

NEW EUROPE AND MENTAL HEALTH*

John Bowis

Member of European Parliament (for London), Rue Wiertz, B-1047 Brussels

INTRODUCTION

There are 450 million people in our world with a neurological or mental disorder; 1 million people in our world commit suicide; 10 million try each year. Some 121 million of us have Depression – 3 in every 100 of us every year. In my country 1 in 3 of people going to their GP have mental health problems – 1 in 6 diagnosed as such. That does not mean that 2 in 3 of us have *good* mental health; it means we may not need, or we may not seek, or we may not be offered, treatment. It may mean we are given inappropriate treatment, with drugs and therapies and institutions and laws that at best may do no harm and at worst may lead to physical and psychological damage. It almost certainly means that we are 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, we can hide but we cannot run; we cannot perform; we cannot contribute to society as we would wish; we cannot lead full and fulfilling lives as we would want. It is an enormous challenge for all of us but particularly for those daily in the front line – doctors, nurses, families and individuals.

MEMORIES FROM THE PAST

When, as a child, I first met mental illness, it was something you didn't talk about. When I first met mental health policy as a member of a Community Health Council, I discovered to my horror that mental health policy had not progressed far from the locks, bolts, restraint garments and isolation rooms, powers to detain and forcible administration of drugs – or so it seemed. In fact, of course, mental health policy was on the move, with more humane surroundings, treatments and therapies, and patients were on the move too – with community housing or hostels or back to their own homes. But the public did not always like that. No longer 'out of sight, out of mind', it became 'out of his or her mind and living next door to me and my children'. Doctors and nurses were on the move too – with community health work, sharing patients with other agencies. And many health professionals did not much like the change. It can be lonely and frightening for a young mental health nurse to be called out at night to a disturbed patient on a crime infested estate and you miss the hospital team support. And some, perhaps many, doctors and nurses felt it was not the way they had been trained as health professionals – to share

* **OPENING STATEMENT MENTAL HEALTH IN THE REGION OF FORMER YUGOSLAVIA**
Portorož, Slovenia, May 2004

knowledge of a patient with a social worker or housing officer or patient. Yet patients want teamwork between agencies as well as confidentiality.

MODERN MENTAL HEALTH POLICY

If modern humane mental health policy is to work, it must have a spectrum of care from secure units to home support and it must have the range of health, social services, housing, training, transport and benefits services working in partnership; it must have trust between professionals, patients and families; it needs government resources, which needs political awareness, and that means public consent and professional support. 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.

STIGMA: A HUMAN RIGHTS ABUSE

Stigma is rampant in all our countries and stigma is an unintentional human rights abuse, born out of fear and ignorance, but just as damaging to the individual as any other form of abuse. We all contribute to the stigmatisation of people who, if they had a physical problem, would receive our sympathy and support. Yet with mental illness we so often turn away and hope someone else will cope. Living with mental illness is tough enough, without having added to the burden of illness, the pain of rejection and stigma. So how do we tackle it? First we could listen to and learn from service users. They should be partners and not just patients. I have always found that I have learned as much from patients as I have from professional advisers. I remember a young man accosting me on the stairs of a hospital I was visiting. The staff wanted to push him away but I wanted to hear what he would say. He told me he knew when he was going to be ill but, if he went to his family doctor, he was told he was not

ill enough to be referred. And so he waited until he was really ill and then cost more to the health service and to himself and his family, as more expensive care and treatment was needed to help him back to health. It taught me the need to have in our service provision for respite and assessment – earlier intervention, based on the patient's own knowledge and experience. Stigma of course is as much self afflicted as imposed by others. We need to know why. Then we could also start by admitting our role in it, in ourselves and in society. We have legislated against discrimination for people with disabilities. Perhaps we need to explore whether such laws could apply effectively, or more effectively, to people with mental illness.

