

Opinion of the European Economic and Social Committee on the Green Paper Improving the mental health of the population — Towards a strategy on mental health for the European Union

(COM(2005) 484 final)

(2006/C 195/11)

On 14 October 2005 the Commission decided to consult the European Economic and Social Committee, under Article 262 of the Treaty establishing the European Community, on the abovementioned proposal.

The Section for Employment, Social Affairs and Citizenship, which was responsible for preparing the Committee's work on the subject, adopted its opinion on 3 May 2006. The rapporteur was Mr Bedossa.

At its 427th plenary session, held on 17 and 18 May 2006 (meeting of 17 May), the European Economic and Social Committee adopted the following opinion by 142 votes to 1 with 1 abstention.

1. Summary

There can be no ambiguity about the importance of mental health in Europe or the need for a strategy in this area, which:

- Covers several different aspects, namely:
 - improving health education,
 - reacting more rapidly to health threats,
 - reducing health inequalities,
 - guaranteeing a high level of social protection and good health by means of an intersectoral strategy.
- Defines objectives:
 - promoting the mental health of all,
 - putting prevention to the fore,
 - improving the quality of life of people with a mental illness or psychiatric disability, and
 - developing a mental health information system and research programme for the EU.
- Draws up recommendations, specifically:
 - a pilot project on the creation of regional information networks linking all the various players,
 - promoting the process of deinstitutionalisation, to make better use of available resources.
- Determines best practice for promoting the social inclusion and protecting the rights of people with a mental illness or psychiatric disability, which should be one of the responsibilities of the European Union's Fundamental Rights Agency.

The emerging recognition of the importance of mental health is connected with several different factors:

- the explosion in mass demand throughout society, driven by a shift from psychiatry to mental health,
- the irreversible entry onto the scene of patients and/or their representatives, who now have an impact on all policies,
- the imbalance between hospital and outpatient care and problems of flexibility across the whole spectrum of health-care from emergency to medico-social services.

2. The issue

2.1 Five of the ten leading causes of disability worldwide are psychiatric conditions, meaning that mental ill health has devastating social and economic consequences for individuals, families and governments.

2.2 People with mental health problems often experience discrimination or exclusion and serious violations of their fundamental rights.

2.3 There is an association between mental ill health and poverty, which increases the risk of mental illnesses and reduces access to the medical treatment essential to mental health. Accordingly, states should put mental health problems high up on their public health agenda.

2.4 However, mental health is often not a priority, partly because not all countries have the requisite capacity to establish comprehensive and efficient mental health services.

2.5 The Community's mental health instrument comes under the European Union's public health programme for 2003-2008, which is based on Article 152 of the EU Treaty. However, the ensuing actions must take account of Member States' competences in relation to organising health services and providing health care.

2.6 The Commission's Green Paper aims to launch a broad-ranging debate on managing mental ill health and promoting mental health, at EU level, within the framework of the European Action Plan. Its reasons for doing so are:

- There is no health without mental health, which is important both for individuals and societies. Mental health enables individuals to realize their potential and find their roles in social, school and working life and is a vital source of social cohesion for the EU, if it wishes to become a knowledge society.
- Mental health problems are a heavy burden. Everyone knows someone close to them who suffers from mental ill health. Mental health problems impair the quality of life of those who suffer from them and their families. Mental ill health is a major cause of disability.
- Mental ill-health has a high social and economic cost and imposes significant losses and burdens on the economic, social and educational as well as criminal and justice systems. Evidence from certain countries shows that mental disorders are one of the leading causes of absence from work, early retirement and disability pensions.
- Stigmatisation, discrimination and non-respect for the human rights and the dignity of people with a mental illness or psychiatric disability still exist. Treatments may fail to respect patients' fundamental rights and dignity, giving rise to feelings of defiance against society and thereby lessening the EU's 'social capital'.

2.7 Following the January 2005 World Health Organisation (WHO) European Ministerial Conference on Mental Health, in October 2005, the European Commission, a collaborating partner of the conference, published a Green Paper on *Improving the mental health of the population: Towards a strategy on mental health for the European Union*, based on the provisions for public health set out in Article 152 of the EC Treaty, and launched an EU-wide consultation process on mental health.

2.8 The clearly stated purpose is to improve the mental health of the European population, as an element in a strategy whose policy objectives go beyond the health field itself to include putting Europe 'back' on the path to long-term prosperity and improving solidarity, social justice and quality of life.

