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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

PR_INI

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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 of Fundamental Rights of the Union[1],

– having regard to Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation[2],

– having regard to the Council Resolution of 18 November 1999 on the promotion of mental health[3],

– 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 its resolution of 23 March 2006 on demographic challenges and solidarity between the generations (2005/2147(INI))[4],

– 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 (A6-0249/2006),

A. whereas one in four people in Europe experience at least one significant episode of mental ill health during their lives; whereas mental ill health affects everyone in the EU either directly or indirectly, 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; whereas good mental health enables citizens to be intellectually and emotionally fulfilled and integrated into social, educational and professional life; whereas, conversely, poor mental health gives rise to expense, social exclusion and stigmatisation,

B. whereas mental health conditions substantially detract from the quality of life of those

[1] OJ C 310, 16.12.2004, p. 41.
[2] OJ L 303, 2.12.2000, p. 16

[3] OJ C 86, 24.3.2000, p. 1.
[4] Texts Adopted, P6_TA(2006)0115.

either directly or indirectly affected,

C. 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,

D. whereas mental health conditions already have a very significant economic, health and social impact, which is set to increase as the rate of incidence rises, given the ageing population and changes in society,

E. 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,

F. whereas, in view of the assignment of competences in the EC Treaty, the added value of a Community strategy on the mental health of the people of Europe lies primarily in the field of prevention,

G. whereas in some European countries up to 85% of the money devoted to mental health is spent on maintaining large institutions,

H. whereas a lack of understanding and investment in mental health promotion has contributed to deteriorating health and disabilities among individuals and societal problems,

I. 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,

J. whereas throughout the European Union not enough attention or resources have been given to the mental health of children and young people, even though mental ill health is increasing significantly among the young,

K. whereas there is a clear gender dimension to the issue of health, particularly as regards eating disorders, neurodegenerative disorders, schizophrenia, mood disorders, anxiety, panic, depression, abuse of alcohol and other psychoactive substances, as well as suicide and delinquency, areas which also require systematic research,

L. whereas women tend to seek assistance from services more than men and are prescribed twice as many psychotropic drugs as men; whereas pharmacokinetic studies have shown that women have less tolerance to such products,

M. whereas the prevention, early identification, intervention and treatment of mental disorders significantly reduces the personal, financial and social repercussions,

N. whereas a great number of people suffer from neurodegenerative disorders and this number is expected to grow on account of, inter alia, longevity and the concomitant increase in the elderly population,

O. whereas in most European Union countries there has been a move from long-term

institutionalised care, both for children with developmental and behavioural problems which jeopardise their normal development, particularly in the educational sphere, and for adults 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,

P. whereas mental health problems related to violence against women and girls are poorly identified; whereas accounts of victimisation are routinely not taken into account and many women and girls are reluctant to disclose a history of violent abuse unless doctors and medical personnel ask about it directly,

Q. whereas the precondition for mental health is an upbringing in a healthy family environment providing both material and psychological security and parental love,

1. Welcomes the Commission's commitment to mental health promotion; calls for greater priority for this in health policies and in the Union's research policy, and believes this should be mainstreamed into the policies and legislation of all Commission Directorates and all Member State ministries, which should make a commitment to harmonising the current national and international mental health indicators, with a view to ensuring a comparable set of data at EU level;

2. Considers that the gender dimension has not duly been taken into account in the Green Paper; calls, therefore, for this dimension to be systematically considered in the measures proposed to promote mental health, in preventive measures and in research, in which studies have to date been insufficient and inadequate, to such an extent that progress on the prevention and cure of mental illness has been significantly less great than in the case of other diseases;

3. Considers the role of doctors in monitoring patients to be of paramount importance;

4. Believes that good mental health is a prerequisite for the overall health and well-being of European citizens and for a healthy economic performance in the EU; encourages and supports all measures which aim to help prevent mental disorders;

5. Stresses the need to think about the best way to use the available Community instruments such as the 7th research framework programme in order to build up a capacity capable of supporting research into mental health in the Union;

6. Believes that any future proposal by the Commission relating to mental health should involve partnership and consultation with and the participation of those who have experienced or are experiencing mental health problems, their families and carers and advocacy NGOs, associations of family members and other interested parties, so as to make decision-making processes more representative and inclusive, and should promote networking among members of the families of psychiatric patients;

