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A person-centred
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- promote policy transfer, learning and support among Member States on EU objectives and priorities; and
- relay the views of the stakeholders and society at large.

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About ESN

The European Social Network (ESN) brings together people who are key to the design and delivery of local public social services across Europe to learn from each other and contribute their experience and expertise to building effective social policy and practice. Together with our Members we are determined to provide quality public social services to all and especially to help improve the lives of the most vulnerable in our societies.





ESN's work on mental health

Mental health has been a cross cutting issue in the policy work of ESN. In 2010 we launched a working group that worked closely with the European institutions in the implementation of the European Pact for Mental Health and Well-being and supported the exchange of research, policy and practice. At European level ESN is active in the Joint Action on Mental Health and Well-being.

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Key Messages

-
- Given the personal, social and economic impact of poor mental health, it should be a major concern across all areas of policy-making, not only in welfare and health systems.
 - Primary, community and acute mental health services have a leading role in defending the rights of people with mental health problems and helping to improve their quality of life.
 - Stigma needs to be tackled in order to improve the quality of life of people with a mental health problem.
 - Mental health services should be person-centred and oriented towards the recovery of service users. Mental health services should:
 - Recognise the resources and strengths of service users and help them improve their lives.
 - Involve users in the design and delivery of the services, and in training for professionals.
 - Draw on the expertise of professionals from different sectors such as social, health, education, employment and housing.
 - Work pro-actively with the private and voluntary sector in the interests of service users.
 - Be based in the community rather than in institutions.
 - National and regional policy-makers should ensure that primary, community and acute mental health services are supported by a clear policy framework and sufficient and sustainable funding.
 - Particular attention should be paid to the different needs of children, young people and older people with mental health problems to promote their recovery and social inclusion.
 - For people of working age who have a mental health problem, active inclusion in the labour market should be seen as a positive element of recovery.
 - All employers should ensure that they have in place strategies to promote mental wellbeing in the workplace.
 - Adding value to Member State policies, the European Union should continue to support mental health through research, awareness-raising, good practice exchange and policy development in the context of the Europe 2020 Strategy¹.

¹ See ESN Policy Statement: Mental Health and the Europe 2020 Strategy, available online at: <http://www.esn-eu.org/mental-health-working-group>

Introduction

People with mental health problems face barriers and prejudices to full integration in society. They may also experience poverty, unemployment, insecure housing, drug and alcohol abuse, and poor family and social support networks. With one in four people experiencing a mental health problem during their lives, it is estimated that the economic costs are €2000 per annum for each European household².

(Poor) mental health is a major social and economic challenge for Europe today. Mental health services, led by medical professionals, have traditionally focused on the clinical aspects of mental health problems and may have relied too much on detention and long-term hospitalisation. Users have come to realise that this approach does not meet their needs and have campaigned to bring about changes based on their personal experience. Although the picture varies across Europe, the emphasis now has moved towards a more person-centred approach, based on the rights of service users.

Social services, with their commitment to supporting people to manage or overcome challenging life circumstances, are well-placed to support these developments. Social services manage, fund and coordinate vital care and support to people experiencing social exclusion and poverty. This support can take many forms, such as working with vulnerable groups, for example with the elderly and children and young people who may suffer abuse or neglect and are therefore more likely to have mental health problems. Social services also provide support for people with complex, recurring and long-term mental health problems. They offer multidisciplinary home care and support for people with acute mental health needs, who would otherwise be hospitalised. In addition, depending on the country, they may either manage or have an input into an assessment of a person's mental health, which may result in compulsory hospitalisation under mental health legislation.

There is a clear ethical case for providing services for people with a mental health problem. In addition, the economic costs of poor mental health are substantial, not only in terms of services and benefits, but also to businesses and the wider economy. This means that there is now a growing case for investing in the promotion of positive mental health, for example, in the workplace.

In 2010, ESN launched a Working Group on Mental Health and Wellbeing, composed of directors of local health and social services, local policy-makers, and researchers from eight European countries³. It reviewed service provision including a range of partnerships between stakeholders at local, regional and national levels. The Group has worked closely with the European Commission and other stakeholders in the context of the European Pact for Mental Health and Well-being throughout 2010 and 2011.

This report aims to share knowledge and learning from the working group and the European Pact. It covers a number of related areas: stigma; person-centred services and recovery; labour market participation of people with mental health problems; and mental health promotion. It also sets out to raise awareness not only of the social but also the economic impact of poor mental health in light of the Europe 2020 Strategy. The report makes the case for person-centred services delivered by social and health professionals working together, with a strong emphasis on the active participation of service users.



Poor mental health is a major social and economic challenge for Europe today.

² McDaid D. (2011) Background document for the Thematic Conference on Promotion of Mental Health and Well-being in Workplaces, Luxembourg: European Communities.

³ Bulgaria, Denmark, Finland, Germany, Ireland, Italy, Spain and UK (See acknowledgements on page 5)

Chapter 1

European and National Policy Context

In recent years mental health – neglected for too long – has risen higher up the policy agenda. At European level, action on mental health is intended to add value to mental health promotion and services at Member State level. This was the aim of the European Pact for Mental Health and Well-being launched in 2008. Across European countries, public sector responsibility for addressing the needs of people with mental health problems tends to be fragmented: it may be a responsibility of either (or both) health and social services, often provided by different levels of government.

In 2001, the World Health Organisation (WHO) published a report arguing that mental health – neglected for far too long – was crucial to the overall wellbeing of individuals, societies and countries. In 2005, the 52 member states of the WHO European Region endorsed a Declaration and Action Plan on mental health focused on tackling stigma, promoting positive mental health and preventing mental illness, offering and ensuring access to community-based services and establishing partnerships across sectors.

In 2005, the European Commission launched a Green Paper intended to stimulate the debate about possible EU action on mental health. The consultation took place in 2006 and its outcomes were the basis for drafting the European Pact for Mental Health and Well-being launched in 2008. In the Pact, the European institutions, Member States and different stakeholders make a commitment to action in the following areas:

1. Prevention of Depression and Suicide
2. Mental Health in Youth and Education
3. Mental Health in Older People
4. Combating Stigma and Social Exclusion
5. Mental Health in Workplace Settings

The Pact is mentioned (in passing) in the European Platform against Poverty and Social Exclusion, a ‘flagship initiative’ of the

Europe 2020 Strategy. This Strategy also includes targets to raise the employment rate in Europe and to lift 20 million people out of poverty and social exclusion. The goals of the Strategy overlap with several of the concerns raised in this report. Mental health, though not referenced specifically, may also be an issue for some people among the groups identified as being particularly ‘at risk of poverty and social exclusion’ such as unemployed young people and homeless people.

European action on mental health is intended to add value to mental health promotion and services in Member States. Across Europe, public sector responsibility for addressing the needs of people with mental health problems tends to be fragmented: it may be a responsibility of either (or both) health and social services provided by different levels of government.

The next section provides a brief overview of the national and regional policy and legal framework in different parts of Europe⁴, including efforts to promote partnership-working arrangements between the public sector and the wider community. In most cases people with mental health problems fall under the umbrella of ‘people with disabilities’, and their rights are covered under mainstream legislation: the national constitution, labour, and equality or anti-discrimination laws. In other cases, there

⁴ The eight countries covered are those which are represented in ESN’s working group on mental health.

are specific national and regional laws in which employment, for example, may be defined as a rehabilitation tool for people with mental health problems.

In Bulgaria, since 2003 a reform has been implemented in the field of social protection and social integration of people with mental health problems. The main priority has been deinstitutionalisation and the development of community-based social services to ensure a relatively independent life and promote social inclusion. Social services, day care centres for children and adults and sheltered housing are funded by the State and managed by municipalities who are allowed to provide direct services or contract them out.

In Denmark, public services for people with mental health problems are organised through health and social services. Hospital and district psychiatry falls under the Ministry of Interior and Health; psychiatric services and medical treatment are planned, regulated and provided by the regions. Social psychiatry is a responsibility of the Ministry of Social Affairs and is implemented by local authorities, either in their Disability or Health Units. Cooperation in service planning and delivery is based on formal and broad 'health agreements' between a region and the municipalities in its area.

In Germany, several institutions are responsible for funding social care, including health insurance, long-term care insurance, and the health departments of local authorities. Mental health services are provided by public, private and voluntary welfare organisations, such as hospitals specialising in psychiatry or with psychiatric units, psycho-social services, or community-based mental health services such as day centres run by welfare NGOs with support from the region and municipalities.

In Finland, the health care system is decentralised and organised at local level by municipalities, which are responsible for organising outpatient mental health care and rehabilitation services through primary health centres and social services. The Ministry of Social Affairs and Health is responsible for regulation and general planning of mental health services, and production of guidelines on issues such as supportive housing, drugs and alcohol. Despite the autonomy

of municipalities to arrange services, many adopt central government recommendations.

In England (UK), mental health services are mainly delivered through social care and health services 'hosted' by the local infrastructure of the National Health Service (NHS). A number of municipalities (counties and unitary authorities) have entered into legal agreements with local NHS trusts to take back direct management of social care staff and resources from the NHS. Legislation has been progressively revised to move towards an integrated model with an emphasis on the social determinants of mental health.

In Italy, health is a regional competence whilst social services are the responsibility of municipalities. Taking the example of the Veneto region, each local health authority has a mental health department that supports adults with mental health problems; those under 18 years old are referred to the Children's Unit, whilst the elderly (over 65) are referred to the Elderly Unit. However, if the person who has mental health problems is a drug addict, social services would be the responsible authority. The mental health department of the local health authority is responsible for all the health and social needs of an individual. For instance, if users have problems with jobs, housing, etc. the mental health department is able to help them through an integrated team composed of psychiatrists and social workers.

In Spain, health and social policies are decentralised and regions determine how health and social services should be organised. While in some regions the responsibilities of mental health services fall under two different regional public authorities, other autonomous regions have integrated health and social services in the same agency (for example, the Region of Castilla-La Mancha). Mental health services are part of the National Health System which is composed of the national government and the regional health care management bodies.

The picture varies across the countries participating in ESN's working group. Good co-ordination is one of the main challenges which will be addressed later in this report.



European action on mental health is intended to add value to mental health promotion and services in Member States.

Chapter 2

Tackling Stigma

Both public stigma and self-stigma can be a major barrier to social inclusion for people with a mental health problem and may represent an infringement of their human rights. Stigma can be experienced not only in everyday life but also within mental health services. Action should be taken to eliminate stigma by improving knowledge of mental health and changing the way it is perceived, not only by the general public but also by social and health professionals and even by people who themselves have a mental health problem. Tackling stigma is vital in order for recovery, active inclusion and mental health promotion to be as effective as possible.

2.1 Mental health in Europe

Mental health problems are experienced by approximately one in ten EU citizens at some point in their lives and, in many EU countries, depression is the most common health problem⁵. A 2006 Europe-wide study of 466 million people in 28 countries estimated that at least 21 million men and women were affected by depression each year⁶. Suicide represents a significant cause of death with about 55,000 Europeans⁷ taking their own lives each year, of which three quarters are men⁸. Mental ill health affects around 27% (83m.) of Europeans annually⁹.

