



From Exclusion to Inclusion – The Way Forward to Promoting Social Inclusion of People with Mental Health Problems in Europe

An analysis based on national reports from MHE members in 27 EU Member States



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Preface

Mental Health Europe (MHE) has a history and plays an important role in raising awareness and in combating the taboos, stigma and prejudices associated with mental illness. Mainstreaming mental health in the field of social inclusion has become a principal activity of MHE and a major area of concern for people with chronic mental health problems. To this end MHE develops European exchange projects together with its member organisations, formulates recommendations for policies and strategies on mental health and social inclusion based on these projects, and lobbies the European Institutions in order to increase awareness of this important issue – just as MHE’s members campaign on the local and national level.

In 2007, MHE carried out its work programme in the field of social inclusion with the title “From Exclusion to Inclusion: Making Social Inclusion a Reality for People with Mental Health Problems in the European Union” supported by the European Commission Community Action Programme to Combat Social Exclusion 2002-2006. The programme was based on the initial results and lessons learned from the MHE transnational exchange project “Good Practices for Combating Social Exclusion of People with Mental Health Problems”. It aimed at increasing efforts to raise awareness at all levels and among all actors of the current challenges and needs faced by people with mental health problems. In particular, the work programme included a particular focus on analysing the situation of social exclusion of people with mental health problems in all the EU Member States; in each of the EU Member States, bringing together the different stakeholders and discussing the present situation of social inclusion of people with mental health problems; becoming actively involved in the EU Social Protection and Social Inclusion process at the national level; and disseminating the results of the activities at all levels.

The results of the work programme have been collated in the present report. MHE hopes that the report can be a helpful instrument, for policy and practice alike, in the promotion of the social inclusion of people with mental health problems. The aim is to work towards a European society in which all people enjoy a high level of mental health, live as full citizens and have access to their human rights and to appropriate services and support when needed, through a better integration of mental health issues into the social inclusion process at the local, national, regional and European level.

MHE would like to thank the MHE members involved in the present work programme for their significant efforts and input in this work.

Mary Van Dievel
MHE Director

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An introductory word

This report presents an overview of the situation of social inclusion of people with mental health problems across 27 Member States of the European Union – Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Scotland, Slovakia, Slovenia, Spain and Sweden.

It is based on national reports, which have been prepared by MHE members with experience in the field of mental health and social inclusion. The documents are not exhaustive, but rather an attempt to collect some basic information about the most pressing challenges and needs people with mental health problems are facing on a daily basis with regard to their access to health and social services, education and training, employment, housing, transport, leisure/social activities and safeguarding of civil and human rights.

Despite the prevalence of mental health problems in Europe and the magnitude of stigma, discrimination and social exclusion faced by people who experience a mental illness, there seems to be great need to strengthen the general understanding and recognition of this issue. In many countries, no clear distinction is being made between people with disabilities and people with mental health problems so that both groups may not be provided with the necessary support services. This report aims to explain the specificity of mental health and mental illness, and to highlight the mechanisms that prevent people with mental health problems in many cases to be active citizens who can participate and contribute to the community and society in which they live.

In 2000, EU leaders established the Social Inclusion Process to make a decisive impact on eradicating poverty and social exclusion by 2010. The present report analyses the contribution of this process with regard to the promotion of social inclusion of people with mental health problems in Europe. Moreover, it sets out concrete suggestions that can help professionals and policy makers to strengthen the framework for national strategy development and policy coordination within and between the Member States in Europe on issues relating to this particularly vulnerable group.

Sogol Noorani
MHE Policy Officer and editor of the report on behalf of MHE

1. Introduction

Mental health and well-being as well as mental health problems are the result of the interaction of biological, social and psychological factors. The latter is often exacerbated by stressful events either in our personal lives or in the wider environment in which we live. The level at which stress may become disturbing varies from individual to individual. However, once it is reached it can affect our overall well-being, affect our coping with daily activities and cause physical ill health.