2.9 The Green Paper is intended to stimulate debate and launch a consultation process with the public authorities, health professionals and patient organisations in 2006, resulting in proposals for action at Community level at the end of 2006, that will constitute the EU's strategy on mental health.

3. The analysis and proposals contained in the Green Paper

3.1 *An unambiguous statement on the importance of mental health for Europe*

3.1.1 According to informed estimates, 27 % of adult Europeans are estimated to experience at least one form of

mental ill health during any one year, of which 6.3 % are somatoform disorders, 6.1 % major depressions and 6.1 % phobias.

3.1.2 Currently, in the EU, more citizens die from suicide than from road traffic accidents or HIV/AIDS.

3.1.3 The implications for society are manifold and the report gives a cost analysis covering loss of productivity, and the expenditure incurred by the social welfare, education, penal and judicial systems.

3.1.4 There are significant inequalities between, and also within, Member States.

3.2 ... which justifies an EU level mental health strategy

3.2.1 The European Union's public health programme currently has several objectives:

- improving health information,
- reacting more rapidly to health threats,
- guaranteeing a high level of social protection and good health by means of an intersectoral strategy,
- reducing health inequalities.

3.2.2 A Community mental health strategy could have the following objectives:

- promoting the mental health of all,
- addressing mental ill health through preventive action,
- improving the quality of life of people with a mental illness or psychiatric disability through social inclusion and the protection of their rights and dignity, and,
- developing a mental health information, research and knowledge system for the EU.

3.2.3 Possible initiatives at Community level could include Council recommendations on the reduction of depression and suicidal behaviour, modelled on a pilot project on the creation of regional information networks linking the health sector, patients and their relatives and community facilitators, which led to decreases in suicide rates of 25 % amongst young people.

3.2.4 In connection with its work to promote the social inclusion of people with a mental illness or psychiatric disability, the European Commission invites the Member States to speed up the process of deinstitutionalisation. In recent years, it has funded a study that has confirmed that replacement of psychiatric institutions by community-based alternatives improves quality of life for patients. In June 2005, a call for tenders was launched for a new study to analyse and present how current financial resources could be best used and provide evidence about the cost of de-institutionalisation.

3.2.5 Other initiatives could be envisaged within this framework at Community level:

- The European Union could identify models of best practice for promoting the social inclusion and protecting the rights of people with a mental illness or psychiatric disability.
- The situation of people with a mental illness or psychiatric disability and psychiatric institutions should be guaranteed by the fundamental rights and human rights set out in the Charter contained in the draft European Constitution.

3.2.6 The European Union wishes to improve knowledge on mental health by supporting research programmes and establishing interfaces between policy and research.

4. Point of view on the proposals

4.1 *The emerging recognition of the importance of mental health is connected with several different factors*

4.1.1 The past few years have been marked by a number of phenomena, including an explosion in demand throughout society, a paradigm shift from psychiatry to mental health and the now irreversible entry onto the scene of patients and their relatives. Each of these aspects has led to changes in laws and regulations, at different rhythms in different countries, depending on the degree to which they have been taken into account at political and administrative levels.

4.1.2 The extensive demand, which has brought all the available services to saturation point, is linked with the complex interaction between society's changing image of mental illness and psychiatry, which has become more generally accepted or less stigmatised, and the services on offer. This change, which has been experienced in all developed countries over the same period, is reflected in the epidemiology, which shows: 15 to 20 % of the diagnosable mental disorders prevalent in any one year in the general population, 12 to 15 % — as many as cardio-vascular disease and twice as many as cancer — resulting in disabilities, and 30 % of all the years lost to premature death or invalidity (WHO, 2004). This pressure is also reflected in the expansion of health planning, which has attributed psychiatry a growing range of tasks over the years.

4.1.3 The combination of increasing demand and changing perceptions has led to increasing demands for outpatient care, thus blurring the traditional polar distinction between illness and health by drawing attention to the continuum of clinical states, up to and including mental suffering. It is now impossible to separate mental disorders from the social environment in which they emerge and necessary to include the social impact of mental disorders in needs assessments. One of psychiatry's main tasks is now to distinguish between psychiatric and non-psychiatric cases and to define what warrants psychiatric intervention, but without narrowing the approach to this aspect alone, so that other partners can share the

burden or be supported in resuming their position as the main actors in assistance or therapy. This dialectic and the sometimes-conflicting tensions between clinical, ethnical and organisational issues bear witness to the paradigm shift from psychiatry to mental health. They also sometimes give rise to contradictory terminology, particularly in official documents. However, at international level, the literature generally makes a clear distinction between psychiatry and mental health.