It is also important to distinguish between mental illness and mental health. Mental illness points to a diagnosed clinical condition of the mind and incorporates disorders such as psychosis, schizophrenia or bipolar disorder. Mental health, meanwhile, is used in the sense of wellbeing: it is about functioning and health of the mind, covering happiness and resilience to life events. However, it is normal for people to experience negative psychological reactions to life events such as the emergence of physical illness, the acquisition of impairment, loss of a relative or an increase in work demands. In fact, many mental health difficulties occur at the same time and

act as a catalyst for more severe impacts on work and social life.

A mental health problem may occur at any age, and can undermine someone's capacity to function in society. While symptoms of mental health problems may lead to disability, damage to social networks or difficulties in developing vocational or interpersonal skills, the diagnosis of such problems may also have unwanted effects on the individual's social and functional capacity due to the stigma attached to mental health problems.

2.2 Dimensions of social stigma

In mental health, stigmatisation is a social process that can be defined as the development of a collection of negative attitudes, beliefs, thoughts or behaviours that develop to influence an individual or group to fear, avoid, or discriminate against people with mental health problems. Stigma can lead to a number of barriers to entering mental health treatment, since people with mental health problems may try to avoid the label 'mentally ill' and the association with mental health services¹⁰. Stigma comprises three related areas (ignorance, prejudice and discrimination) and two manifestations: public stigma (i.e. reaction that the public has against those with a mental health

⁵ Special Eurobarometer (2010) 345/Wave 73.2 Mental Health –TNS Opinion & Social.

⁶ Sobocki P., Jönsson B., Angst J. and Rehnberg C. (2006) Cost of Depression in Europe, *The Journal of Mental Health Policy and Economics* 9, 87-98.

⁷ Special Eurobarometer (2010) 345/Wave 73.2 Mental Health –TNS Opinion & Social.

⁸ European Communities (2008) European Pact for Mental Health and Well-being. Available online at: http://ec.europa.eu/health/archive/ph_determinants/life_style/mental/docs/pact_en.pdf

⁹ O'Sullivan C., Thornicroft G., Layte R., Burfeind C., McDaid D., Salize H.J., Daumerie N. and Caria A. (2010) Background document for the Thematic Conference on Promoting Social Inclusion and Combating Stigma for Better Mental Health and Well-being, Luxembourg: European Communities.

¹⁰ Corrigan P.W., Markowitz F.E. and Watson A.M. (2004) Structural levels of mental illness stigma and discrimination, *Schizophrenia Bulletin* 30(3), 481-491.

Stigma	Stereotype	Prejudice	Discrimination
	Lack of knowledge	Attitude	Behaviour
Public Stigma	Negative belief about a group (e.g. dangerousness, incompetence, character weakness)	Agreement with belief and/or negative emotional reaction (e.g. anger, fear)	Response to prejudice (e.g. avoidance, withhold employment and housing opportunities, withhold help)
Self Stigma	Negative belief about the self (e.g. character weakness, incompetence)	Agreement with belief, negative emotional reaction (e.g. low self-esteem, low self-efficacy)	Response to prejudice (e.g. fails to pursue work and housing opportunities)

Figure 1: Comparing and contrasting the definitions of public stigma and self-stigma using Corrigan's definitions¹¹.

problem and self-stigma (i.e. the prejudice people with a mental health problem have with themselves).

People with mental health problems are amongst the most excluded of all European citizens¹². Common ideas about madness, danger, violence or inability to cope occur with alarming regularity in the media and wider society¹³.

2.3 Users' personal experience of stigma

Stigma and discrimination may be present in society at large as well as structurally in health and social services. This structural discrimination may be due to the low political priority given to mental health, the absence of specific legislation or budgets for mental health¹⁴.

Mental health service users have spoken out about different life situations in which they felt they experienced individual discrimination from staff working in mental health services¹⁵. Mary Nettle, a mental health user consultant from the UK reported that "it could be difficult for people with mental health problems to get personal budgets because they are thought not to be competent to look after money".

Claire Barcham (ADASS, UK) added that people who are allocated a personal budget may want to spend their money on a support dog, massage or membership of a club rather than on traditional services, such as a day centre. Lise Jul Pedersen, from the Danish National Users' Movement, argues that education is vital: "I think it is necessary

to change the way professionals think before they actually start treating people with mental health problems".

Whether it is experienced in everyday life or in mental health services, stigma may represent a violation of the human rights of people with mental health problems under various national and international laws. The UN Convention on the Rights of Persons with Disabilities¹⁶, for example, enshrines the right to: "equal recognition before the law" and to "living independently and being included in the community".

2.4 Tackling stigma in practice: the region of Castilla-La Mancha (Spain)

"Activities to combat stigma must be coordinated, with key indicators and clear evaluation and with the participation of different institutions and social agents."

Marta Nieto and Susana Garcia Heras, Health and Social Foundation of Castilla-La Mancha, Spain.

"We need to encourage the participation of people with mental illness in the design, planning, implementation and evaluation of strategies against stigma."

Antje Welke, Department for Old Age, Nursing Care, Rehabilitation and Health, German Association for Public and Private Welfare.

Given these concerns, what are the strategies that should be undertaken to fight stigma and guarantee the full social inclusion and participation of people with mental health problems?

In the experience of ESN's mental health

¹¹ Corrigan P.W. and Watson A.C. (2002) Understanding the impact of stigma on people with mental illness, *World Psychiatry* 1(1), 16-20.

¹² Grammenos S. European Foundation for the Improvement of Living and Working Conditions (2003) *Illness, disability and social inclusion*, Luxembourg: European Communities. Available online at: <http://www.eurofound.eu.int/publications/EF0335.htm>

¹³ Sayce L. and Curran C. (2007) Tackling social exclusion across Europe in *Mental health policy and practice across Europe*, Open University Press, World Health Organization on behalf of the European Observatory on Health Systems and Policies.

¹⁴ WHO (2005) End human rights violations against people with mental health disorders, Geneva. Available online at: <http://www.who.int/mediacentre/news/releases/2005/pr68/en/>

¹⁵ ESN (2010) Implementing local personalised services: recovery from a professional and user's perspective, ESN workshop at the European Pact conference Promoting Social Inclusion and Combating Stigma for Better Mental Health and Well-being, 8 November 2010, Lisbon.

¹⁶ UN General Assembly, Convention on the Rights of Persons with Disabilities (2007) Resolution adopted by the General Assembly, 24 January 2007, A/RES/61/106. Available online at: <http://www.unhcr.org/refworld/docid/45f973632.html>

working group, actions to prevent and fight stigma should have at least three objectives:

- To improve the knowledge of mental disorders; their causes, treatments, diagnosis, etc.
- To change negative attitudes to mental illnesses and people with mental health problems and promote positive attitudes and images.
- To end structural discrimination in mental health.

The Region of Castilla-La Mancha, for example, has designed a strategy divided into different actions according to target groups:

- People with mental health problems and their families: Promoting participation and empowerment through peer support and psychological interventions on self-stigma.
- Health professionals and health services: As health and social care professionals may be a source of stigmatization,

strategies on education, information and training are recommended. Mental health and social services should be oriented towards a recovery approach.

- Mass media: Protest against the media using misleading information about mental illness (treatment, causes, and effects) and developing guidelines for journalists may modify how mass media inform about ill mental health. Mass media may be a source of positive images of people with mental health problems. Specific campaigns may be developed and evaluated.
- Labour market: Supported employment programmes, adaptation of the labour context to characteristics and needs of people with mental health problems, specific strategies for mental health awareness, fiscal and social benefits for employers.
- Education: activities to promote positive mental health and information about mental health problems, promoting the acceptance of diversity in schools.



Stigma can be experienced not only in everyday life but also within mental health services.

Chapter 3

Recovery: A Person-centred Approach

The experiences of contemporary practice in various European countries show how social and health services have moved towards a person-centred approach focused on recovery. They reveal some of the continuing challenges of putting service users first and integrating social and health services provided by different public, voluntary and private agencies. Practice examples also underline the importance of tackling stigma in order for a person's recovery to be successful.

3.1 Defining a person-centred approach

Across Europe, there is a growing movement towards person-centred services, which combine personalisation, choice and user participation. This contrasts with the traditional public services model that positions users as passive recipients of services designed and delivered by professionals.

In personalisation, the aim is that each person may be able to organise the services they need around themselves and be considered as an individual with assets. This carries with it an element of choice in what types of services a person wishes to use and how. It also pre-supposes user participation (both of user groups and of individuals in their own cases) in that users should participate in service design in order that services respond to their actual needs, rather than perceived needs and preferences. In person-centred services, the focus is placed on the strengths and resources of service users, rather than on their mental health problem(s).

However, this does not mean an abdication of professional responsibility: professionals still need to be there both to provide appropriate services and (at least in an ideal situation) to advise and guide service users in their choices and enable them to achieve their personal goals, for example in education, family, community and working life.

Since the 1960s, the user movement has advocated for services to respect their

dignity and promote their independence. They have worked alongside professionals towards introducing the recovery approach as a means to improve their quality of life¹⁷. Users have been involved in service design and delivery in various ways: through consultation on service (re)design; training and education of staff within services; user-led research; by creating, designing and running peer-led services; and consequently providing new understandings of mental illness and poor mental health. However, moving towards greater user involvement has not been without its tensions for other stakeholders, for whom it may have entailed a decline in influence. Whilst there have been great improvements in the involvement of service users as a group and as individuals, there is still a long way to go.

“A person-centred approach is about moving from the provision of services based solely on professional expertise to one in which services are co-produced alongside citizens.”

Lucy Butler, Mental Health, Drugs and Alcohol Policy Network, Association of Directors of Adult Social Services (ADASS), UK.

3.2 Understanding recovery

Recovery promotes the expectation that people using services can and want to take as much control as possible over their own lives. It can be seen as a journey somebody with a mental health problem makes towards a better quality of life. For Marianne Cohen,

¹⁷ Lise Jul Pedersen (6/6/11), Danish National Users' Movement, e-mail interview with ESN.

Head of Recovery DK, the recovery-oriented approach represents a “challenge to the system”. In the words of former service user, Lise Jul Pedersen, “it is important that social services change the focus of their work to users’ needs and wishes in life: users want to be helped to regain a valued role in society”.

“Users want to be helped to regain a valued role in society.”

Lise Jul Pedersen, former service user, Denmark.

Recovery-oriented mental health services are built on two facts. First, not all mental health problems are chronic. In the past years, research has shown that well over half of the people with serious mental health problems (for example, schizophrenia) can enjoy a good quality of life, with few or no traces of their illness remaining¹⁸. Second, people with the best chance to ‘recover’ are those with a strong motivation to change their lives. This motivation can often be conditioned by whether those around them are committed – in attitude and in practice – to support people’s personal ambitions and hopes for a better life¹⁹.

The recovery star (see Figure 2) is a tool that allows professionals and users together to evaluate the various aspects of a person’s life and their progress towards wellbeing.

In recovery, all social, health and education professionals working with a service user should be able to relate to his/her hopes and dreams and recognise his/her resources and potential. Indeed, many users say that a turning point for them was meeting someone – whether a professional or another user – who was willing to share their own experiences of mental health problems²¹.