7. Highlights the sizeable differences in mental health expenditure in individual Member States, both in terms of the absolute amount and as a proportion of health care expenditure as a whole;

8. Believes that different actions will be needed to achieve the three aims of mental health promotion, mental health improvement and mental disorder prevention; believes that the aims of such actions should be to provide appropriate information, to obtain relevant knowledge and develop appropriate attitudes and skills in order to safeguard the mental and physical health and improve the quality of life of European citizens;

9. Stresses the need for careful use of terms such as "Mental Ill Health", "Mental Health Disorders", "Severe Mental Illness" and "Personality Disorder";

10. Stresses the importance of the need for early screening, detection and diagnosis and of integrated, tailor-made treatment;

11. Stresses the need to combat, through appropriate action, inequalities in the treatment of mental diseases which are evident in this field;

12. Calls for people with learning disabilities 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, discrimination, stigma and lack of support for themselves and their families and carers; calls, at the same time, for greater efforts to recognise cognitively gifted children and young people as such and to provide better support for them;

13. Stresses the importance of mutual help and the leading role played by people's experience of treatment, illness and recovery;

14. 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 severe mental illness, those with long-term and terminal illnesses, the disabled, prisoners, ethnic and other minority groups, rough sleepers, migrants, persons in precarious jobs and the unemployed, and the range of mental health and care issues of specific reference to women;

15. Recognises that personality disorder presents particular challenges of diagnosis, treatment or management and care, requiring more research and distinct policies; calls on the Commission also to devote attention to aggression, the determinants of aggressive behaviour and its psychological consequences;

16. Acknowledges that men and women may have different mental health needs, and calls for more research particularly into the link between compulsory in-patient care and self-harm and the higher rate of prescription of psychotropic drugs among women;

17. Stresses the need for research into the proven variations in structure and activity between the brains of men and women, in order to develop separate approaches and treatments for the two sexes in the field of mental health;

18. Calls for support for mothers during the prenatal and postnatal periods in order to prevent depression or other psychopathological conditions which manifest themselves in significant numbers of cases in these situations;

19. Believes that good mental health of mothers and parents helps children to develop without hindrance and grow into healthy adults;

20. Calls for a multi-disciplinary and multi-agency response to tackling complex mental ill health situations, such as how best to support children or adolescents with developmental or behavioural problems or eating disorders, and/or whose parents in many cases themselves suffer from mental ill health (or are kept in long-term institutions);

21. Notes that socially-defined images of how girls' and women's bodies should look have an impact on women's and girls' mental health and well-being, resulting inter alia in an increase in eating disorders;

22. Points out that mental ill health and mental disorders commonly have their roots in early childhood and stresses the importance of research into a healthy early childhood;

23. Stresses the importance of continuing training and in-service training of the intermediaries: teaching staff, care workers, social and judicial services and employers;

24. Welcomes the fact that the Green Paper recognises that social and environmental factors, such as personal experiences, family, and social support; living conditions such as poverty, living in big cities, and rural isolation; and working conditions, such as job insecurity, unemployment, and long working hours, play a role in the mental health of people; stresses that mental disorders are one of the reasons for early retirement and disability pensions;

25. Considers that good working conditions contribute to mental health and calls for employers to introduce "Mental Health at Work" policies as a necessary part of their health and safety at work responsibility, with a view to ensuring the 'best possible jobs' for and best possible incorporation into the labour market of persons with mental disorders, and that these should be published and monitored within existing health and safety legislation, while also taking workers' needs and views into account;

26. Welcomes the social initiatives within social policy and employment policy to promote the non-discriminatory treatment of individuals with mental ill health, the social integration of individuals with mental disabilities, and the prevention of stress in the workplace;

27. With regard to the EU employment strategy, emphasises the influence of mental health on employment as well as the influence of unemployment on people’s state of mental health;

28. Believes Member States should work together to find and implement effective strategies to reduce suicide, particularly among young people and other at risk groups;

29. Calls for greater recognition of the connection between discrimination, violence, and poor mental health, which underlines the importance of combating all forms of violence and discrimination as part of the strategy for the promotion of mental health through prevention;