4.1.4 Lastly, the final and far from least important aspect has been the growing power of users and representatives of families. This is evidence of a wide-reaching change, both in France and worldwide, which is not confined to psychiatry and has been intensified by various diseases (such as HIV/AIDS), which have transformed the relationship between doctors and patients. One of the most noteworthy signs of this change is the emergence of legislation on patients' rights and the reference to users and their families in administrative documents relating to the organisation of psychiatric services and response to needs and their actual implementation.

4.1.5 Community representatives and representatives of all potential users have also taken a more active role. There are increasing interfaces between municipal policy and health policy. Elected representatives are increasingly drawn in by the repercussions of the changes in psychiatry, which increasingly require their involvement.

4.1.6 These changes have made the imbalance between hospital and outpatient care and the problems of flexibility along the whole care spectrum, from emergency to medico-social services, all the more acute. They have also drawn attention to the frequent failures of deinstitutionalisation, the incomplete integration of psychiatry into general hospitals. Given the porous nature of the boundaries between the medical and social fields and between professions and training, initial and continuous training for new functions are a key to future solutions. In addition to these profound changes, new issues have emerged, including those of prisoners with mental disorders and elderly people with neurodegenerative pathologies that translate into mental disabilities and particularly deprived groups of the population.

4.1.7 In most developed countries, the accumulation of factors including the end of the Second World War, the awareness of the experience of concentration camp victims and human rights, a critical view of psychiatric hospitalisation as practised at the time, the development of psychoactive drugs, the emergence of patients' movements and budget constraints, have plunged psychiatry into a process of transformation that the international literature refers to as 'de-institutionalisation'. This means moving the focus of care and services away from hospitalisation towards approaches based on keeping patients within their own environment.

4.1.8 However, a number of stumbling blocks have emerged whenever deinstitutionalisation has been based on dehospitalisation: a tendency for society and psychiatry to hold large numbers of people with mental disorders in prison or transfer them to it, vulnerable or marginal patients left to their own devices, whose care has been broken off or finished, without housing or welfare benefits and becoming homeless; the so-called 'revolving door syndrome' whereby some patients enter into a vicious circle of being admitted to hospital, discharged, and admitted again. Over time, the combination of these phenomena, successive budget cuts and the increasing demand have brought emergency psychiatric departments and hospitals to saturation point, ultimately resulting in the creation of additional full-time hospital beds, that could probably have been avoided. Serious incidents, such as attacks by or on people with a mental illness or psychiatric disability have sometimes contributed to this trend. Policy makers have then been susceptible to public opinion, which has pushed them either to introduce measures prioritising public safety or to draw up mental health strategies.

4.2 *Information and the media*

Mental health is most often mentioned by the media in connection with violent incidents involving people suffering from mental disorders (although the figures are actually no higher than for the general population). The effect of this is to create negative stereotypes and heighten fears about safety, which in turn leads to greater intolerance and rejection of people suffering from mental ill health. We cannot allow information on mental health to remain, as it is now, an uncontrolled increasingly sensitive issue; we need to clarify the whole information process, focusing on averting serious effects and using the media and media professionals to reach the general public.

4.3 *The prerequisites for and content of an EU mental health strategy*

4.3.1 The EESC supports the Commission initiative on developing an integrated European strategy on mental health. It believes that the discussion on researching, identifying and developing such a strategy must take place in the context of the knowledge society. This means, among other things, that European society must acquire:

- a clear idea of the concepts relevant to mental health and their implications;
- a precise understanding of the extent of the problem as it currently stands, but also of its likely development;
- strong support for substantive participation of European society in shaping conditions for developing alternative integrated solutions.

4.3.2 Consequently, in order to meet needs on this scale, it is necessary to draw up an ambitious programme and define a common strategy based on a small number of shared principles. It is worth pointing out that other, smaller scale, health problems are already given priority attention. There are also considerable differences between European countries in regard

to the mental health situation. Furthermore, the states which are due to join the EU in the long-term have considerable ground to make up in this area and the gap may well widen before their actual accession.