For Marianne Farkas, a researcher at the Boston Centre for Psychiatric Rehabilitation, “a recovery-oriented approach is necessary but not sufficient; because if job opportunities, access to higher education and bank loans are not created, somebody may have all the interpersonal connections, but would still not be able to achieve the meaningful life they want. How many people... have jobs, go back to school, and have decent housing?”²². This is a reminder that it is necessary to tackle stigma across the whole of society in order for recovery to be successful.

3.3 Recovery in practice: the experience in Aarhus (Denmark)

“A professional should have the personal skills to be able to show empathy and connect with the individual together with professional knowledge about diagnoses, rights implementation, etc.”

Marianne Cohen (Recovery DK).

Recovery made new and significant demands on the way social services were organised in the City of Aarhus as well as on staff qualifications. In its Department of Social Psychiatry, recovery begins with an initial evaluation in which the user and a team of professionals summarise the situation and draft a realistic action plan, which may include medical and/or psychiatric treatment, education, employment and social initiatives²³. A personal coordinator would support the user to follow the action plan and access the different services. The services may be provided by various agencies brought together in one organisation – called ‘local psychiatry’.

The Aarhus experience shows that a personal coordinator can make a very positive contribution to the procurement of treatment, and to the continuity of support in line with the recovery action plan. Furthermore, the coordinator helps reduce case management work time by the different professionals involved. Overall, coordination between different actors is believed to be a key factor in improving users’ quality of life²⁴.

Sharing personal experiences is valuable and many people find that meeting with other users, who have often had many similar experiences, is an important part of their recovery; this is known as Peer Support²⁵ and is also available in Aarhus. However, users also recognise that this is not always a straightforward experience since some mental health problems make it difficult for people to relate to others.

Redesigning services to focus on recovery has produced positive results in Aarhus, as can be seen from Figure 3, which illustrates the development in users’ quality of life and satisfaction with services. Following this evaluation, recovery was embedded more widely across the Directorate of Social Services.

¹⁸ Harding C.M., Brooks G.W., Ashikaga T., Strauss J.S. and Breier A. (1987) The Vermont longitudinal study of persons with severe mental illness, I: Methodology study sample and overall status 32 years later, *American Journal of Psychiatry* 144, 718-726.

¹⁹ Topor A. (2004) *Fra patient til person* (‘From patient to person’), Akademisk Forlag (Academic Publishers), 1. Udgave (First edition).

²⁰ Mental Health Providers Forum, Recovery Star Approach. Available online at: <http://www.mhpf.org.uk/recovery/StarApproach.asp>

²¹ Topor A. (2002) *Vendepunkter* (‘Turning points’), Videnscenter for Socialpsykiatri (Centre of Knowledge on Social Psychiatry), 1. Udgave (First edition).

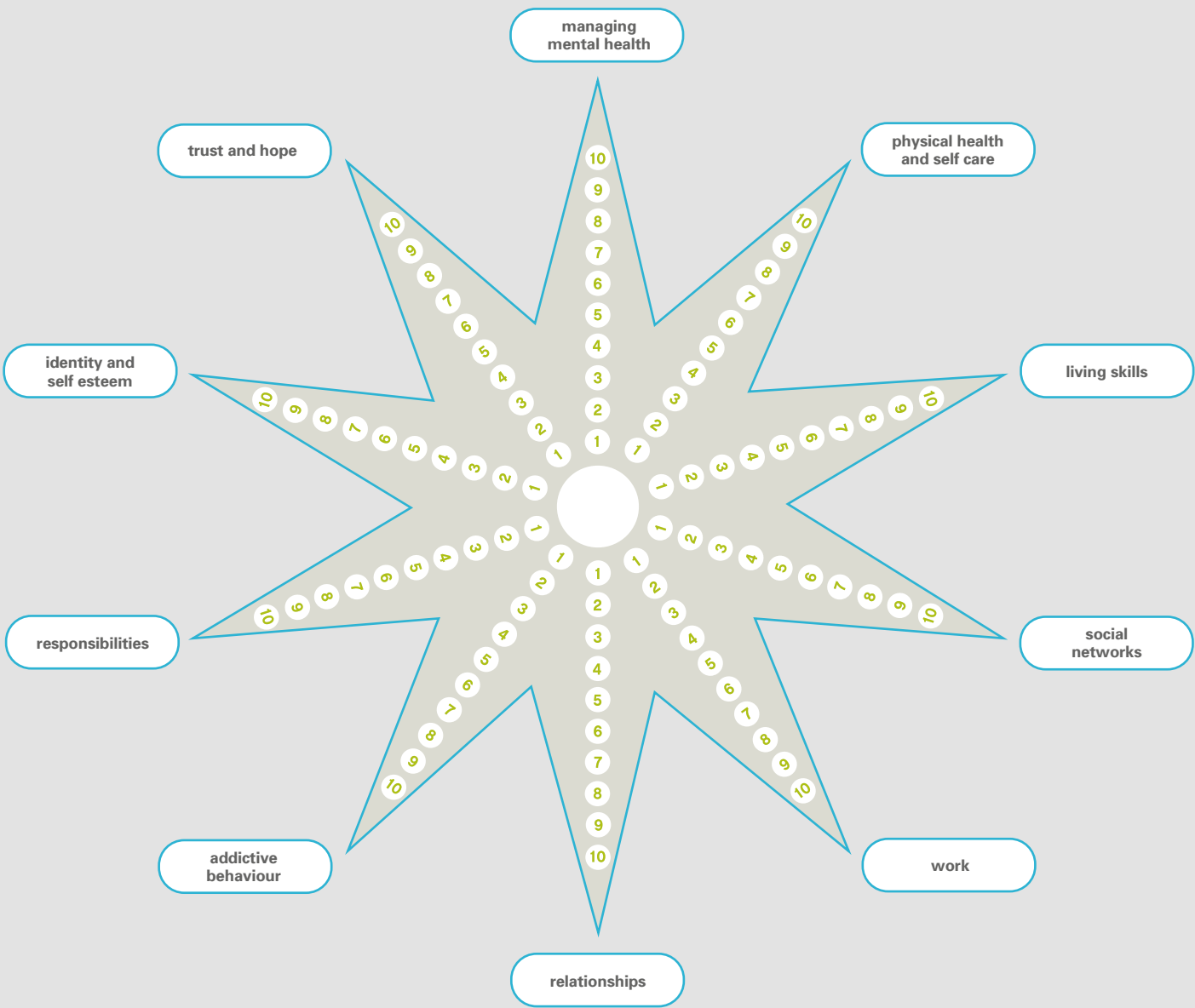
²² Farkas M., Interview conducted by Lise Jul Pedersen, Danish users’ movement. Available online at: <http://www.youtube.com/watch?v=wZUYn6c0EDw&feature=related>. This interview is part of a DVD provided for training purposes to social services staff at the Municipality of Aarhus, Denmark.

²³ Wilken J. P. and Hollander D. (2005) *Rehabilitation and Recovery: a comprehensive Approach*, SWP Publishers Amsterdam.

²⁴ Vanderplasschen W. (2004) *The Development and Implementation of Case Management for Substance Use Disorders in North America and Europe*, *Psychiatric Service* 55(8), 913-922.

²⁵ For further information, please visit The International Community for Hearing Voices. Available online at: <http://www.intervoiceonline.org/>

Figure 2: Recovery Star–Core dimensions of Recovery.²⁰



Recovery Star © Mental Health Providers Forum and Triangle Consulting Social Enterprise Ltd.
Developed by Joy MacKeith and Sara Burns of Triangle Consulting with the Mental Health Providers Forum. Second edition revisions by Sara Burns, Onyemaechi Imonioro and Joy MacKeith.
www.outcomesstar.org.uk
www.mhpf.org.uk

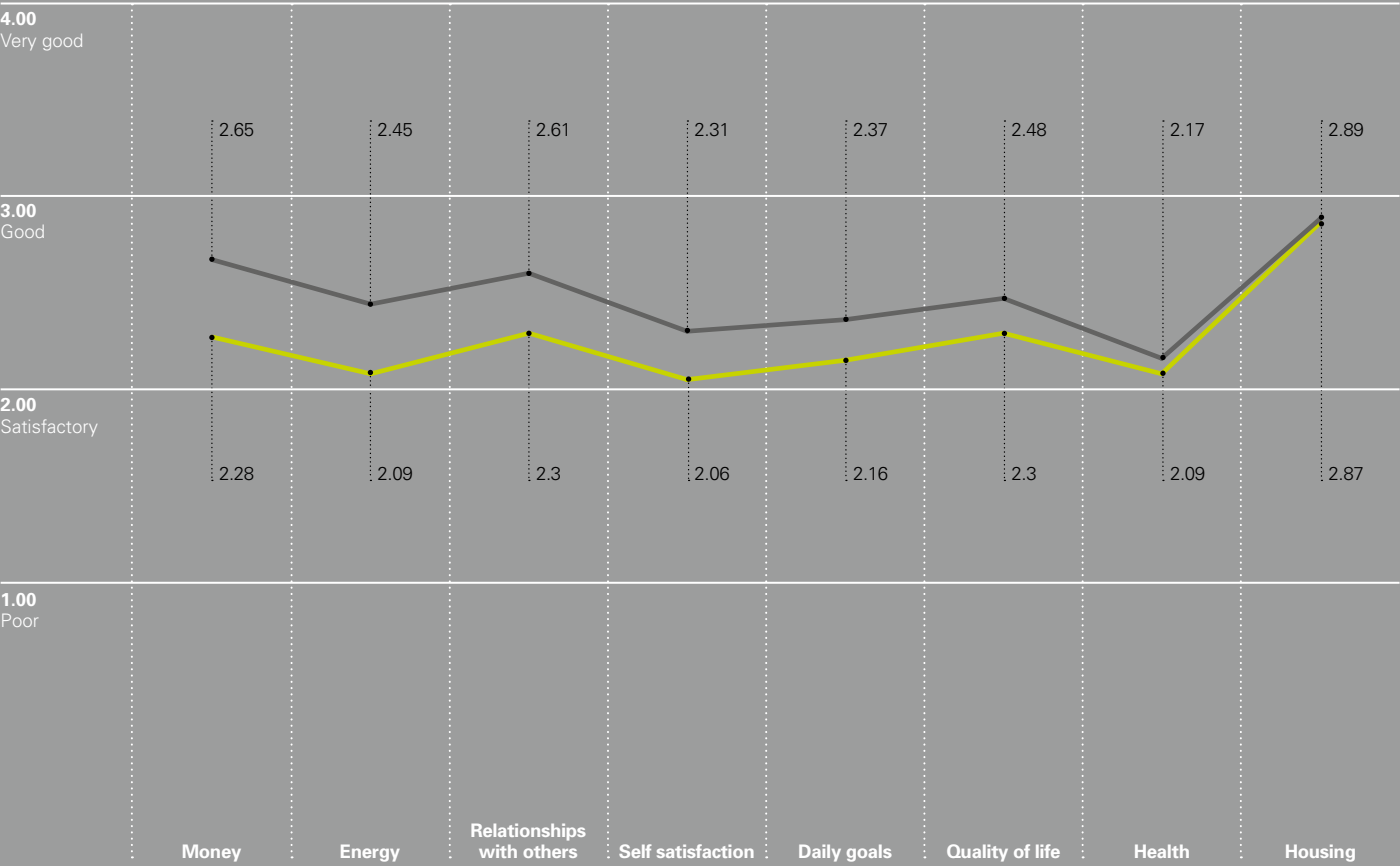
Figure 3: Users' Improvement in their Quality of Life (WHO index) from 2007-2009 in Aarhus, Denmark.