30. 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 research into the mechanisms and causes of neurodegenerative diseases or other psychiatric illnesses in the elderly and to their prevention as well as their care, including the development of new therapies;

31. Further believes that emphasis should be placed on the link between the consumption of alcohol and illegal drugs and mental disorders; considers that alcohol and drug addiction cause serious mental and physical health problems and problems for society as a whole; calls on the Commission to review without delay what detoxification programmes and methods of treatment are the most effective;

32. Stresses that people with mental disorders should be treated and cared for with dignity and humanity and that medical care and support services should be effective and of a high quality, accessible to all sufferers and universal; 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; and that there should be information and advice for those who wish to withdraw safely from medication;

33. Believes that the use of force is counterproductive, as is compulsory medication; believes that all forms of in-patient care and compulsory medication should be of limited duration and should, wherever possible, be regularly reviewed and subject to the patient's consent or, in the absence of such consent, to authorisation by the appropriate authorities used only as a last resort;

34. Takes the view that any restriction of personal freedoms should be avoided, with particular reference to physical containment, which requires monitoring, verification and vigilance by democratic institutions responsible for upholding individual rights, in order to guard against abuses;

35. Calls for the defeat of stigma to be at the heart of any future strategy, e.g. by establishing annual campaigns on mental health issues in order to combat ignorance and injustice, 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; considers furthermore that with a view to improving the mental health and conditions of patients, basic social and civil rights should be guaranteed, such as the right to housing and economic support for those unable to work and the right to marry and manage one's own affairs; further believes that stigma is in fact a form of discrimination and should be tackled by anti-discrimination laws;

36. Recognises that an element of the stigma is a widespread perception that mental health disorders are acute and lifelong, whereas it is important to stress that, with appropriate help, people can recover, while others will achieve remission or a sufficient level of functionality or stability;

37. 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 in-patient services for acute, chronic or secure needs but always with independent monitoring of anyone who receives compulsory in-patient care;

38. Stresses, with this in mind, the need to support cooperatives formed by psychiatric patients and all activities geared to the inclusion of users and former patients and to earmark resources for the training of staff, so as to enable them to take account of all the needs of psychiatric patients;

39. Stresses the need for continuous training on mental health matters for general and family practitioners and other professionals in primary healthcare services;

40. Recognises that local government has an integral role to play in promoting good mental health, supporting those in poor mental health within their local communities and bringing together the various strands of a multi-agency approach to mental health service delivery;

41. Believes that dual diagnosis of people with mental health and addiction problems should normally lead to concurrent treatment;

42. Stresses that mental and physical aspects of health are interlinked, that mental disorders can have a biological, social, emotional or historical basis which must be addressed in order for other approaches to be successful, and that some psychiatric medicines can actually worsen the underlying biological condition;

43. Calls for greater attention to the psychological consequences and symptoms of somatic diseases; stresses the need to give equal importance to mental and physical well-being in hospital care protocols, including for the treatment of serious and/or incurable illnesses; and believes it is essential for medical and paramedical personnel working in other specialised fields to undergo continuous training in psychopathology since disorders often remain undiagnosed or are underestimated;

44. Supports the Commission's comments on deinstitutionalisation, as long-term stay in psychiatric institutions can lead to the protraction and exacerbation of psychopathological conditions, reinforcement of stigma and social exclusion, but acknowledges that greater efforts must be made to convince the public of the better results achieved when people with severe mental or learning disorders receive care in the community;

45. Suggests that the Commission should collect, through the Public Health Programme, data on mental illness, recovery rates of treated patients and the effectiveness of their reintegration in society;

46. Suggests the Commission identify sites and examples of good practice and disseminate details of these to all Member States, these "Demonstration Sites" being comparable to WHO sites under their "Nations for Mental Health" programme; considers that demonstration sites, "demonstration treatments" and "demonstration prevention strategies" could be important ways of reducing mental-health inequalities between Member States; calls on the Commission to involve knowledge institutes in identifying demonstration

sites, demonstration treatments and demonstration prevention strategies;

47. Believes that, because all persons (according to UN General Assembly Resolution 46/119) have the right to the best available mental health care, best practice and relevant information should be disseminated and be available to all citizens;