Difficult situations in our personal life that can affect our state of mind include the loss of loved ones, family breakdown and unemployment. Stressors in the wider environment can be linked with rapid changes in societies. In today's Europe, unemployment, job insecurity, poverty, homelessness, economic and political instability affect the lives of many, making it hard to meet their basic needs. It becomes hard to believe that hopes and goals are achievable so that people begin to despair. Opportunities for interpersonal contact may be reduced due to new forms of living, working and communicating. Modern information technologies and the scattering of families may weaken the support system that helps us to face life's challenges.

Feeling that one has less control over one's life can lead to a perceived loss of meaningful involvement in the world and to feelings of helplessness and hopelessness. People experiencing such situations may as a consequence experience mental health problems, ranging from depression to psychoses, schizophrenia and manic-depressive illness. These illnesses can lead to social exclusion, and social exclusion on the other hand may worsen mental illness, leading to a vicious circle from which it is only very hard to escape.

Certain social factors can perpetuate this situation. Poverty and social deprivation often result in high levels of unemployment, poor living conditions or homelessness, exposing individuals to stress and increased risk of mental disorders. Life in rural areas including isolation, lack of transport, communications and services leave limited possibilities for rural inhabitants in need of support. The multiple roles that women fulfil in society increase their vulnerability to mental distress and illness. And people experiencing racism are found to frequently suffer from mental health problems.

The effects of mental disorders can dominate people's lives and affect their ability to interact with others, to carry out tasks and to think clearly. Certain forms of mental illness can produce apathy, lack of interest and motivation and a reluctance to engage with other people. These symptoms can make it very difficult for people to search for a job, attend an interview or meet the demands of the work place including forming relationships with work colleagues. The symptoms also generally inhibit the prospect of making and keeping friendships thereby increasing social isolation.

The introduction of effective medication to treat mental disorders has led to the treatment of many related symptoms and complaints. However, the positive effects of drugs are often accompanied by various side-effects affecting movement and behaviour all together marking people with mental health problems out as different from their neighbours and colleagues and creating stigma.

Stigmatisation of people with mental health problems is expressed by members of society wishing to distance themselves from people with such illnesses, being reluctant to work with them, marry them, live close to them or have them as friends and results in their segregation and social isolation. The media are very influential in the formation of public attitudes about mental illnesses. However, they often add to public prejudices by headlines and news stories dramatising the rare occasions when a member of the public is harmed or killed by a person experiencing mental health problems.

Faced with stigma and prejudice from society, people with mental health problems in many cases come to view themselves as inferior to others. They may accept the image that others hold of them, and the impact on their self-image is disastrous, leading to more social withdrawal and lack of motivation to achieve their goals.

This report attempts to highlight some of the impacts of mental health problems on the lives of people who are affected. In the first part, the link between mental illness and social exclusion is explained by drawing on some specific aspects of social exclusion such as unemployment, poverty and homelessness. The report also looks at policy initiatives in the European Union – at EU level as well as in the EU Member States – that aim to tackle the situation and how these initiatives could be advanced to improve their impact. The second part of the report looks at the situation of social exclusion of people with mental health problems in 27 Member States of the European Union, based on national reports from MHE members. Problems are analysed as well as good practices highlighted that can help promoting social inclusion, in individual EU Member States as well as in the Union as a whole. The contribution of the Open Method of Coordination and in particular the National Action Plans on Social Inclusion is being assessed as a tool to address this situation. Finally, conclusions and recommendations are drawn from the whole analysis, addressed to policy makers and practitioners alike, to support developments towards achieving mental health and well-being as well as social inclusion for all in Europe.

2. The state of evidence

2.1. About mental health problems

There are varied forms of mental disorders. Some are mild and may just last a few weeks, whereas others are more severe and may last a lifetime; some are not even noticeable, while others are difficult to hide from the social environment. Mental disorders such as depression and schizophrenia place a heavy burden on individuals and communities and that are generally linked with stigma and social exclusion.

More than 27% of adults in Europe are estimated to experience at least one form of mental ill health during one year¹. Depression disorders and schizophrenia are the most common forms of disabling mental disorders in the European Union. By the year 2020, depression is expected to be the highest ranking cause of disease in the western world².