User Survey 2009

User Survey 2007

Survey questions

- Have you had enough money to meet your needs over the past two weeks?
- Have you had enough energy to accomplish everyday tasks in the past two weeks?
- How satisfied have you been with your relationships with other people in the past two weeks?
- How satisfied have you been with yourself in the past two weeks?
- How satisfied have you been with your skills to carry out daily tasks in the past two weeks?
- How would you rate your quality of life?
- How satisfied are you with your health?
- How satisfied have you been with your housing situation in the past two weeks?



3.4 Recovery in practice: the experiences from Ireland

“Cooperation between health and other sectors in the delivery of mental health services [...] has historically been ad-hoc. Now we want to ensure it becomes systematic.”

Eithne O'Donnell and Terry Madden, Dublin City Council, Ireland.

A number of projects in Ireland have sought to promote cooperation between community stakeholders to deliver better outcomes for users. PROTECT (Personalised Recovery-Oriented Treatment, Education and Cognitive Therapy)²⁶ is a partnership initiative in County Wicklow to develop personal recovery plans for all people diagnosed with a psychotic illness. It is delivered by a partnership of:

- the Health Service Executive's (HSE) mental health services
- the DETECT service providing early intervention for people with first-episode psychosis and their families
- SHINE, a voluntary organisation
- Wicklow County Council providing social housing
- Employers' Services
- New Dawn (E.V.E. Ltd Eastern Vocational Enterprises)

The partners provide a range of person-centred and recovery-oriented services in the community. This is an example of collaboration between service users and service providers to achieve better outcomes for people with mental health problems.

St. Brendan's Psychiatric Hospital in Dublin provides another example of cooperation between mental health and other services: here, psychiatric and community mental health services operate through multidisciplinary teams composed of consultants, psychologists, occupational therapists, nurses and social workers. The service includes emergency accommodation units for homeless people experiencing mental health problems and users in rehabilitation. For older persons with mental health problems, a number of places in nursing homes are available.

The hospital's rehabilitation service is

community-oriented: social workers use 'Wellness & Recovery Action Plan'²⁷ (WRAP) projects, which provide a systematic, planned approach to assist people in recovering and maintaining 'wellness'. WRAP is a tool for the professionals – mental health social workers, occupational therapists and mental health nurses working in rehabilitation and in the community – to give control back to the patient. It is most often used in rehabilitation services offered by mental health social workers and other professionals at the hospital.

Professionals on the ground recognise the need for a multi-dimensional approach to working with people with mental health difficulties. Local co-operation in many parts of the country works because of the commitment of the different professionals to work together. However, Eithne O'Donnell and Terry Madden underline that “bureaucracy is a continuing issue and there needs to be a commitment at government level to the person-centred approach and a realisation that people with mental health problems have diverse needs”.



²⁶ Further information about this project is available online at: <http://www.hse.ie>

²⁷ Further information about WRAP is available online at: <http://www.imhrec.ie/recovery-wrap/>

Chapter 4

Active Inclusion in the Labour Market²⁸

People with mental health problems who are in employment have a better chance of making a recovery. However, employment rates of people with mental health problems are generally low. National governments and the EU have therefore developed legislative and policy frameworks to promote access to employment by preventing discrimination and providing specific support to help people with a mental health problem into employment.

4.1 Understanding employment trends

"Everyone has a need to use their abilities and society needs everybody to contribute. The challenge is to match the two."

Anders Møller Jensen, Former Director of Social and Psychiatric Services, Denmark.

Working life is one important way for people to feel included in society. Besides allowing people to earn money, work provides non-economic benefits²⁹, including identity and status, social contacts, and a sense of personal achievement. Work can give people with mental health problems opportunities to participate in society. Service users, families and professionals consider it an important element of recovery³⁰.

Although the proportion of people who recover tends to rise proportionally with their rate of employment³¹, employment rates amongst people with mental health problems are generally low. There are various reasons why it is difficult to provide data about the (un)employment rates of people with mental health problems. The breakdown of employment statistics by health status or disability is not often available. Furthermore, people with a long-term illness may be considered economically inactive rather than unemployed and may therefore be entitled to a disability benefit instead of unemployment benefit.

Employment rates also vary greatly

according to impairment: a UK study³² found that those experiencing serious mental disorders such as schizophrenia, bi-polar disorder and severe personality disorder were associated with significantly lower employment rates³³. In Poland, the employment rate for people with disabilities was 14% compared with 51% for the general population (no breakdown by disability category was available)³⁴. Bearing in mind the difficulties of reliable data and the variability in employment rates according to specific conditions, most countries have employment rates of between 20% and 30% (see Figure 4).

Most users (70-90%)³⁶ with severe mental health illnesses want to work in jobs for which any person can apply, in regular places of business, paying at least the minimum wage with mostly non-disabled co-workers³⁷. Fewer people with mental health problems than with physical disabilities are able to find satisfying work. However, both groups would have to overcome stigma and discrimination, which are not only found in public opinion and sometimes their own families but also among mental health professionals, who may see unemployment as an inevitable consequence of mental illness.

4.2 Legislative and policy framework

European and national policy and legislation is not specific to mental health, but refers to disability in general, despite the fact that

²⁸ Disclaimer: Since in most cases there is no specific legislation for people with mental health problems, this chapter refers to 'people with disabilities' where appropriate.

²⁹ Boardman J., Grove B., Perkins R. and Shepherd G. (2003) Work and employment for people with psychiatric disabilities, *British Journal of Psychiatry* 182, 467-468.

³⁰ Bond G.R. (2004) Supported Employment: Evidence for an Evidence-Based Practice, *Psychiatric Rehabilitation Journal* 27, 345-359.

³¹ Topor A. (2004) Fra patient til person ('From patient to person'), Akademisk Forlag (Academic Publishers), 1. Udgave (First edition).

³² Marwaha S., Johnson S., Bebbington P., Stafford M., Angermeyer M.C., Brugha T., Azorin J.M., Kilian R., Hansen K. and Toumi M. (2007) Rates and correlates of employment in people with schizophrenia in the UK, France and Germany, *British Journal of Psychiatry* 191, 307.

³³ Perkins R. and Rinaldi M. (2002) Unemployment rates among patients with long-term mental health problems. A decade of rising unemployment, *Psychiatric Bulletin*, 26, 295-298.

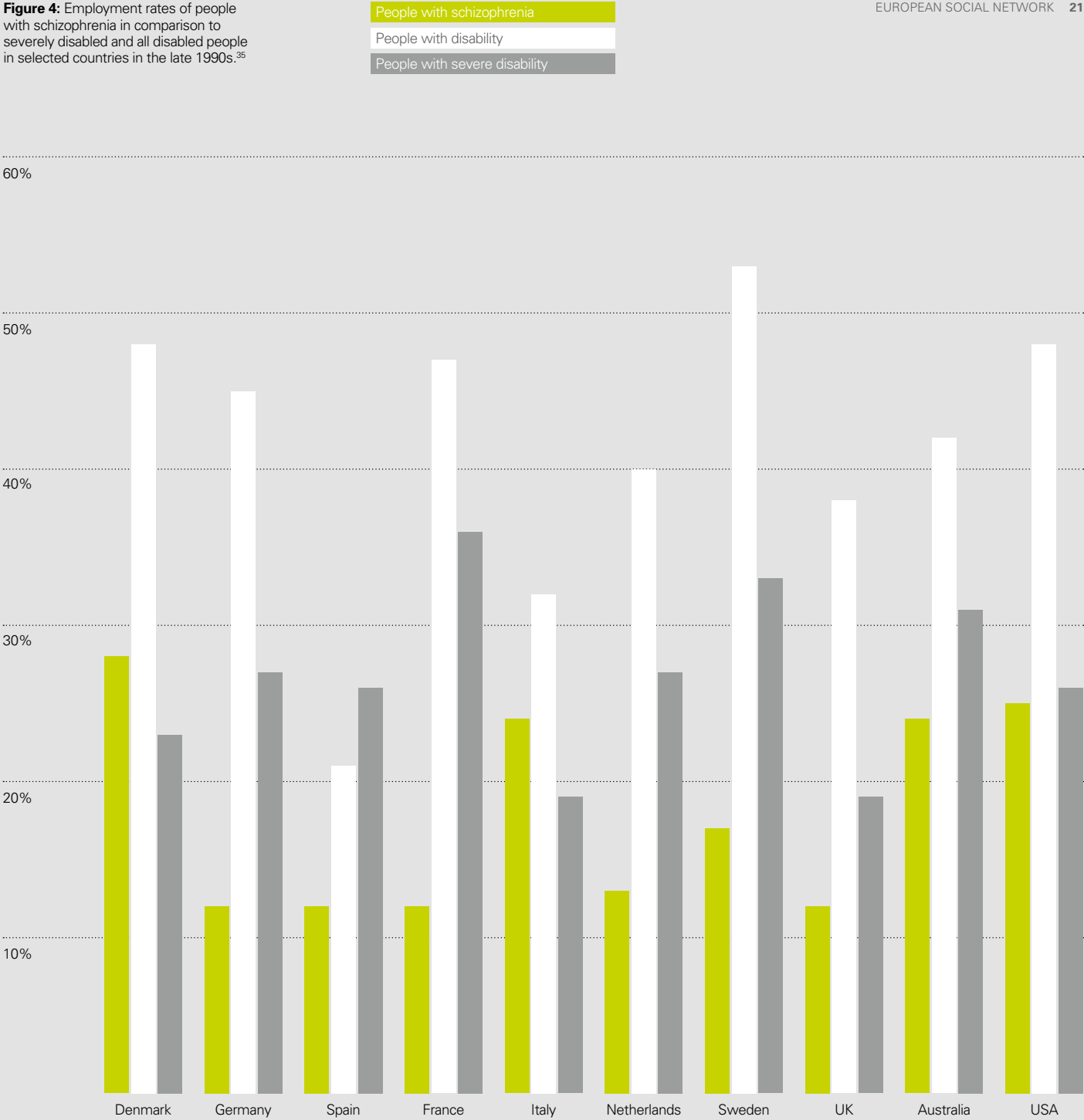
³⁴ Further information is available online at: http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_is_labour_force_survey_IIIq_2009.pdf

³⁵ McDaid D., Knapp M., Medeiros H. and the MHEEN Group (2008) Employment and mental health: Assessing the economic impact and the case for intervention, PSSRU, LSE.

³⁶ Bond G.R., Becker D.R., Drake R.E., Rapp C.A., Meisler N., Lehman A.F., Bell M.D. and Blyler C.R. (2001) Implementing supported employment as an evidence based practice, *Psychiatric Services* 52, 313-322.

³⁷ Dixon L., Hoch J., Clark R., Bebout R., Drake R., McHugo G. and Becker D. (2002) Cost-effectiveness of two vocational rehabilitation programs for persons with severe mental illness, *Psychiatric Services* 53(9), 1118-1124.