48. Believes that the term "treatment" should be interpreted broadly, with the emphasis on identifying and eliminating social and environmental factors, while the use of medication should be a last resort, particularly in the case of children and young people; criticises the growing medicalisation and pathologisation of life stages, without a comprehensive search for causes; calls for account to be taken of factors such as personal experiences, family, social support and living and working conditions which play a role in mental illness as well as genetic factors;

49. Further believes that in addition to treatment, an appropriate social and work environment as well as family and community support are required to prevent mental health problems and improve and promote mental well-being and the therapeutic strategy for and rehabilitation of sufferers of mental disorder; stresses the need for research into environments conducive to mental health and recovery;

50. Urges the Commission to support continuing reforms in any Member State that practised the abuse of psychiatry, over-use of medication or incarceration, or inhumane practices such as caged beds or excessive use of seclusion rooms, particularly in the new Member States, and calls on the Commission to place the reform of psychiatry on the agenda for EU accession negotiations; considers that prison is not a suitable environment for those suffering mental ill health and that alternatives should be actively pursued;

51. Calls for more research into therapeutic and psychological interventions, into the development of more effective drugs with fewer side effects, into determinants of mental disorders and suicide, into outcome measurements for investment in mental health promotion and into methods contributing to successful recovery and remission; calls, in particular, for special attention to be devoted to research into medicines more suitable for children; stresses, moreover, that research must not be confined to pharmaceuticals but must extend to epidemiological, psychological and economic studies on the community and the social determinants of mental illness; further calls for an increase in the involvement of service users in all aspects of mental health research;

52. 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 former service users; and cross-border provision;

53. Believes that mental heath services should receive sufficient funding to reflect the cost of mental disorders to individuals, health and social care services, and society as a whole, so as to be effective and command public confidence;

54. Believes that it is essential to apply high quality, individualised methods of promoting mental health, taking into account the particular needs of individuals and target groups;

55. Recognises the valuable contribution that family members and 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 information and support from professionals if they are to continue providing care; further recognises the valuable contribution that service users can make in supporting each other;

56. Stresses the need to use vocabulary and terminology which will help to combat stigma, e.g. measures to eliminate prejudice, change attitudes and criticise stereotypes in regard to every category of mental disorder;

57. 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, to assess the adequacy (in terms of numbers and training) of existing mental health professionals and infrastructure, and to disseminate information on best practice to all Member States and all parties involved in the treatment of mental health; stresses that patients' organisations, those providing treatment, care institutions and knowledge institutes must be involved in this Coordinating and Monitoring Group;

58. Calls on the Commission to follow up the Green Paper with a proposal for a directive on mental health in Europe and the defence of and respect for the civil and fundamental rights of persons suffering from mental disorders;

59. Urges the EU and ACP countries to work closely on investing in good mental health through development and Cotonou policies;

60. Instructs its President to forward this resolution to the Council, the Commission, the governments of the Member States, the candidate countries, 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 in-patient 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 notrable 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.

25.4.2006

OPINION OF THE COMMITTEE ON EMPLOYMENT AND SOCIAL AFFAIRS

for the Committee on the Environment, Public Health and Food Safety

on improving the mental health of the population: towards a strategy on mental health for the European Union
(2005/2058(INI))

Draftswoman: Kathy Sinnott

SUGGESTIONS

The Committee on Employment and Social Affairs calls on the Committee on the Environment, Public Health and Food Safety, as the committee responsible, to incorporate the following suggestions in its motion for a resolution:

1. Welcomes the Green Paper and the Commission's proposal to establish an EU strategy on Mental Health; agrees that the mental health of the EU population could be considerably improved; agrees that this improvement is important for social justice and the socio-economic development of the EU population;

2. Points out that there are many types of mental illness that cause different needs and require different types of support;

3. Considers that, together with facilities for the treatment of mental illness, provision should also be made to activate the respective mechanisms to prevent mental disorders, where possible; in this context, considers that it is essential to record the social, environmental and other factors that could constitute causes of mental instability or illness for EU citizens;

4. Recommends that every strategy in the field of mental health should take into account the socio-economic and cultural differences of the population under study;

5. Welcomes the fact that the Green Paper recognises that social and environmental factors, such as personal experiences, family, and social support; living conditions such as poverty, living in big cities, and rural isolation; and working conditions, such as job insecurity, unemployment, and long working hours, play a role in the mental health of people; stresses that mental disorders are one of the reasons for early retirement and disability pensions;