It is already possible to list a number of prerequisites:

4.3.3 Before a common strategy can be defined, there has to be a common definition and explanation of terms and concepts, such as 'mental ill health' and 'person suffering from mental disability'.

4.3.4 Another considerable advance and prerequisite for action is that mental health be recognised as a priority, in accordance with actual needs.

4.3.5 From a different angle, this will require cataloguing of evidence of existing needs and current responses to those needs.

4.3.6 In terms of action, the proposals in the Green Paper are to be welcomed. The proposals concerning mental health focus on children and adolescents, the working population and the elderly.

4.4 *Towards a mental health approach integrating the person and their environment*

4.4.1 Mental health is concerned with the suffering of individuals within their family and community environments in a given society. The issue requires a combined approach, including:

- measures for combating mental illness, which must necessarily combine prevention, care and re-integration,
- preventive measures for specific target groups,
- care provision to address the mental suffering of particular population groups,
- positive mental health initiatives aimed at changing harmful behaviour on the part of individuals, groups or society itself.

4.4.2 From this perspective, emphasis must be placed on the three aspects of prevention (primary, secondary and tertiary), with the balance between them depending on the particular area concerned. Initiatives need to be developed in a number of areas, including the promotion of mental health and public information, the acquiring and maintaining of healthy ways of living and the creation of an environment favourable to individual self-development. The same goes for other prevention measures aimed at reducing the incidence of mental disorders by addressing risk factors and pathogenic situations, including:

- early intervention for mothers and infants presenting with symptoms of depression or feelings of non-fulfilment,
- targeted measures for children who are failing at school,
- information and support for families faced with mental illness,

- studies of risk factors or expressions of mental distress in different ethnic and cultural backgrounds,
- the introduction of consultation-liaison psychiatry, permitting a more holistic approach to somatopsychic pathologies as well as both active and passive family involvement, (such as teaching coping strategies and how to support those suffering from an illness and, if necessary, providing financial assistance). Psychological support is preferable to the use of psychotropics alone.

4.4.3 There is no question that meeting children's and adolescents' needs is a priority. The demands are not only expressed or borne by families, but also by educational, judicial and social institutions, the police and local authorities, experiencing increasingly serious situations affecting ever-younger children and families with multiple problems. It is primarily families and children who are affected by societal change.

4.4.4 Coherent and coordinated organisation should lead to provision of a basket of services, coordinated and structured around three basic modules or programmes:

- a programme focusing on early childhood, families and the partners working with this age group in the social, health, education and judicial fields;
- a programme focusing on school age children, families and the partners;
- a programme focusing on adolescents, their families and the partners.

4.4.5 In addition to offering programmed outpatient care and services, each module should also offer options for more intensive care within institutions, correlated to age, care during acute incidents and long-term care. To ensure that programmes are flexible and responsive, psychiatric services should be involved in early diagnosis, crisis prevention and outpatient support for families and their partners.

4.4.6 These basic programmes should be complemented by specialised programmes for at-risk groups or situations that would make primary as well as secondary prevention a realistic option in areas such as early diagnosis of developmental problems, disorders affecting young children, dysfunctional early-years parental care, young single mothers, families with multiple problems and addiction problems suffered by youths. Further attention must be given to the social, educational and judicial structures (including prevention services and prisons) that admit individuals with serious social problems who already have, or are likely to develop, mental health problems as a result of the gravity of their situation or its cumulative effects.

4.5 *The relationship between work, unemployment and health*

4.5.1 In view of their impact on mental health, attention should be paid to improving conditions for those both in and out of employment. The issue of work and mental health touches on questions such as the value attributed to work and its personal cost, the impact of unemployment and invalidity.

4.5.2 The responses that need to be found to these issues in connection with social exclusion are equally important for mental health.

4.5.3 Lastly, the ageing of the population will require appropriate responses. Only 20 % of elderly people have what the WHO terms an 'successful ageing', meaning that 80 % suffer from various illnesses and loss of autonomy. Mental illness does not disappear with advancing age, quite the reverse. Senile dementia, which affects only 1 % of 60 year olds becomes more common with age, affecting 30 % of the over 85s. Over 70 % of these individuals have behavioural problems.

4.6 *Asylum seekers*

4.6.1 The issue of mental health arises in connection with support for asylum seekers during the reception procedure, their living space and conditions and their personal lives, which embody their personal history and psychic temporality. The seriousness of the traumas they have suffered, often involving extreme, intentional and collective cruelty, bears witness to situations of organised violence. Within this population, post-traumatic stress is often worsened by multiple bereavements and very painful experiences of exile.