Figure 4: Employment rates of people with schizophrenia in comparison to severely disabled and all disabled people in selected countries in the late 1990s.³⁵



people with disabilities are a diverse group of people who may face different barriers to employment.

At EU level, the rights of disabled people in the labour market are promoted through the 2000 Employment Framework Directive³⁸. Its purpose is to improve employment opportunities through the principle of equal treatment, i.e. to prohibit employers from taking matters related to an individual's disability into account when those matters are irrelevant to their ability to perform the job.

In order to implement this principle, the Directive relies primarily on the prohibition of direct and indirect discrimination. Direct discrimination is defined as treating an individual "less favourably" on grounds of disability, implying a comparison with another individual that received better treatment. Indirect discrimination prohibits an employer from adopting what may appear a neutral provision or practice but in reality "put[s] persons with a particular disability at a particular disadvantage compared with other persons".

Employers often focus on the disability rather than an individual's ability to perform the job, and may therefore conclude that he/she is unsuitable for the post. The Directive places a duty on employers to provide "reasonable accommodations to enable a person with a disability to have access to, participate in, or advance in employment, or to undergo training, unless such measures would impose a disproportionate burden on the employer".

This ambition behind the legislation was recently reinforced by Council conclusions on the European Pact for Mental Health and Well-being (June 2011), which invite Member States to take measures against the discrimination of people with mental health problems and promote their access to work.

In 2008, the Commission published specific policy guidance for Member States on the 'active inclusion of people excluded from the labour market'³⁹. This recommends an integrated and comprehensive strategy with three strands: sufficient income support; inclusive labour markets; and access to quality services. Raising employment rates in general is a major

aim of the Europe 2020 Strategy – in the Strategy, disability in general is recognised but not specifically mental health.

At a national level, the rights of people with mental health problems are covered under mainstream legislation: the national constitution, labour, equality or anti-discrimination laws (which may have derived partly from European legislation). In some countries, there are specific national and regional laws in which employment may be defined as a rehabilitation tool.

In Bulgaria, Art. 48 of the Constitution recognizes that "all citizens have the right to work and that the State must take care of creating the conditions for realization of this right". Therefore, people with a disability should be enabled to exercise their human right to work. The Ministry of Labour and Social Policy passed an order in January 2011 by which a "National Programme for training and improved employment of people with permanent disabilities" was set up⁴⁰.

In Ireland, the 1998 Employment Equality Act and the 2005 Disability Act provide the legislative framework to facilitate the equal treatment of people with disabilities. According to legislation, it is illegal to discriminate on grounds of disability in employment. The Disability Act 2005 (part 5) states that public sector organisations are obliged to promote and support the employment of people with disability and achieve a statutory minimum 3% target of staff with disability.

Likewise, in the UK, the 2010 Equality Act makes it illegal to discriminate on the basis of a range of 'protected characteristics' including disability (i.e. mental ill-health) and places a duty on services to make 'reasonable adjustments' to support access to work⁴¹. More recently, the Equality Act (2010) makes it illegal to ask questions about health/impairment before making a job offer⁴².

In Finland and Denmark, there are no preferential employment policies for people with mental health problems, and they are covered under mainstream legislation. However, special services such as vocational rehabilitation and training are provided to enhance the employment opportunities for persons with mental health problems.

³⁸ Council of the European Union (2000) Council Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation, Official Journal L 303, 02/12/2000 P. 0016-0022.

³⁹ European Commission (2008) Commission Recommendation of 3 October 2008 on the active inclusion of people excluded from the labour market (2008/867/EC). Available online at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:307:0011:0014:EN:PDF>

⁴⁰ Further information about this programme is available online at: <http://www.az.government.bg/Projecys/Prog/HU/Uvrej.htm>

⁴¹ Further information is available online at the Equality and Human Rights Commission website: <http://www.equalityhumanrights.com/advice-and-guidance/guidance-for-employers/the-duty-to-make-reasonable-adjustments-for-disabled-people/>

⁴² Ibid.

In Germany, the Federal Employment Agency offers psycho-social services to companies and compensates them for the reduced output of employees with a disability. Various other (local and regional) provisions aim to foster the inclusion of people with disabilities into the labour market, such as sheltered workshops and 'integration companies' in which 25-50% of employees are people with disabilities.

In Spain, measures facilitating access to employment for people with mental health problems are addressed in the field of disability. The constitution recognises the government's role in establishing policies of prevention, treatment, rehabilitation and integration of those with physical, sensory and mental health problems. For public and private companies with over 50 employees, national legislation⁴³ requires that 2% of workers are people with disabilities. Special Employment Centres were set up to secure meaningful employment for people with disabilities and fulfil the personal and social needs they may have. In addition, further legislation⁴⁴ recognised supported employment as a step towards competitive employment.

In Italy, both national and regional legislation aims at building support tools to employ people with disabilities. National legislation states that 7% of a company's workforce must be people with a disability level of 46%⁴⁵. In addition, national legislation defines how Local Health Areas (LHA) can work to select, train and help people to be employed. National and regional legislation⁴⁶ establishes the creation in every LHA of Work Integration Services which train people for employment. Finally, companies are entitled to have a relief in insurance payments and other taxes.

4.3 Contemporary approaches to active inclusion

As can be seen from the examples above, legislation and policy across the EU commit health, social and employment services to help people with mental health problems find employment. The various programmes tend to be categorised as either 'train then place' or 'place then train' models. They encompass different degrees

of care and support and may be based on agreements between local health, social and employment services and other service providers.

Traditional vocational schemes are called 'train then place' models, which assume that people require a period of preparation before entering into competitive employment; a clinical assessment evaluates workplaces and time schedules. Sheltered employment is a well-established 'train then place' model, in which pre-vocational training is paid less than the minimum wage or there may be no wage at all. These schemes have been largely unsuccessful in helping people with severe mental illnesses to move on to competitive employment⁴⁷. More recent approaches based on recovery are called 'place then train' models, such as 'individual Placement and Support' (IPS). This involves placing someone in competitive employment and providing on-the-job support. IPS programmes have been found to be more effective than 'train then place' models at helping people with severe mental illness to obtain and keep competitive employment⁴⁸.

Improving employment rates among people suffering from poor mental health is not only a matter for anti-discrimination legislation or public employment services, but also for the benefits system (in terms of returning to work without losing benefits) and people themselves (managing their mental health and working life). In order to change this, in Sweden, systems have introduced 'part-time' sick notes, which make it more economically viable to work part time than to be sick full time. In the UK, 'wellness' certificates specifying what a claimant can do in relation to work (rather than what they cannot do) are being introduced.

The impact of work on other aspects of the lives of people with mental health problems remains largely unexplored in research. Some studies have found a reduction in the utilisation of health services which may reflect an overall health improvement⁴⁹. Research has also found that competitive employment produces higher rates of improvement in people's health symptoms than other work programmes⁵⁰.

⁴³ Law 13/1982, of April 7.

⁴⁴ Royal Decree 870/2007, of July 2.

⁴⁵ Legge 68 March 12 1999 "Norme per il diritto al lavoro dei disabili" (*Law for work rights of disabled people*).

⁴⁶ Legge November 8 2000, n. 328 "Legge quadro per la realizzazione del sistema integrato di interventi e servizi sociali" (*Legislative framework for an integrated system of social services*), DGR n. 1138 del 6 maggio 2008, "Linee guida per il funzionamento del Servizio per l'Integrazione Lavorativa (SIL) delle Aziende ULSS del Veneto" (*Guidelines for the operation of the labour market integration services of the local health units*).

⁴⁷ Boardman J. (2003) Work, employment and psychiatric disability, *Advances in Psychiatric Treatment* 9, 327-334.

⁴⁸ Boardman J., Grove B., Perkins R. and Shepherd G. (2003) Work and employment for people with psychiatric disabilities, *British Journal of Psychiatry* 182, 467-468.

⁴⁹ Jackson Y., Kelland J., Cosco T.D., McNeil D.C. and Reddon J.R. (2009) Non-vocational outcomes of vocational rehabilitation: reduction in health services utilization, *Work* 33(4), 381-387.

⁵⁰ Bond G.R., Resnick S.G., Drake R.E., Xie H., McHugo G.J. and Bebout R.R. (2001) Does competitive employment improve non-vocational outcomes for people with severe mental illness?, *Journal of Consulting and Clinical Psychology* 69(3), 489-501.

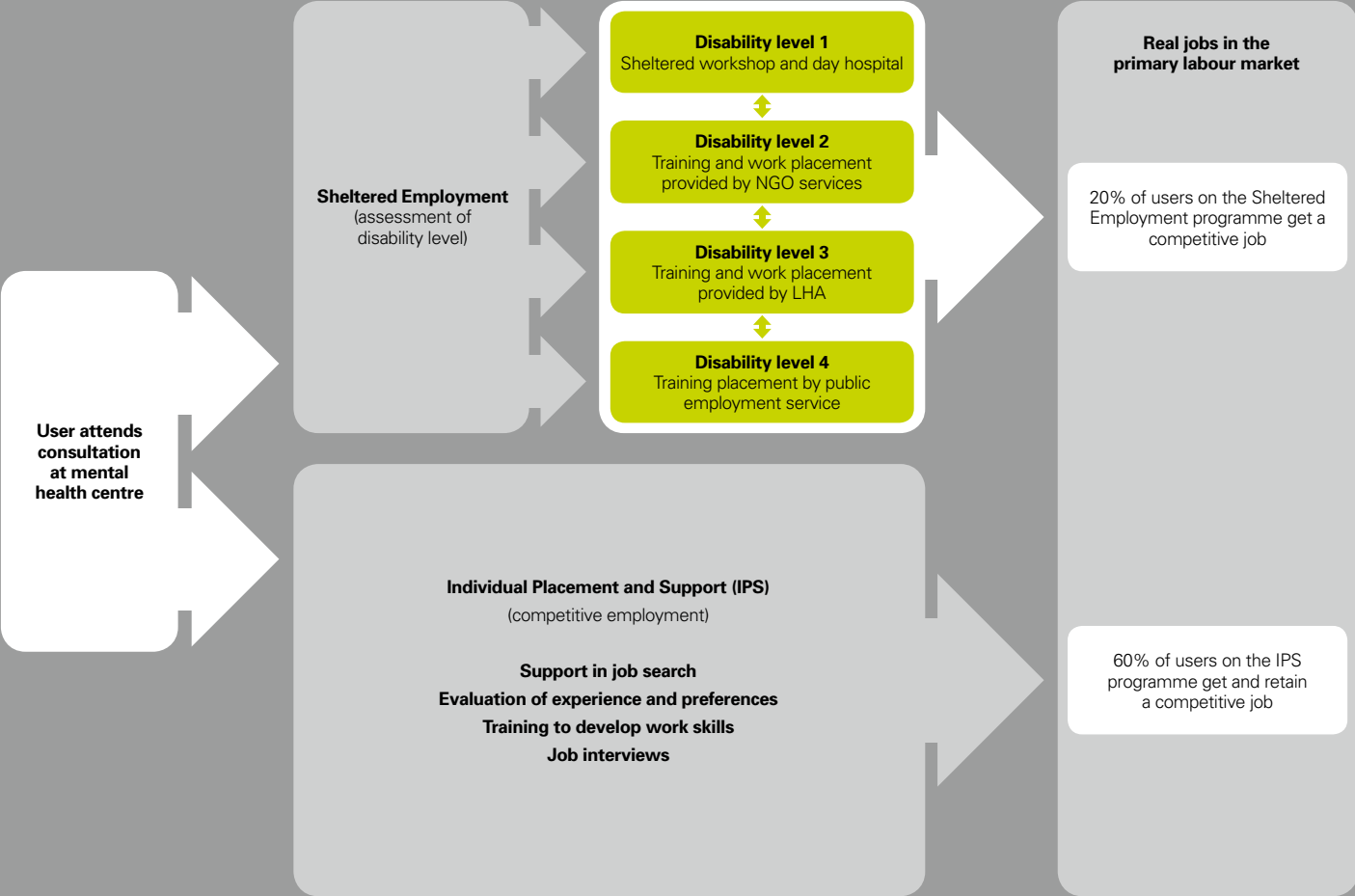


Figure 5: The pathway to competitive employment in Treviso.