6. Welcomes the social initiatives within social policy and employment policy to promote

the non-discriminatory treatment of individuals with mental ill health, the social integration of individuals with mental disabilities, and the prevention of stress in the workplace;

7. Points out that the de-institutionalisation of mental health services and the establishment of services within the primary healthcare system may support social integration;

8. Notes that the Green Paper envisages that the first priority forcombating mental ill health is to provide effective and high-quality mental health and treatment services through medical and psychologically-based interventions, which means that suitable infrastructure and sufficient financial resources must be available; believes, however, that the first priority for combating mental ill health should be the same approach as for supporting mental health and preventing mental illness; considers that medical treatment cannot take the place of social factors which maintain the health of society in general; believes that there should be more emphasis on preventing mental ill health through social and environmental interventions accessible to people with mental ill health such as those described in section 6.1 of the Green Paper;

9. Points out that patients suffering from mental illness should have access to all existing treatments, which may improve their health situation regardless of social or economic factors; therefore asks Member States to ensure that all mental health treatments are both accessible to patients and covered by health insurance schemes; asks Member States to ensure a safety net of medical treatment for those citizens who are not covered by national insurance schemes;recommends that Member States ensure that there are Health and Safety policies in the work place, which explicitly address mental health promotion as well as its prevention, the identification and management of depression, and the prevention of suicide, and that Member States identify and support workplaces in which employees are particularly at risk from mental disorders;

10. Considers that good working conditions contribute to mental health and that therefore companies should have policies in place to support workers who may develop or already suffer from mental ill health;

11. Considers that Member States should actively pursue the training and placement of health-care professionals;

12. Considers that financial support may be necessary for those caring in a personal capacity for people with mental illness; considers that support for self-help groups is also required;

13. Considers that in the context of prevention and appropriate care, prison is not a suitable environment for those suffering mental ill health and that alternatives should be actively pursued;

14. Considers that, given that police officers may be involved in dealing with people exhibiting some signs of mental ill health, awareness of such conditions should be part of their training;

15. Welcomes the fact that the Green Paper, in section 6.1, recognises the importance of the promotion of mental health and the prevention of mental ill health for improving the

mental health of the EU population; believes that every effort should be made towards sustainable inter-sectoral linkages incorporating multi-sectoral and multidisciplinary approaches;

16. Calls for measures to combat the stigmatisation of and human rights violations and discrimination against people with mental ill health, and to promote actively their social inclusion; considers the users, families, and carers as essential partners in the development of services in the workplace and community; stresses the importance of awareness-training within the workplace; considers the users, families, and carers as essential partners in the developments of services and therefore urges their empowerment and all their participation in every aspect of the planning and running of services;

17. Highlights the vital role that employers have in recruiting and retaining individuals with experience of mental distress and the role the EU has in combating the stigma and discrimination faced by individuals with experience of mental distress; notes that the Employment Framework Directive 2000/78/EC provides a framework to prevent discrimination on the basis of disability and must be implemented fully; considers it vital that mental illness is regarded as a disability in all Member States;

18. Notes that, according to the Green Paper, there are considerable disparities between the suicide rates in the different Member States; considers that the socio-economic, environmental and health factors responsible for this disparity should be investigated, as well as the effects of the above factors on the mental health of citizens; recommends that Member States provide support to networks of people with mental and behavioural disorders and their families, assess and advocate policies and programmes that reduce stigma and social exclusion, and implement public information programmes to improve the public's knowledge regarding the causes, symptoms and treatment options for mental disorders;

19. Notes, moreover, that conditions should be laid down concerning the use of the available Community instruments, such as the 7th research framework programme, for the development of research opportunities and support for research into mental health in the EU;

20. Reminds the Commission also that persons with disability and chronic illness are vulnerable and particularly need support to prevent developing depression and other mental conditions;

21. Believes that coercion is extremely counterproductive in treating mental ill health; agrees that compulsory in-patient and/or community-based care should be applied only once less restrictive, voluntary alternatives have failed; stresses that effective mechanisms to respect people's fundamental rights, must be included in the processes and procedures relating to compulsory admission and treatment; urges movement away from institutionalisation and highlights the importance of community-based care;