MENTAL HEALTH LAWS AND MODERN MENTAL HEALTH SERVICES

We have mental health laws to give rights to patients in hospital; but are they adequate to cover rights – including rights to treatment – in the community? We need to educate and inform so we can break the chain of prejudice and ignorance that links public, media, patient and government. 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. There is little point in campaigning to put mental health up the political and budgeting agenda if the Minister cannot convincingly argue to his colleagues that 'x' million Euros invested will lead to 'y' percentage improvement in problem 'z'. If you place people neatly into a hospital ward, politicians, press and public feel you have dealt with a health problem and will not enquire too closely what you are

achieving behind the hospital gates. If people are visible, so is the nature of their health problem, and questions are asked as to whether the policy is working, how much is being spent and what it is achieving – all wrapped up, of course, in terms of sympathy and concern for the patients who would “surely be happier and better looked after” in a nice, and, preferably remote, sanatorium.

We will not achieve modern mental health services, if we cannot show that we have a policy that works. Health professionals will say you can measure improvement in adaptive social skills, assertiveness, self control, peer sociability, and so on. The politician will find eyes and understanding glazing over and ask if you could translate that into cost of drugs, number of days as inpatient, the number of hours of social worker support, the length of time on social security benefit, and the likely reduction in hostile newspaper columns. The local resident will ask if the man next door is safe, if those moods are cured, if he can really look after himself and who to tell if one can see someone’s health deteriorating. As a constituency MP, I believe communities are, on the whole, prepared to be tolerant, if they know what the problem is, what to expect and when and where to go for help. If they know none of these things, they tend to react first against the policy and then against the individual. The woman who told me she was worried because her upstairs neighbour kept walking off having left the gas stove burning and she didn’t know whom to ring, had a point! So services need to be as visible as patients; their regimes need to be as understood as the illnesses, even if that brushes up against the rights of patient confidentiality; and the safety net needs to be accessible and confidence-building for patient and community alike.

Europe has no magic wand to make health and social care work but it can and probably will provide some of the answers, not least by sharing experience of best – and worst – practice. Under the Treaties Europe cannot direct the running of national health services but health has been a competence of the European Union since the 1950s Treaties, when health and safety at work

were specified as areas for European policy. Over the years the competence has grown, with public health, notifiable diseases and blood safety. The Treaty of Amsterdam placed health promotion firmly on the agenda and required that a Health Impact Assessment be carried out on any major new policy, alongside assessments on cost, jobs and the environment. Europe will not prescribe standards for health services but, under its agreed Health Action Programme, it will describe good practice. It will map Europe’s health challenges and the various ways these are being met in each Member State. It will put in place effective collaborative systems to combat health emergencies, including bio-terrorism. It will collect data on health determinants and thus help to formulate policies on health promotion. My forecast is that before long this will extend to social care as well. Throughout Europe, governments are finding it ever more difficult to resource health. Countries like Britain, with “Beveridge” systems based on taxpayer contributions, are looking for more private money; while Countries, such as Germany and France, with “Bismarck” systems based on compulsory insurance, are having to ask taxpayers to top up insurance schemes. Taxpayers, chargepayers and insurance premium payers cannot fork out ever-higher amounts. Employers, unions, charities, trusts, can all play their part, but only up to a point. It is time for us to play a bigger role in our own health. The missing link in health policy is Health Promotion. And that is precisely where Europe’s third health competence comes in, after public health and health emergencies. Europe is ahead of most national governments in understanding that, if we want to afford illness services in the future, we have to educate, enable and support individuals and families to take their own decisions to keep themselves physically and mentally healthier and freer from disease, disorder and disability.