‘Sheltered Employment’ or ‘Individual Placement and Support’ is used in Treviso depending on a user’s particular situation, needs and preferences. It is intended that users progress through the different types of activity towards an ‘ordinary’ job, i.e. competitive employment.

4.4 Active inclusion in practice: the example of Treviso (Italy)

There are two types of work programme available in Treviso: 'Sheltered Employment' or 'Individual Placement and Support', depending on a user's particular situation, needs and preferences (See Figure 5).

In sheltered employment, the process of getting a job begins with an assessment of illness and work history. It may result in a 'certificate of disability' which entitles the person to certain social security benefits and to specialist services provided by the mental health centre of the local health authority (ULSS). The 'certificate of disability' gives someone a 'disability and shelter level', which in turn indicates what type of services they are likely to need and what their pathway to work might involve.

People with a high disability level usually go to day hospitals (costs unknown) or to services provided by NGOs (at a cost of €8000 per person per year). Those with a lower disability level are supported by the local health authority's (LHA) work integration service (€2500 per person per year) or the public employment services (€4500 per person per year) to seek a job in the primary labour market. The LHA's mental health services continue to monitor a person's progress to see if they could move to a different level of service or into the primary labour market.

As an alternative, the service user may express a preference for Individual Placement and Support (IPS), in which he/she meets one-on-one with an employment specialist to seek a job based on his/her preferences, skills and experiences. In this case, there is no clinical assessment or certificate of disability. The user determines possible jobs and employers, and the final goal is competitive employment. There is no training stage before employment. All users are encouraged to consider competitive employment. According to the LHA evaluations in Treviso, IPS has shown better results (60% success rate) in employment than the traditional sheltered employment (20%).

4.5 Active inclusion in practice: the UK government programme 2008-11

In 2008, over 3 million adults of working age were not in work and receiving incapacity benefits in the UK, and poor mental health was a significant reason. The government introduced 'Pathways to Work', a special programme focusing on those who had been receiving incapacity benefits for over a year⁵¹.

For a person with mental health problems, the 'pathway' might begin with a community psychiatric nurse or psychiatrist, who encourages him/her to consider returning to work. A medical assessment identifies what he/she can do, rather than what he/she cannot do. Next, the user drafts an individual action plan with a personal advisor setting out his/her needs and circumstances, barriers, capabilities, experience, aptitudes and aspirations.

Once the action plan is agreed, the personal advisor refers the user to partner organisations for work-related training and helps develop skills in managing their condition⁵² and in other supportive measures such as debt advice. Once the user is 'work-ready', he/she can participate in site visits to employers, get a work trial, complete an apprenticeship and start a job. He/she will be offered in-work support for a period of up to 13 weeks and in case of failure can return to any earlier step on the pathway.

The user is regularly consulted and can review the action plan with the personal advisor. This gives a sense of ownership and responsibility. It may draw on the services of health care professionals, social services, employment offices, third sector and employers. As in the practice examples described in the previous chapter, this programme is seen as part of the process of 'recovery'.

⁵¹ Pathways to Work came to a close in April 2011 and a new programme – Get Britain Working – is being phased in from summer 2011.

⁵² The Condition Management Programme (CMP) is a short programme (approx. 4-16 sessions in length) aimed at helping participants to understand and manage their health condition or disability. Further information is available online at: http://library.nhsggc.org.uk/mediaAssets/Leaflets/nhsggc_leaflet_condition_management_programme_leaflet.pdf

Chapter 5

Investing in Mental Wellbeing in the Workplace

The economic and social costs of poor mental health and wellbeing were already well-known, but only lately has the case for investment been made so strongly. Workplace wellbeing strategies with several components (including mental health) have been shown to produce better results than individual projects. They enable employees to detect signs of poor mental health and take responsibility for their own and each other's wellbeing. Public health services have supported private employers and other public sector bodies to improve wellbeing in the workplace. Mental health promotion and prevention appear to be more cost-effective than tackling mental ill health after it has occurred.

5.1 Building the evidence

“Some of the biggest threats for society today are mental health problems and substance abuse. It is necessary to promote good mental health at individual, social and community levels.”

Eija Stengård, Mental Health Promotion Unit, National Institute for Health and Welfare, Finland.

The economic impact of mental health problems is substantial at more than €2000 per annum for every European household⁵³. The cost of cardio-vascular diseases in the EU was estimated in 2007 as €36 billion⁵⁴, this compares to the cost for depression alone of €136.3 billion⁵⁵.

All over Europe, governments are struggling to cope with the growing numbers of their citizens not in work and claiming sickness benefits – wholly or partly as a result of poor mental health. In Germany, 30-35% of early retirements are the consequence of mental health problems. In the United Kingdom between 1996 and 2006 the numbers claiming incapacity benefit for mental health problems rose from 26% to 43% of all claimants and poor mental health was a factor in 70% of all claimants' cases⁵⁶.

According to the Centre for Mental Health in the UK, at any one time one

worker in six will be experiencing depression, anxiety or problems relating to stress. The total cost to employers is estimated at nearly £26 billion each year. That is equivalent to £1,035 per year for every employee in the UK workforce (see Figure 6).

In the Veneto Region (Italy), the direct costs (i.e. treatment and services) of mental ill health amount to €21 million for 6000 service users. Indirect costs (or the costs of not intervening) are 2-6 times higher and include:

- the costs of unemployment
- absenteeism
- presenteeism
- impaired performance at work
- sick leave and disability benefits
- the impact on family
- behaviour that results in accidents or criminal damage.

Consequently, there is an economic case for investing in positive mental health. However, there is also a moral case, given that “people with long-term mental health problems are likely to die 20 years earlier than their contemporaries.”⁵⁷

Moreover, “they have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely

⁵³ McDaid D. (2011) Background document for the Thematic Conference on Promotion of Mental Health and Well-being in Workplaces. Luxembourg: European Communities.

⁵⁴ Leal J., Luengo-Fernandez R., Gray A., Petersen S. and Rayner M. (2006) Economic burden of cardiovascular diseases in the enlarged European Union, *European Heart Journal* 27(13), 1610-1619.

⁵⁵ McDaid D., Zechmeister I., Kilian R., Medeiros E., Knapp M., Kennelly B. and the MHEEN Group (2008) Making the Economic Case for the promotion of mental well-being and the prevention of mental health problems, London: London School of Economics and Political Science.

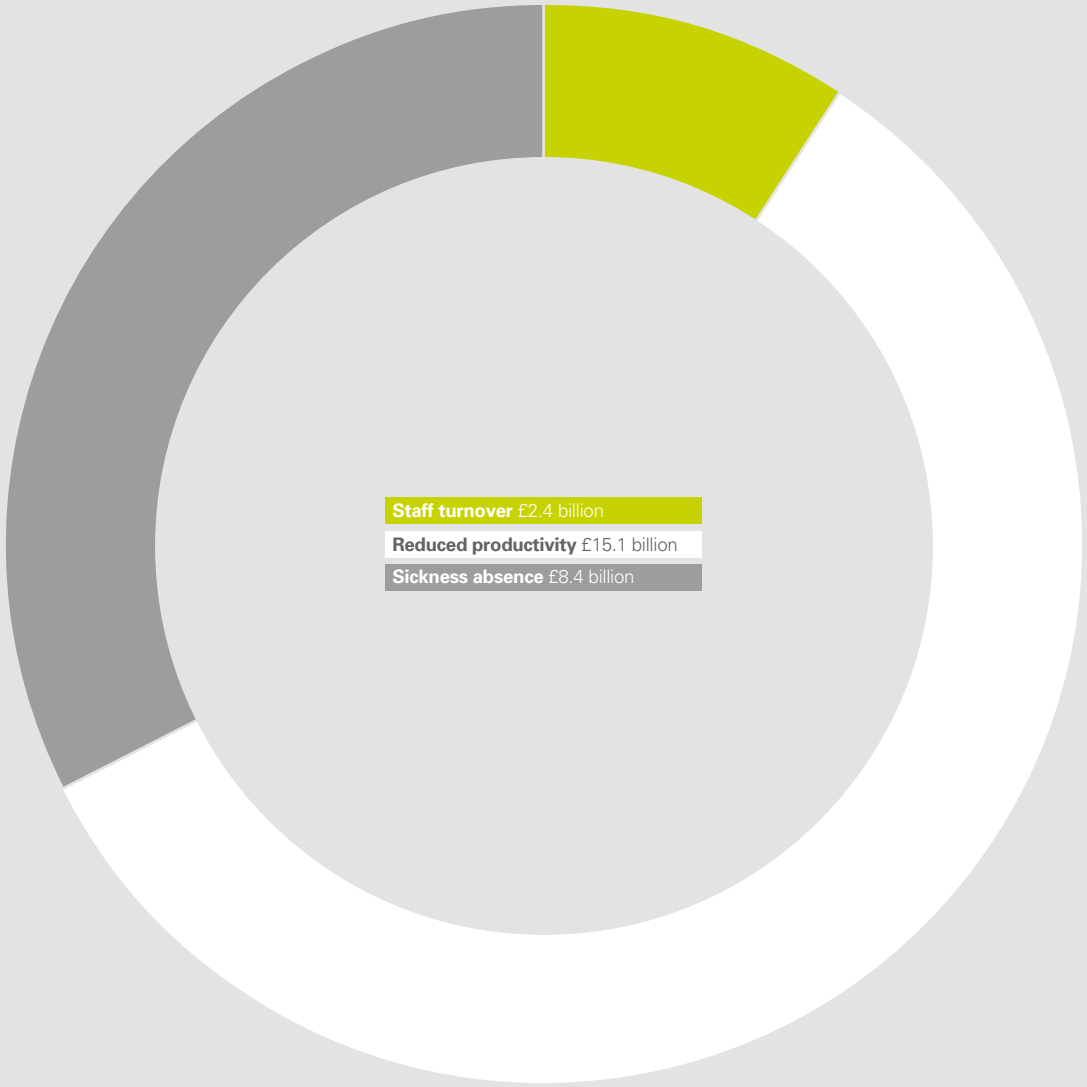
⁵⁶ Department of Health (2011) No health without mental health: A cross-government mental health outcomes strategy for people of all ages, London: HM Government.

⁵⁷ Brown S., Kim M., Mitchell C. and Inskip H. (2010) Twenty-five year mortality of a community cohort with schizophrenia, *British Journal of Psychiatry* 196, 116-121.