Depression can produce sadness, loss of interests in activities and low levels of energy. Furthermore, other symptoms such as loss of confidence and self-esteem, feelings of guilt, diminished concentration, disturbance of sleep and appetite and even thoughts of death and suicide can occur. Depressive feelings are common, especially after experiencing difficult life situations like the loss of loved ones, family breakdown or unemployment; however, when symptoms persist for several weeks, a depressive disorder may be diagnosed. Depression can vary in severity from mild to very severe, like in the case of manic-depressive (or bipolar) disorders. Mostly it is episodic but it can also be recurrent or chronic. Symptoms of depression become manifest in different ways in women and men. Although it can affect individuals at any stages in life it occurs in many cases in the middle ages as well as in adolescence and young people; current demographic changes have led to an increase in depression in older people.

Schizophrenia is a severe disorder that often begins in late adolescence or early adulthood. It is characterised by significant distortions in thinking and perception and inappropriate emotions. Strong beliefs in false ideas or that have no basis in reality (delusions) can occur; and behaviour may likewise be very disturbed leading to negative social outcomes. The course of schizophrenia is varied; people with schizophrenia recover completely in about one-third of cases, but they may also be affected by a chronic or recurrent course leading to incomplete social recovery. Advances in medical therapy and psychosocial care can help many people developing schizophrenia to expect a full and lasting recovery. However, after the more obvious symptoms disappear some lasting impacts may remain such as a lack of interest and initiative in daily activities and work, social incompetence and inability to take interest in pleasurable activities. These effects can result in continued disability and poor quality of life, and they can place a significant burden on families².

2.2. Mental health problems and social exclusion

Mental health problems can be seen as both a cause and a consequence of social exclusion. A range of risk factors influence the development of mental health problems, including socio-economic disadvantage or poverty, unemployment, poor living conditions or homelessness, being a member of a minority group and experiencing racism or discrimination and being a lone parent or a teenage mother. Once mental health problems develop, they may have a negative impact on employability, income, access to adequate housing, opportunities to access services and being part of a social network. Being deprived of many essential elements of life, people with mental illness are often facing serious economic deprivation, social isolation and social exclusion.

Stigma and self-stigmatisation are among the key factors contributing to the social exclusion of people experiencing mental health problems. The link between mental ill health and social exclusion becomes evident in view of three main sources of social disadvantage, unemployment, poverty and homelessness.

2.2.1. Stigma, discrimination and self-stigmatisation

The concept of stigma is key to understanding experiences of social exclusion of people with mental health problems. Stigma generally refers to any characteristic, trait or disorder that labels a person as being different from "normal" people resulting in inacceptance or even sanctions from the community³. Global evidence relating to the stigmatisation of people with mental health problems suggests that in most countries they are considered not to have the same value as people who do not have mental illness. The main experiences relating to stigma are blame from others as well as, or sometimes leading to, shame of oneself. The result is in many cases rejection and avoidance of people with mental illness⁴.

A Eurobarometer study in the EU-15 Member States in 2003⁵ found that people with mental health problems were most likely to be perceived as not having "the same chance of getting a job, training or promotion" as anyone else. Eighty-seven per cent thought they would have less chance than anyone else: higher than for physically disabled people (77 per cent), people over 50 (71 per cent) and people from ethnic minorities (62 per cent). Much lower proportions thought that young people or gay or lesbian people would have less chance.

Stigmatisation of people with mental health problems occurs in many areas of life such as in the family or at home, in personal relationships, at work, in leisure and free time activities, travel, insurance and financial services, debt, entitlements of citizenship such as voting and importantly access to quality health care. It can be seen as a concept that encompasses three main problems, ignorance (problems of people's little or incorrect knowledge about mental illnesses), prejudice (problems of fear, anxiety and avoidance of people with mental health problems) and discrimination (in many aspects of life at home, in personal relationships or at work)⁶.

Another common reaction is that people with mental illness who anticipate rejection and discrimination impose upon themselves a form of self-stigma. This reaction is frequently connected to feelings of shame resulting partly from perceived personal guilt, moral failing or weakness and partly from actual discrimination from others. However, even in the absence of discriminatory behaviour by others the sense that there has been a failure, by the individual who experiences mental illness, can be overwhelming. The result is that people suffer from low self-esteem and self-confidence, depression as well as low levels of life satisfaction and employment⁷.