22. Considers also that increasing the awareness of the public, the social partners and other responsible bodies in regard to mental ill health, its prevention, and treatment options, and encouraging the integration of the mentally ill and individuals with disabilities into working life, may result in greater acceptance and understanding by society;

23. Believes that the objective of promoting mental health must be given greater priority in national health systems, in view of its repercussions for personal, family and social wellbeing and in line with WHO and ILO recommendations;

24. Believes that it is necessary to devote more resources to promoting mental health by means of preventive research actions, notably from the viewpoint of the EU's ageing population and thus the more frequent occurrence of neurodegenerative disorders such as Alzheimer's and Parkinson's disease;

25. Highlights the growing medicalisation of life situations, whereby certain life situations are increasingly being defined as illnesses and, as such, treated medically;

26. Notes that the responsibility for organising and financing health care, including health care for the mentally ill, is solely a matter for national governments;

27. Emphasises that mental health is both a health issue and a social issue; points out also that the increasing incidence of mental illnesses, together with the improving but costly possibilities for treating them, pose a considerable challenge to national social security systems;

28. Highlights the sizeable differences in mental health expenditure in individual Member States, both in terms of the absolute amount and as a proportion of health care expenditure as a whole;

29. With regard to the EU employment strategy, emphasises the influence of mental health on employment as well as the influence of unemployment on people’s state of mental health;

30. Emphasises the need for the public to be better informed on mental health issues and the huge importance of timely detection of often hard-to-identify mental illnesses in order to limit their health as well as their social and economic impact;

31. Believes that there is a need for thorough research into explaining existing differences in the organisation and provision of medical and social care for people suffering mental disorders as well as into the different results of this care; believes that, in order to conduct such research, it is necessary to have unified definitions and methodology and that the basic characteristics of care for the mentally ill must be quality, differentiation, complexity, and continuity; believes that medical and social institutions not fulfilling the above qualification should not participate in the provision of the healthcare;

32. Believes that care for the mentally ill must be consistently constructed in such a way so as to avoid the unnecessary or unjustified long-term hospitalisation of patients whose illness can be treated in outpatient institutions run by qualified staff; believes that it is always necessary to ensure the therapeutic use of communication with the patient’s social background and to provide the patient with social services and a useful programme aimed at maximising the patient’s social and employment potential; believes that, for this reason, the Member States should make the necessary funds available to help finance independent accommodation and employment for suitable patientsand to provide permanent adequate social and health care for others.

PROCEDURE

Title	Improving the mental health of the population. Towards a strategy on mental health for the European Union
Procedure number	2005/2058(INI)]
Committee responsible	ENVI
Opinion by Date announced in plenary	EMPL 16.3.20006
Enhanced cooperation – date announced in plenary	
Draftswoman Date appointed	Kathy Sinnott 27.10.2005
Previous drafts(wo)man	
Discussed in committee	21.3.2006 19.4.2006
Date adopted	20.4.2006
Result of final vote	+: 39 –: 0 0: 0
Members present for the final vote	Jan Andersson, Roselyne Bachelot-Narquin, Milan Cabrnoch, Alejandro Cercas, Ole Christensen, Derek Roland Clark, Jean Louis Cottigny, Proinsias De Rossa, Harald Ettl, Carlo Fatuzzo, Joel Hasse Ferreira, Stephen Hughes, Karin Jöns, Jan Jerzy Kułakowski, Sepp Kusstatscher, Jean Lambert, Bernard Lehideux, Elizabeth Lynne, Thomas Mann, Mario Mantovani, Jan Tadeusz Masiel, Ana Mato Adrover, Maria Matsouka, Marie Panayotopoulos-Cassiotou, Pier Antonio Panzeri, Jacek Protasiewicz, José Albino Silva Peneda, Kathy Sinnott, Jean Spautz
Substitute(s) present for the final vote	Edit Bauer, Mihael Brejc, Udo Bullmann, Françoise Castex, Marian Harkin, Anne E. Jensen, Jamila Madeira, Leopold Józef Rutowicz, Elisabeth Schroedter, Evangelia Tzampazi, Yannick Vaugrenard
Substitute(s) under Rule 178(2) present for the final vote	
Comments (available in one language only)	