⁵⁸ Sainsbury Centre (2007) Mental Health at Work: Developing the business case. Available online at: http://www.centreformentalhealth.org.uk/pdfs/mental_health_at_work.pdf

Figure 6: Mental ill health costs to businesses in the UK.⁵⁸

The total cost to employers is estimated at nearly £26 billion each year. This is equivalent to £1,035 annually for every employee in the UK workforce.



to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation. They are [also] more likely to have poor physical health.”⁵⁹

5.2 Promoting mental health through wellbeing in the workplace⁶⁰

Given the social and economic costs of poor mental health, there is a case for promoting positive mental health. The workplace provides a convenient setting in which to address the mental health of a large proportion of the adult population. In addition, the economic and social benefits of a mentally healthy workforce can be seen at different levels: in the national economy, in the company and for each individual.

It is also important to recognise that social and health services are themselves major employers in Europe. The sector employs around 10% of the EU’s working population and between 1995 and 2001, it accounted for 18% of all jobs created.⁶¹ Given the trend in demographic ageing, it is also to be expected that the sector will grow in the future. Besides the habitual stresses of working life, jobs in the sector often involve working with people in the most vulnerable and difficult times of their lives, which may entail additional emotional and psychological impacts for social and health professionals.

Various economic and social benefits of mental health promotion have been identified, for example: better productivity and quality of work, increase in creativity and innovation, better health and safety and an increase in social inclusion as well as in psychological and social wellbeing. General wellbeing strategies may also reduce the vulnerability of employees to work-related mental health problems⁶². Other benefits to employers include improved ‘brand’, improved staff retention and reduced sick leave⁶³.

Mental health strategies in the workplace may be targeted at individuals, groups of workers or the organisation as a whole. The first essential step is to raise awareness of the importance of wellbeing. It is also necessary to undertake risk assessment for stress and poor mental health at work, for instance, looking at job content, working conditions, terms of employment, social relations at work, health, wellbeing and

productivity. In such strategies, employees are encouraged to take responsibility for their own and each other’s wellbeing. Further, a good leadership and management style can help promote a good working environment⁶⁴.

Wellbeing at work schemes should have several components, not just focusing on mental health. Studies on the economic return from health promotion⁶⁵ suggest that these programmes must include a combination of at least three components, for example: smoking prevention and cessation; stress management; and medical self-care – amongst others. Such wider programmes produce an average reduction in sick leave, health costs, workers’ compensations and disability costs of approximately 25%⁶⁶.

In Finland, approximately €2 billion is invested annually in wellbeing at work. This figure, however, is below 10% of the total annual costs of early retirement, sick-leave and accidents⁶⁷. Wellbeing at work projects have reduced absenteeism by 27%, medical treatment costs by 26% and insurance costs by 32% (on average). The average return on investment is valued at €5.8 on every euro. In the best cases, productivity gains can be ten-fold⁶⁸.

5.3 Wellbeing in practice: A major telecoms company

British Telecom group has developed a new way of promoting health and wellbeing. Pre-employment questionnaires were abandoned in favour of an approach which encouraged employees to consider learning a range of ‘coping strategies’ when first joining the company. A ‘wellness passport’ developed between an employee and their line manager describes potential health or other problems that might occur in the future, how to spot them and what to do once they occur.

The results of BT’s ‘Workfit Positive Mentality’ information and education programme were:

- 68% learned something new about ways to look after their mental health
- 56% tried some of the recommendations and were continuing to practise them at the time of the follow-up

⁵⁹ Department of Health (2011) No health without mental health: A cross-government mental health outcomes strategy for people of all ages, London: HM Government.

⁶⁰ ESN recognises the importance of positive mental health in other areas of life, but this report follows the European Pact for Mental Health in its focus on the workplace.

⁶¹ European Commission (2009) Green Paper on the European Workforce for Health. Available online at: http://ec.europa.eu/health/ph_systems/workforce_en.htm

⁶² Knapp M., McDaid D. and Parsonage, M. (2011) Mental health promotion and mental illness prevention: The economic case, Department of Health.

⁶³ The Work Foundation (2011) Health and Well-Being in the Workplace: Supporting Mental Health and Combating Sickness Absenteeism, Centre for Parliamentary Studies, 21st June 2011.

⁶⁴ McDaid D. (2011) Background document for the Thematic Conference on Promotion of Mental Health and Well-being in Workplaces, Luxembourg: European Communities.

⁶⁵ Chapman L. (2005) Meta-Evaluation of Worksite Health Promotion Economic Return Studies, The Art of Health promotion, *American Journal of Health Promotion*.

⁶⁶ Ibid.

⁶⁷ Ahonen, G. (2010) Työkyvyn taloudellinen merkitys (‘Economic impact of working ability’) in Martimo, K-P. et al. (eds) *Työstä terveyttä (Health at work)*. Työterveyslaitos (Finnish Institute of Occupational Health), 36-46.

⁶⁸ Ibid.



Depression is the most common mental health problem, affecting more than 20 million men and women in Europe each year.

- 51% had noticed improvements in their mental wellbeing
- Sickness absence rates due to mental health problems have fallen by 30% in four years despite pressured market conditions
- Ceasing pre-employment medical checks has saved the company £400 000 per year⁶⁹.

A strong case can be made to the business sector that workplace wellbeing strategies can produce significant cost-savings. However, some smaller companies may need public support to implement such schemes, as in the example of Verona Local Health Authority below.

“For some employees stress is an incentive to increase their activity, work capacity and productivity; for others it may become a crisis.”

Hristo Bozov, Deputy Mayor, Municipality of Varna, Bulgaria.

5.4 Wellbeing in practice: Verona Local Health Authority (Italy)

Health and social services can also benefit from improved investment⁷⁰. Verona Local Health Authority in partnership with the University of Verona has set up a workplace wellbeing scheme for employees of local businesses to detect working conditions that may affect staff's mental wellbeing and provide them with support.

Between 2005 and 2010, about 500

workers complained about a negative working situation. To define the problems and their psychological consequences, workers attended a consultation with an occupational therapist and a psychologist. Semi-structured interviews assessed the working environment, the quality of communication with colleagues and the employer, and when the problems occurred.

About 80% of those who asked for consultation were suffering from a work-related psychopathology such as mixed anxiety and depressive disorder (51.6%), adjustment disorder (16.9%), depression disorder (17.9%), anxiety disorder (12.1%), post-traumatic stress disorder (1.5%).

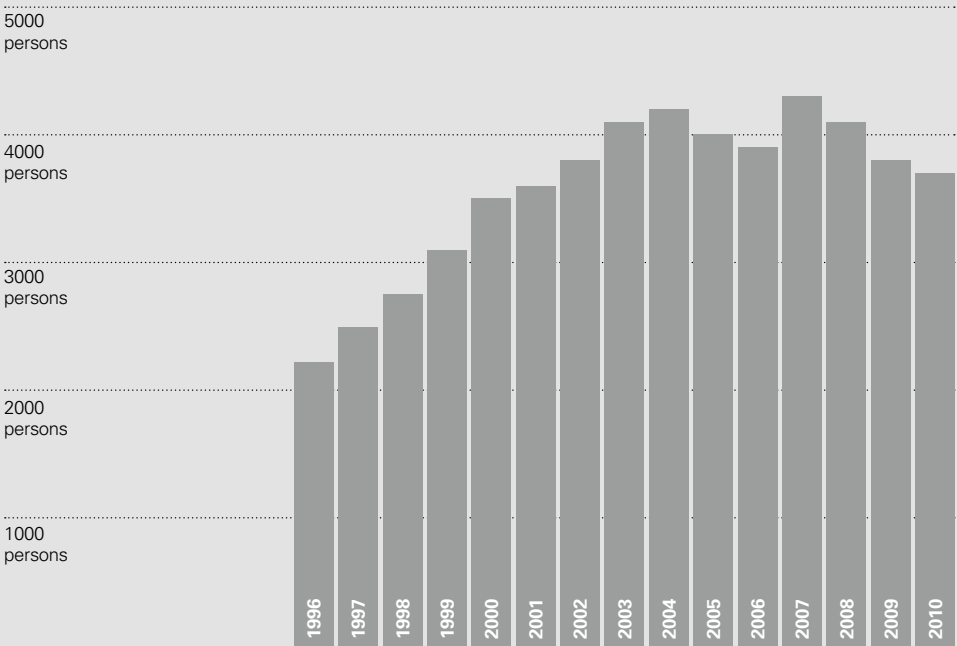
The most common negative working conditions identified during the interviews were: bullying, sexual harassment, work-related distress and distress outside work. These people receive psychological support and, if necessary, psychiatric treatment. Verona Local Health Authority has also been trying to improve workplace conditions with the support of companies' occupational therapists, harassment advisers and other mediators.

Telephone interviews and questionnaires are used to evaluate the participants' health status 12-24 months after the first consultation. Provisional results suggest that working conditions improved for approximately 60%.

⁶⁹ Further information is available online at: <http://www.dwp.gov.uk/health-work-and-well-being/case-studies/ot-mental-health/>

⁷⁰ Knapp M., McDaid, D. and Parsonage, M. (2011) Mental health promotion and mental illness prevention: The economic case, London Department of Health.

Figure 7: Number of people who have been transferred from work pension schemes to disability pensions due to depression (Source: Finnish Centre for Pensions).



People recovering from depression
Rehabilitation and return to work

People who have become ill
Early recognition and treatment
of depression

Risk groups
Prevention of depression

Working age population
Promotion of wellbeing and
mental health at work

Figure 8: MASTO project: Action and corresponding target groups.



In general, workers reported improvements in their work situation and mental health due to awareness and the actions taken in the workplace. Results suggest that early detection and diagnosis, individual psycho-therapeutic support and actions aimed at improving working conditions can help staff to improve their mental and physical health. Professional and person-centred psychological support seems to be most effective. In contrast, legal action to solve problems at work does not seem to have been as effective.

5.5 Wellbeing in practice: Finland's national programme to fight depression⁷¹

For governments and policymakers across Europe, the wide prevalence of depression and its disabling symptoms represent not only a huge public health challenge but also a substantial – and potentially growing – economic cost. Such economic burden is dominated by the indirect costs of lost productivity due to absenteeism, presenteeism, long-term unemployment, early retirement and premature mortality.

The workplace bears the greatest proportion of the costs associated with depression and is therefore an important arena in which to address prevention, early diagnosis, and adequate treatment of depression. Such interventions can be cost-saving, or highly cost-effective, either in the short- or long-term. Therefore, programmes tackling depression at the workplace should be developed; possibly being supported by government⁷².

In Finland, depression poses a particular threat to the country's working capacity, where over 200 000 people have depression each year and 1 in 5 people suffer from depression during their life. In addition, work disability due to depression has increased greatly since the end of the 90s (See Figure 7).

In Finland, the numbers of people taking early retirement and on sick leave due to depression have increased significantly, and therefore, costs of work-related depression have increased significantly, too. Depression-related sick days and work disability pensions cost €639 million in 2010. Social Insurance paid €79 million in disability pensions, while sickness benefit costs accounted for €116 million⁷³.