2.2.2. Social exclusion and social disadvantage

Social exclusion is a multidimensional problem, and the different aspects of exclusion will, if they are not dealt with, in most cases increase disability and impede recovery. The main sources of social exclusion and social disadvantage include unemployment, poverty and homelessness. For people with mental health problems recovery is linked to a great extent to the availability of these social and economic opportunities as well as choices for treatment and support.

2.2.2.1. Unemployment

People with mental health problems have the lowest employment rate across Europe. The unemployment rate of persons with a moderate mental illness such as mild depression tends to be twice as high as for persons with no illness or disability; and the unemployment rate of people with a severe mental illness such as schizophrenia is about three times as high as for persons with no illness or disability. Even where people with mental health problems are working, there are often large pay gaps between wages of disabled and non-disabled people. Earnings for disabled people in Germany are 35 per cent less than non-disabled; 20 per cent less in Ireland and 6 per cent less in Sweden. Moreover, 9 per cent of disabled people of working age in Europe have no income from

either employment or benefits. They make up 1.4 per cent of the total European working age population⁸.

In many cases, exclusion begins in childhood. In some European countries children with mental health problems do not attend primary school because of a lack of infrastructure to support their education. A high percentage of young people with mental health problems leave school without qualifications, are excluded from school, underestimated or, as a result of continuous stigma and discrimination, have low aspirations about their own futures⁹. For people with mental health problems, unemployment increases dramatically after the age of 50 years. In some Member States, barriers to employment result in the employment rate of women with a physical or mental disability being significantly lower than that of non-disabled women.

In the European Union, a large number of people with mental health problems are based in separate "sheltered workplaces". These initiatives offer a form of occupation but the salaries are generally very low, in many cases far below the accepted minimum wage. Sheltered work also offers only limited prospects of progressing to the open labour market. In Belgium, France, Spain, Ireland and Scotland less than 3 per cent take up open employment each year⁸.

With regard to financial benefits associated with unemployment, the majority of European countries provide social protection in the form of financial assistance to those who are unable to work. People with mental health problems often receive sickness or incapacity benefits rather than unemployment payments. However, the result is that this classifies people as economically inactive rather than unemployed which can lead to a lack of access to employment services that help people get back into work. In addition, applying for and receiving these benefits is in many countries a difficult and lengthy process, thereby increasing the risk of falling into the "benefit trap". In this situation, individuals who take paid work become financially vulnerable. For people with mental health problems who may, due to their illness or the possibility of a relapse, have limited possibility of going again through the long and strenuous process of applying for financial assistance, the only option remaining is often to stay on their benefits⁹.

2.2.2.2. Poverty

Poverty and financial disadvantage are often associated with mental ill-health. In many cases, they are sources of stress, which in turn represent a contributory factor for the development and severity of mental illness. Conversely, there are several reasons why mental health problems can become an obstacle to peoples' capabilities to change their income and financial situation. They may be unable to retain their work due to remission and then relapse, or they may face stigma and discrimination preventing them from entering the labour market in the first place.

A survey on the association of severe mental disorders and poverty in Britain in 2000¹⁰ found that psychotic disorder was 17 times more common in those earning between £100 and £200 per week, and 35 times more common in those earning under £100 per week, compared with those earning over £500 per week. Moreover, one-third of respondents with a psychotic condition were in debt, with council tax, telephone, rent, gas, water, electricity, TV and mail-order payments being among the most commonly reported debts. One in ten respondents with a psychotic disorder had had their telephone disconnected due to debt, with serious implications for their ability to make social arrangements.

The consequence of low income, unemployment and labour market insecurity is that many people with mental health problems are dependent for their income on social security transfers. The financial problems experienced by parents who rely on long-term benefits because they are unable to work due to a mental illness are in turn a contributory factor to child poverty¹¹. The hardship for children becomes harder in the case of single-parent families. A survey of 2000 families living in poor parenting

environments found neighbourhood deprivation to be a mediating factor in parental mental health and vice-versa, and consequently in child poverty and well-being¹².