22.6.2006

OPINION OF THE COMMITTEE ON WOMEN'S RIGHTS AND GENDER EQUALITY

for the Committee on the Environment, Public Health and Food Safety

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

Draftswoman: Marta Vincenzi

SUGGESTIONS

The Committee on Women's Rights and Gender Equality calls on the Committee on the Environment, Public Health and Food Safety, as the committee responsible, to incorporate the following suggestions in its motion for a resolution:

A. whereas good mental health enables citizens to be intellectually and emotionally fulfilled and integrated into social, educational and professional life; whereas, conversely, poor mental health gives rise to expense, social exclusion and stigmatisation,

B. whereas there is a clear gender dimension to the issue of health, particularly as regards eating disorders, neurodegenerative disorders, schizophrenia, mood disorders, anxiety, panic, depression, abuse of alcohol and other psychoactive substances, as well as suicide and delinquency, areas which also require systematic research,

C. whereas women tend to seek assistance from services more than men and are prescribed twice as many psychotropic drugs as men; whereas pharmacokinetic studies have shown that women have less tolerance to such products,

D. whereas victims of violence also suffer in similar fashion to victims of war from post-traumatic stress; whereas long-term protection of victims is a condition for rehabilitation; whereas stress resulting from fear of further violent attacks adversely affects both the mind and the body's immune defences,

E. whereas mental health problems related to violence against women and girls are poorly identified; whereas accounts of victimisation are routinely not taken into account and many women and girls are reluctant to disclose a history of violent abuse unless doctors and medical personnel ask about it directly,

1. Congratulates the Commission on its Green Paper but considers that the gender dimension has not duly been taken into account; calls, therefore, for this dimension to be systematically considered in the measures proposed to promote mental health, in preventive measures and in research, in which studies have to date been insufficient and inadequate, to such an extent that progress on the prevention and cure of mental illness has been significantly less great than in the case of other diseases;

2. Stresses the need to think about the best way to use the available Community instruments such as the 7th research framework programme in order to build up a capacity capable of supporting research into mental health in the Union;

3. Calls for primary health care providers to receive appropriate training so that mental health problems related to domestic violence, sexual abuse, highly-gifted children, chemical toxicity, environmental pollution and acute and chronic stress in women and girls are correctly diagnosed;

4. Calls for aspects regarding psychological and psychopathological suffering among children and families to be given greater consideration and for appropriate policies to be put forward, given that this concerns the prevention of adult disorders, which, if they appear in a serious form during adolescence, tend to become chronic;

5. Calls for support for mothers during the prenatal and postnatal periods in order to prevent depression or other psychopathological conditions which manifest themselves in significant numbers of cases in these situations;

6. Criticises the growing medicalisation of the processes and stages of development of women's and girls' bodies, as a result of which puberty, pregnancy or menopause are increasingly being defined as 'illnesses' or 'disorders' which have to be treated medically, thereby ignoring social and cultural definitions of what is 'normal' in women's and girls' health and for their bodies;

7. Notes that socially-defined images of how girls' and women's bodies should look like have an impact on women's and girls' mental health and well-being, resulting inter alia in an increase in eating disorders;

8. Recalls that mental disorders are the most frequent cause of early retirement and retirement on grounds of disability; calls for a specific strategy to improve the mental well-being of elderly people, in particular elderly women, given that women live longer, by means of support networks and voluntary programmes;

9. Recalls that mental and physical health are intimately linked; stresses the need to give equal importance to mental and physical well-being in hospital care protocols, including for the treatment of serious and/or incurable illnesses, with a view to helping improve patients' quality of life;

10. Welcomes the proposal to deinstitutionalise mental health services and to abolish large psychiatric institutions, while at the same time promoting the establishment of alternative

small-scale residential facilities and the provision of decentralised specialist services that facilitate re-entry into society and are geared to the needs of patients and their families; welcomes the efforts to integrate mentally ill people into society and calls on the Member States to support such initiatives;

11. Calls on the Member States to ensure that better information and awareness-raising services are provided for the public, families, care providers and other players on mental illness and care and prevention strategies, which would raise the level of tolerance, understanding and acceptance of active participation in society by people with mental illnesses;