The aims of the MASTO Project (2008-2011), initiated by the Finnish Ministry of Social Affairs and Health, are to reduce work-related depression, and to promote and support practices increasing wellbeing at work, early support in tackling work ability problems, good treatment and rehabilitation for those suffering from work-related depression, and support to remain in employment and return to work.

This is done through the participation of different administrative sectors, social partners and the third sector. Vocational rehabilitation, partial sickness allowance or partial disability pensions and collaboration between workplaces, health care and rehabilitation services offer the opportunity for a secure return to work.

⁷¹ Further information is available online at: http://www.stm.fi/en/strategies_and_programmes/masto

⁷² Martin Knapp (15/08/2011), LSE, King's College London, Institute of Psychiatry, NIHR School for Social Care Research, e-mail interview with ESN.

⁷³ This information has been retrieved from the MASTO Project website. Available online at: http://www.tartumasennukseen.fi/c/document_library/get_file?folderId=3013709&name=DLFE-14954.pdf

Conclusions

Mental health problems have a major impact on a person's life and on those around them. The costs are high, not only for individuals and their families, but also for the community, business and society. However, responsibility for primary, community and acute mental health services has been fragmented, leading to tensions and divisions that hamper service delivery. Investment in mental health services has been low compared with other areas of welfare or health spending.

A number of conclusions (and key messages) have emerged from ESN's work on mental health and from this report, which has highlighted the concerns of mental health service users, and drawn on findings from research and contemporary policy and practice examples.

The stigma associated with poor mental health is a barrier to effective treatment and support, social inclusion, and ultimately an improved quality of life. Action should therefore be taken to improve knowledge of mental health problems and change perceptions by making mental health a political priority. These actions need to target not only the general public but also health and social professionals and people with mental health problems themselves.

Strategies to tackle stigma should be pursued alongside the development of person-centred mental health services focused on a person's recovery. Participation of service users in the design and delivery of services is therefore crucial. The commitment of health and social services and other stakeholders to work together is essential for recovery across the different areas of a person's life, including their active inclusion in the labour market. Primary, community and acute mental health services cannot act effectively without a supportive policy and legislative framework and sufficient and sustainable funding at national and regional level. Local government can play a key role in providing

leadership and coordination, particularly between health and social care. Given all the dimensions of a person's life, recovery can only happen in the community, not in institutions.

It has not only been argued that strategies to combat stigma and promote recovery need to be pursued in tandem, but that mental wellbeing can be improved for everyone, for instance through workplace wellbeing strategies. There is real potential here for mental health services to support local employers to promote mental health and wellbeing. Public, private and voluntary stakeholders have a responsibility to invest in mental wellbeing for all.

At European level, the Commission's Directorate-General (DG) for Health and Consumers launched the European Pact for Mental Health and Well-being, which has drawn on the expertise of (other) European, national, regional and local stakeholders. Research, awareness-raising, good practice exchange and policy development at EU level should continue to add value to action taken within the Member States in support of the Europe 2020 Strategy.

There are many professionals, service managers, politicians and (former) service users who are wholly committed to improving the quality of life of people with mental health problems – and we are grateful for the contribution some have made to this report. Yet much can still be done, and ESN is committed to working with its members and other stakeholders to improve the quality of life for people with a mental health problem and promote mental wellbeing for all.

European Joint Action on Mental Health and Well-being

The case for investing in health including mental health has become clearer and stronger over the past decades in Europe. Mental disorders are highly prevalent in Europe: they represent a major burden for society and are associated with significant losses of productive human capital. Positive mental health and wellbeing are key factors for social cohesion, economic progress and sustainable development in the EU.

Up to 50 million European citizens are diagnosed with mental health problems. The improvement of Europeans' mental health would contribute to the realisation of several Europe 2020 targets. In this context, a Joint Action on Mental Health and Well-being has been developed for 2013-2016, building on the European Pact for Mental Health and Well-being (2008-11). It establishes a process for structured cooperation between Member States, EU institutions, relevant stakeholders and international organisations. It brings together 49 associated and collaborating partners (including the European Social Network) from 30 European countries.

Representing managers of public mental health services across social and health care, ESN is a prominent stakeholder in the Advisory Committee of the Joint Action and is working closely with its members on the following three work packages:

- Developing community-based and socially inclusive approaches
- Promoting cooperation across education, health and social sectors in mental illness prevention amongst children and adolescents
- Mainstreaming mental health in all policy areas

ESN will support the situation analysis, evidence and practice mapping, national capacity building workshops, and the drafting of national and European reports across these themes.

ESN is working with members as national focal points to contribute to these three work packages. The Joint Action will contribute to tackle the challenges posed by mental health problems and constitutes a unique opportunity for ESN members to take forward the policy process. For further information, please contact Alfonso Lara Montero, Senior Policy & Research Officer at alfonso.montero@esn-eu.org.

Glossary

Active inclusion

Policy concept developed by the European Commission, which has three components: (1) Adequate income support; (2) Inclusive labour markets; (3) Access to quality services. In 2008, the Commission published a 'Recommendation' to Member States comprising policy guidelines for the development of active inclusion policies⁷⁴.

Community-based care

Any type of care, supervision and rehabilitation outside the hospital by health and social workers based in the community (WHO: Atlas, 2001). Community care is associated with the provision of services and care at home rather than in an institution⁷⁵.

Disability

Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner of or within the range considered normal for a human being⁷⁶.

Discrimination

The EU Directive 2000/78/EC of 27 November 2000, establishing a general framework for equal treatment in employment and occupation, lays down a general framework for combating discrimination on the grounds of religion or belief, disability, age or sexual orientation as regards employment and occupation. Member States had to adopt the laws, regulations and administrative provisions necessary to comply with this Directive by 2 December 2003 at the latest.

1. For the purposes of this Directive, the "principle of equal treatment" shall mean that there shall be no direct or indirect discrimination whatsoever on any of the grounds referred to in Article 1.
2. For the purposes of paragraph 1:
 - (a) direct discrimination shall be taken to occur where one person is treated

less favourably than another is, has been or would be treated in a comparable situation, on any of the grounds referred to in Article 1;

(b) indirect discrimination shall be taken to occur where an apparently neutral provision, criterion or practice would put persons having a particular religion or belief, a particular disability, a particular age, or a particular sexual orientation at a particular disadvantage compared with other persons.

Europe 2020

The European Union's overall strategy for smart, sustainable and inclusive growth over the next ten years. There are seven 'flagship initiatives' relating to smart, sustainable and inclusive growth. The EU has agreed five targets on employment, research & development, climate change & energy, education, poverty & social exclusion. EU Member States report on progress and policy developments annually; the Commission makes country-specific recommendations and reviews overall progress⁷⁷.

Mental health

Measurement of the way people, organizations and communities think, feel and function individually and collectively. Societies benefit socially and economically when people have good mental health⁷⁸.

Mental health services⁷⁹

Mental health conditions can impact on different aspects of a person's life including housing, employment, relationships and physical wellbeing. Mental health professionals work in primary health and social care settings (treating emotional or psychological conditions), and in specialised mental health services (treating severe disorders). They may be general practitioners, counsellors, community

⁷⁴ European Commission Recommendation of 3 October 2008 on the active inclusion of people excluded from the labour market (notified under document number C(2008) 5737). Available online at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32008H0867:EN:NOT>

⁷⁵ WHO (2001) Atlas: Mental Health Resources in the World. World Health Organisation, Geneva.

⁷⁶ WHO (1980) The International Classification of Impairments, Disabilities and Handicaps (ICIDH). World Health Organisation, Geneva.

⁷⁷ European Commission (2010) Europe 2020 Strategy, European Communities. Information available at: http://ec.europa.eu/europe2020/index_en.htm

⁷⁸ Corey L. and Keyes M. (2002) The Mental Health Continuum: From Languishing to Flourishing in Life, *Journal of Health and Social Behavior*, vol. 43, no. 2.

⁷⁹ Part of the information used to write this definition has been taken from: <http://www.nhsdirect.wales.nhs.uk/encyclopaedia/m/article/mentalhealthservices>

mental health nurses, clinical psychologists, psychiatrists, psychotherapists and social workers. In the past, there has been a distinction between 'frontline' primary care for mental health conditions (general practitioners and community mental health nurses) and more specialised services (psychiatrists or clinical psychologists). Despite differences in the organisation of services across Europe, there seems to have been a widespread shift towards providing some specialised services in community settings, such as day centres or a person's home.

Personalisation

Enable the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive⁸⁰.

Poverty

The European Commission defines being 'at risk of poverty' as living in a household whose income is below 60% of their country's median household income. According to this measure, 80 million people in the EU – or 16% of the population – are currently at risk of poverty⁸¹.

Presenteeism

"Presenteeism is defined as lost productivity that occurs when employees come to work but perform below par due to any kind of illness. While the costs associated with the absenteeism of employees have been long studied, the costs of presenteeism are newly being studied."⁸²

Recovery

"A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."⁸³

Recovery can be either social or total. In social recovery, a person still displays clinical signs and symptoms but these symptoms do not hinder the individual from participating in social life. In total recovery, they no longer display any symptoms and are no longer connected to any form of psychiatric treatment⁸⁴. For service users, recovery is a lived experience, whilst for professionals, it is the process that guides their work.

Social exclusion

The denial of social, political and civil rights of citizens in society or the inability of groups of individuals to participate in the basic political, economic and social functioning of the society⁸⁵.

Stigma

A collection of negative beliefs, attitudes or behaviours that influence an individual or group to fear, avoid or discriminate against people with particular characteristics. Stigma can have a twofold impact: public stigma (the reaction that the general population has towards people with mental health problems) and self-stigma (the prejudice which people with mental health problems turn against themselves)⁸⁶.

⁸⁰ Scottish Government (2009) Changing Lives, Service Development Group. Available online at: <http://www.socialworkscotland.org.uk/resources/pub/PersonalisationPapers.pdf>

⁸¹ Europe 2020 initiative: European platform against poverty and social exclusion. Available online at: <http://ec.europa.eu/social/main.jsp?catId=961&langId=en>

⁸² Levin-Epstein J. (2005) Presenteeism and paid sick days. Washington, D.C.: CLASP Center for Law and Social Policy. Available online at: <http://www.clasp.org/publications/presenteeism.pdf>

⁸³ William Anthony, Director of the Boston Center for Psychiatric Rehabilitation. Available online at: <http://www.mhrecovery.com/definition.htm>

⁸⁴ Recovery DK, What does recovery mean? Available online at: <http://www.recovery.dk.dk/>

⁸⁵ Silver H. (1994) Social exclusion and social solidarity: Three paradigms, International Institute for Labour Studies Discussion Paper No 69.

⁸⁶ Corrigan P.W. and Watson A.C. (2002) Understanding the impact of stigma on people with mental illness, *World Psychiatry* 1(1), 16-20.

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This report aims to share the knowledge and learning from ESN's working group and European policy on mental health and wellbeing, and was launched at the European Parliament with the support of Nessa Childers MEP. It covers a number of related issues: stigma; person-centred services and recovery; labour market participation; and mental health promotion. It also sets out to raise awareness not only of the social but also the economic impact of poor mental health in light of the Europe 2020 Strategy.

The report is also available at www.esn-eu.org/publications in deutsch, español, français and italiano.

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