Health promotion does not of course benefit from the negative strength of public concern about illness policies. It is true of physical health promotion, but it is even more true of mental

health prevention and promotion, that it is little understood by governments, politicians or even health service administrators. So we have to explain to policy makers, not least in terms of cost:

- *If fewer people smoke, you cut the cost of cancer services.*
- *If more people eat and drink and exercise sensibly, you cut cardiovascular and diabetes service costs.*
- *If motorists drive at an appropriate speed to their environment, A & E costs less.*
- *If housing policy cuts overcrowding, it also cuts the cost of TB.*
- *If families in difficulty are supported earlier, you cut the cost of child and adolescent mental health services.*
- *If employers have in place effective mental health-at-work policies, with, for example, non-threatening and confidential counselling services and flexible work schedules for carers, they will have a more productive workforce.*

And, if you look at the local or national newspaper headlines – crime, drunkenness, accidents, absenteeism, street hooliganism, disruptive pupils, rough sleepers, drug addiction – which of these has no connection with mental health promotion and prevention. As much as within modern hospital or community healthcare, there will be a role for effective mental health care and promotion in every walk of life and every occupation. And I mean mental health care and not just mental illness care.

In the European Union we are making slow but definite progress. Our Treaty of Amsterdam has given the EU competence for Health Promotion and a Finnish initiative during their Presidency last year has ensured that Mental Health Promotion is to be a part of that. The Tampere declaration led to a unanimous Resolution by the Council of Ministers, which called for action “to promote mental health, in particular among children, young people, elderly people and at work.” We have been debating our European health action programme in the

Parliament, ensuring a mental health dimension to that. We have made neurological and mental health a major player in the EU Research programme. And most recently I insisted that my Report to establish the European Centre for Disease Prevention and Control referred specifically to mental as well as physical health. We have brought the new Member States into the EU health programme and we are looking to support our future Member States – not least of course our fellow Europeans in South East Europe. Slovenia is inside and Croatia has knocked on the door and we hope others will want to follow. In any case we are committed to giving support to the countries of the region. Collaboration between agencies can certainly work: health, social services, education, housing, benefits, not just in individual cases; but to improve mutual understanding and input; and dual diagnosis treatment services working in parallel. Above all what we can do is show and share good practice; show what works; show how many people in each locality can be supported in wellness and helped to avoid illness and disability across a range of areas.

WHAT IS STIL TO BE DONE?

A tremendous amount is being done – a tremendous amount more could be done if Prevention and Promotion were understood for the powers they are. But the twin peaks are to convince the public to believe and to convince governments to spend. And they are interdependent. If the public believe, they will put pressure on the government to spend. If the government spends they will make public belief possible. We know that neuropsychiatric disorders are responsible for one third of disabilities, 15% of inpatient cost, nearly a quarter of drugs cost, half the caseload of our social workers; in my country over 90 million days lost at work a year. And one in three of us will be affected during our lives. If it is me, or my wife, my son, daughter, grandchild, do I not want me or them to be hugged rather than rejected; do I not want us to be loved rather than

forgotten; do I not want us to be in places we know and not within blank, cold, alien walls; do I not want to have hope and not self-fulfilling despair. If I understand it can be me or any of us and for sure it will be many of us then will I not want the best or at least a better service. And, in so deciding, will my prejudices not fade at least a little? Politicians, of course, have to be encouraged. Megaphone politics is rarely effective but most politicians want to make a difference in their allotted span on the political stage. Contrary to popular perception, we are persuadable and we can be particularly persuaded if we are shown the cost of doing nothing and the blame that might then be attached. But, to be less cynical, most politicians, given the chance, will want to do what

is to the benefit of disadvantaged or vulnerable people, to detect human rights abuses and promote equity. In your hands and the hands of your fellow health professionals are the skills of healing and care but you cannot achieve the best on your own. Carers and advocates can speak up and persuade by sharing their experience. They need you and you need them. The media can spread the truth at the best. Politicians can listen, learn, understand and then act to provide better services and to help others overcome fear and ignorance and prejudice. None of us can do it alone. Together we can overcome. And we must, because none of us are immune from mental illness - and none of us are protected from stigma.

Correspondence:

*John Bowis, OBE,
Member of European Parliament (for London),
Rue Wiertz, B-1047 Brussels
e-mail: jbowis@europarl.eu.int*