12. Takes the view that families living with people suffering from mental illnesses should receive considerable support in the form either of open residential structures or of medical and psychological assistance in the home;

13. Takes the view that the Commission and Member States should monitor the proportionally high growth of diseases linked to new lifestyles – eating disorders, depression, suicide, abuse of pharmaceuticals and drug use – which are increasingly affecting younger population segments;

14. Calls for greater recognition of the connection between discrimination, violence, and poor mental health, which underlines the importance of combating all forms of violence and discrimination as part of the strategy for the promotion of mental health through prevention;

15. Considers that men who commit violence against women should not only be punished but should also receive appropriate training in empathy, self-awareness and self-control before they are released again; takes the view that men who continue to persecute women after detention should be placed under supervision or be taken back into custody;

16. Stresses that exposure to chemicals and environmental pollution has an effect on women's and girl's bodies and consequently on their mental health.

PROCEDURE

Title	Improving the mental health of the population – towards a strategy on mental health for the European Union
Procedure number	2006/2058(INI)
Committee responsible	ENVI
Opinion by Date announced in plenary	FEMM 16.3.2006
Draftswoman Date appointed	Marta Vincenzi 21.3.2006
Previous drafts(wo)man	-
Discussed in committee	3.5.2006 22.6.2006
Date adopted	22.6.2006
Result of final vote	+: 18 –: 0 0: 1
Members present for the final vote	Edit Bauer, Hiltrud Breyer, Maria Carlshamre, Edite Estrela, Věra Flasarová, Nicole Fontaine, Zita Gurmai, Esther Herranz García, Rodi Kratsa-Tsagaropoulou, Urszula Krupa, Angelika Niebler, Christa Prets, Teresa Riera Madurell, Raül Romeva i Rueda, Amalia Sartori, Britta Thomsen, Anna Záborská
Substitute(s) present for the final vote	Kartika Tamara Liotard
Substitute(s) under Rule 178(2) present for the final vote	Guido Sacconi
Comments (available in one language only)	

PROCEDURE

Title	Improving the mental health of the population. Towards a strategy on mental health for the European Union
Procedure number	2006/2058(INI)
Committee responsible Date authorisation announced in plenary	ENVI 16.3.2006
Committee(s) asked for opinion(s) Date announced in plenary	FEMM EMPL LIBE ITRE 16.3.2006 16.3.2006 16.3.2006 16.3.2006
Not delivering opinion(s) Date of decision	LIBE ITRE 19.4.2006 20.3.2006
Enhanced cooperation Date announced in plenary	
Rapporteur(s) Date appointed	John Bowis 29.11.2005
Previous rapporteur(s)	
Discussed in committee	29.5.2006 13.7.2006
Date adopted	13.7.2006
Result of final vote	+ : 51 - : 0 0 : 1
Members present for the final vote	Adamos Adamou, Georgs Andrejevs, Johannes Blokland, John Bowis, Frieda Brepoels, Dorette Corbey, Chris Davies, Avril Doyle, Mojca Drčar Murko, Edite Estrela, Anne Ferreira, Karl-Heinz Florenz, Alessandro Foglietta, Matthias Groote, Françoise Grossetête, Cristina Gutiérrez-Cortines, Satu Hassi, Marie Anne Isler Béguin, Dan Jørgensen, Christa Klaß, Holger Krahmer, Urszula Krupa, Marie-Noëlle Lienemann, Jules Maaten, Linda McAvan, Roberto Musacchio, Péter Olajos, Adriana Poli Bortone, Frédérique Ries, Guido Sacconi, Karin Scheele, Carl Schlyter, Horst Schnellhardt, Richard Seeber, Kathy Sinnott, Jonas Sjöstedt, Bogusław Sonik, María Sornosa Martínez, Antonios Trakatellis, Thomas Ulmer, Anja Weisgerber, Åsa Westlund, Anders Wijkman
Substitute(s) present for the final vote	Bairbre de Brún, Jolanta Dičkutė, Jutta D. Haug, Karin Jöns, Caroline Lucas, Justas Vincas Paleckis, Amalia Sartori, Renate Sommer, Glenis Willmott
Substitute(s) under Rule 178(2) present for the final vote	
Date tabled	18.7.2006
Comments **(available in one language only)**	