around the provider organisations. That must go hand in hand with the skills and dedication of doctors, therapists and nurses, research scientists, managers of hospitals, clinics and community teams and the support of advocacy NGOs. But, if one is ill or recovering from illness, one needs the security of a home, not in the isolation of high-rise flats on run down estates, but in communities where the living environment will be part of the support and stability one needs. One needs access to activities that will aid recovery, support from family and neighbours. All these are just as important as medication or therapy sessions but organising that range of support may be beyond one, at least for the time being.

So many of us are going to need this enlightened care. Scientific and societal advances have brought new challenges and new costs in mental health and social care. A healthier longer living population means later years of high dependency, often with mental as well as physical frailty; lifestyle, education and work pressures, changes in family structures, isolation, forced population movements, can all trigger mental health problems – psychoses, neuroses and often with an addiction link; new drugs, therapies and treatments have come at an escalating cost; new costs accompany new beds, centres, day care and community teams. And policy changes on where and when to treat and care have often added uncertainty to the standard problems of lack of understanding and inadequate resources, together leading to prejudice and the breeding grounds of stigma.

The crucial question is how to divert more political attention and then financial resources to mental health. Mental Health really only penetrates the political and public mind, when there is a crisis. In the UK we achieved more progress on mental health, in terms of cash, initiatives and reforms, when one man jumped into the lion's den at London Zoo and another stabbed a stranger on the Underground, than at any other time, because Colleagues across Government saw the need to do something and Press, Parliament, Public and NGOs clamoured for it. But it was at a price – the price of lowered public confidence and increased stigma.

Mental Health promotion does not even benefit in that way from negative stories. There is little understanding by governments, politicians or even health service planners of mental health promotion. The main reason is they have no idea what it is about or why they should be interested. Mental Health suffers from a quadruple whammy. There is no constant public, professional and media pressure on government and health service managers to do more, spend more, achieve more. Unlike heart disease or AIDS or cancer, there is little understanding of what can be done to treat, cure and rehabilitate. There is even less understanding of what can be done to prevent mental illness and promote mental health. And there are few outcome measurements that Health Departments and Managers, much less public and politicians, can understand. Governments, employers, trade unions, schools, colleges, local councils and communities, families and individuals all need to be helped to understand the role they can play in ensuring mental wellbeing and so prevent, reduce or mitigate mental health problems.

Our challenge as policymakers is to understand what it means to have a mental health problem. It almost certainly means that one is labelled, patronised, despised, feared and, to a greater or lesser extent, segregated – in society, within our family, at work, at play and even

within our health and social services. In a perverse reversal, one can hide but one cannot run; one cannot perform; one cannot contribute to society as one would wish; one cannot lead full and fulfilling lives as one would want.

Then we have to accept our policymaking responsibilities. A service, which does not gain professional, public and political support, fails patients and their families doubly. It fails to treat and care adequately and it prompts a downward spiral of public confidence and so reinforces stigma.

We need to educate and inform, so that we can break the vicious vein of prejudice that runs through public attitudes, media coverage and government priorities. We need to listen and learn from service users and see and involve them as partners and not just patients. We need to look within ourselves and within our society and acknowledge that we allow an institutionalised stigmatisation to infect our political, social and health systems. Our twin aims must be to convince the public to believe and to convince Commission and Member States to act. If the public believe, they will put pressure on the European Union to act. If the European Union acts, they will make public belief possible.

We need to look into the eyes of people with mental health problems. When we do, we see reflected back the confusion of emotions and thoughts. We see the fear and worry. We see the tears of frustration and despair. But we also see the hope – the hope that we will listen; that we will understand; that we will care; that we will act; that we can help.