4.7 *The mental health issue*

4.7.1 The same issue arises in connection with the sizeable prison population with mental health problems, who receive very little in terms of care provision.

4.7.2 Support must be given for the establishment of depression, suicide and addiction prevention programmes.

4.7.3 With regard to deinstitutionalisation and the new model it proposes, a new period began in the late 1990s, marked by the end of both the downward trend in hospitalisation model and the illusions about de-institutionalisation, with a resulting need for a combined approach offering both effective community-based care and full-time hospitalisation. Too much focus on hospitalisation means that resources are not available to develop the range of services in the community needed by patients and their families. Conversely, too much focus on outpatient services is ineffective without back-up from hospital services that are permanently available, and accessible at short notice, for patients with acute symptoms requiring brief periods of in-patient hospital treatment. Lastly, it is only possible to avoid over-use of hospitalisation if outpatient services have the resources to prevent it, for example, by supporting patients undergoing long-term in-patient care, to ensure that they are adequately prepared for their discharge from hospital, supporting patients receiving care in the community to ensure that such care is adequate and meets their needs and supporting patients who need to alternate between outpatient care and hospitalisation.

4.7.4 The decision to treat a person suffering from mental illness by means of hospitalisation or outpatient care is strongly influenced by specific factors such as the patient's degree of isolation and the training model and culture of the professionals concerned as well as by more general, socio-cultural factors such as the degree of tolerance within the particular society and the profile of vulnerability in the area concerned, which may lead to preferences for particular approaches and impact on the availability of alternatives. It is therefore impossible to make categorical recommendations regarding the number of hospital beds required for patients in an acute phase, without taking account of local conditions.

4.7.5 Moreover, the most important factor is the nature of the treatment, in other words, what benefits it is intended to provide, for which needs, and to what level, above and beyond the setting in which it is dispensed.

4.7.6 It is generally acknowledged that hospital treatment has a number of advantages, with regard to availability of trained staff, a secure and appropriate environment for patients and therapeutic support under safe conditions. However, these advantages disappear if a lack of beds means that too many non-cooperative patients with very severe disorders are grouped together within a hospital, leading to unacceptable or dangerous disruptions to the surrounding work.

4.7.7 A number of international and French studies have shown that up to 40 % of the patients with acute disorders voluntarily seeking or prescribed hospital admission, can be treated with other forms of therapy, provided that they are willing to cooperate or can be persuaded to do so, for example, with the support of close family or social support networks (emergency or crisis support). As alternative approaches become more effective, there is a tendency for hospitalisation to be reserved for the 'unavoidable' cases, including patients requiring a two-pronged psychiatric and physical assessment, patients presenting with particularly severe mixed, acute disor-

ders, relapses from known psychiatric disorders, or uncontrollably violent or suicidal behaviour. In such cases, compulsory hospitalisation is often necessary. As we shall see, this has an impact on organisation and treatment.

4.7.8 In view of the above, the same studies recommend a minimum threshold of 0.5 beds per 1 000 adult inhabitants for patients in acute phases, a figure which will have to be reviewed if the target objective of an 80 to 85 % service occupation rate is envisaged, as we recommend. Naturally, this minimum threshold is premised on the assumption that upstream and downstream alternative treatment sites are sufficiently equipped and effective and does not include secure beds for acute patients receiving psychiatric care within the criminal justice system, beds for adolescents or elderly people. If the requirements for proper ambulatory services are not met, coming too close to this threshold would lead to the creation of extremely costly additional psychiatric or medical beds.

4.8 *Environment of care*

4.8.1 Whilst the threshold for bed numbers may vary from country to country, the minimum standards for accommodation can be more assertively presented. All accommodation should be fit for its purpose and, whilst possibly provided in older settings, must aspire to contemporary values of dignity and respect for residents. It is essential for the purposes of recovery that the environment is appropriate. Environmental risks must be assessed and addressed in regard to the particular needs of the residents.

4.8.2 The residents should have access to a wide range of therapies that compliment and contribute to their care and treatment. All mental health staff should contribute to this environment by being appropriately trained, skilled and humane in their approach.

Brussels, 17 May 2006.

The President
of the European Economic and Social Committee
Anne-Marie SIGMUND