2.2.2.3. Homelessness

Mental health and well-being are also closely related to the physical environment. Living in insecure or unsafe housing, including problems of overcrowding, noise and generally poor conditions can constitute a source of stress and mental and physical ill health. The rate of mental health problems among people experiencing homelessness is especially high. The most common forms of mental illness among homeless people are schizophrenia, depression and other affective disorders as well as substance dependence. Less than one third of homeless people with mental health problems receive treatment. For older people, mental illness can become the entry into homelessness¹³.

A case-control study of homeless men with schizophrenia¹⁴ found that homelessness followed the onset of psychosis in one-third of men. This gives some hope of preventing homelessness in at least this proportion of men with schizophrenia. Studies of the childhood histories of homeless people reveal a high prevalence of institutional care. A study that compared homeless people with and without mental illness¹⁵ showed that both groups were similar in terms of demography and the experience of childhood poverty. However, the homeless people with a mental illness comprised a higher proportion who had been taken into care as children, who had suffered physical or sexual abuse in childhood, and who had a primary caregiver who was mentally or physically disabled.

2.3. Mental health policy in Europe

In the last few years, mental health and well-being has gained a significant increase in political attention. Recent European policies have made an important step from a narrow focus that looks at mental disorders within the specialist psychiatric domain to recognising mental health as a crucial social factor with wide-ranging implications for health and social services and care, family life, the labour market and the community as a whole. The main EU policies and actions addressing mental health and well-being include initiatives in the fields of social inclusion, public health, human rights and research.

2.3.1. EU approach to social inclusion and mental health

At the Lisbon European Council of March 2000, parallel to the development of the EU's Lisbon Strategy for Growth and Jobs, the so-called Social Inclusion Process was established at the European level to make a decisive impact on eradicating poverty and social exclusion by 2010. Since then, the European Union has established a process for national strategy development as well as for policy coordination on issues relating to poverty and social exclusion between all Member States, known as the Open Method of Coordination. Under this method, Member States agree to common objectives or goals that guide the entire process; they agree to common indicators which show how progress towards these goals can be measured; they prepare national strategic reports, in which Member States set out how they will plan policies over an agreed period to meet the common objectives; and they evaluate these strategies jointly with the European Commission.

To support the initiatives carried out under the Open Method of Coordination, a Community Action Programme to Combat Social Exclusion 2002-2006 was established to provide a practical framework for the exchange of best practice and mutual learning. The EU's new integrated programme for employment and social solidarity, PROGRESS (2007-2013), supports these goals and contributes to the Lisbon Strategy by focusing on providing jobs and equal opportunities for all and ensuring that the benefits of the EU's growth and jobs drive reach everyone in society.

Since its set-up in 2000, the Open Method of Coordination highlighted how countries perform well in certain areas, while encouraging other Member States to perform better. It also created a better basis for policy making by involving a range of actors such as NGOs, social partners, local and regional authorities and those working with people experiencing poverty and social exclusion.

A recent EU initiative aims to tackling poverty and promoting inclusion of people furthest from the labour market by adopting a new strategy for 'active inclusion'. This new approach combines three crucial elements for ensuring the integration of disadvantaged people in the job market, adequate income support, access to inclusive labour markets and quality social services.¹⁶

Despite all these initiatives to combat social exclusion at the European level, the EU approach that has been adopted for tackling the situation of people with mental health problems is to address the category of disabled people as a vulnerable group that faces a higher risk of poverty, social exclusion and discrimination. The European Union works towards narrowing the gap in the employment rates between disabled and non-disabled people through the implementation of active employment measure at Member State level. However, mental illness and disability such as physical or intellectual disability are very different. People with mental illness need mental health care and supportive social services, but they have no intellectual impairment and can live, learn and work independently when their mental health problem is controlled. Only by recognising the differences, these groups can be provided with the necessary support systems.

2.3.2. Other EU policies and initiatives addressing mental health

In the field of public health, the first EU-Public Health Programme 2003-2008 was established as the main instrument for action at Community level in the field of mental health. It is based on Article 152 of the Treaty establishing the European Community. The Second Programme of Community Action in the Field of Health 2008-2013 builds on the achievements of the previous Programme in aiming to contribute towards the attainment of a high level of mental health and greater equality in health matters throughout the Community. In 2005, a European Commission Green Paper on mental health¹⁷ launched an extensive consultation. The document outlined the relevance of mental health for some of the EU's strategic policy objectives (prosperity, solidarity and social justice, quality of life of citizens), proposed the development of a strategy on mental health at Community-level and brought forward possible priorities and suggestions for actions. According to the Council decision of Ministers for Labour, Social Affairs, Equal Opportunities, Health and Consumer Protection of 6th December 2007, the follow-up on the Green Paper will be a high level conference on mental health, with focus on prevention of suicide, mental health in youth and education, mental health in workplace environments, elderly people. At this event, it is expected to establish a cross-sectoral European Pact for Mental Health¹⁸.

The promotion of mental health and the prevention of mental health problems are laid down in the Community Strategy 2007-2012 on Health and Safety at Work. According to this Strategy, the workplace can be an appropriate place in which to prevent psychological problems and promote better mental health¹⁹. This approach is furthermore supported by Directives, guidelines and reports on working time, work-related stress and violence at work, respectively²⁰.

Under the EU's Sixth Framework Programme for Research 2002-2006, funding opportunities relevant to mental health and well-being were provided for projects undertaking research activities in the fields of neurological disorders and diseases; life sciences and health; policies related to public health and quality of life issues; and improvements in quality of life²¹. The objective of health research under the Seventh Framework Programme 2007-2013 is amongst others to improve the mental health of European citizens, in particular by promoting mental health and preventing mental

disorders in children and adolescents; addressing health inequalities; evaluating suicide prevention strategies; and optimising the delivery of health care to European citizens²².

The annual work plans of the Second Programme of Community Action in the Field of Health, the Safety and Health at Work Strategy as well as the Seventh Framework Programme on Research will be key instruments to support the objectives of the recently adopted EU Health Strategy "Together for Health: A Strategic Approach for the EU 2008-2013". Building on current work, this Strategy aims to provide, for the first time, an overarching strategic framework for core health issues, including mental health issues²³.

In the field of human rights, the general principle of EU law that applies to people with mental health problems is the principle of disability based on non-discrimination. Article 21(1) of the EU Charter of Fundamental Rights – proclaimed in December 2000 and gaining legally binding force upon ratification by all Member States of the Treaty of Lisbon – prohibits discrimination based amongst others on the ground of disability.

Article 13 of the EC Treaty provides the legal basis for appropriate action to combat discrimination based amongst others on disability. Pursuant to Article 13, the EU had put in place a strategy to combat discrimination, including a Directive establishing a framework for equal treatment in employment and occupation amongst others on the grounds of disability and the Community Action Programme 2001-2006 to Combat Discrimination. The PROGRESS Programme 2007-2013 will bring together a number of existing European programmes under one heading, including the anti-discrimination programme.²⁴

2.3.3. Policies addressing mental health in EU Member States

Although there are several EU policies and initiatives addressing mental health, sometimes in a more and sometimes in a less direct way, implementation of policy goals is patchy across Europe. There is a wide variety of mental health initiatives and actions across Member States, highlighting the diversity of Europe and the importance of sharing information, monitoring and cooperation.

In all European countries, there is some activity being undertaken to promote the mental health and well-being of all, while supporting the social inclusion of those people experiencing mental health problems. Some actions are coordinated and financially sustained, while others are more ad hoc and require support and sustainability. Moreover, there is an enormous variety in the availability and quality of mental health related services resulting from different situations, traditions and cultures in the Member States.²⁵

The diversity in mental health in Member States makes it difficult to draw simple conclusions or to propose uniform solutions. However, national policies on mental health are vital in order to address the health and social needs of persons with mental health problems.

3. National reports on mental health and social inclusion

3.1. Social inclusion of people with mental health problems in Europe

Mental Health Europe is a European network, which represents associations, organisations and individuals across Europe that are active in the field of mental health and well-being in Europe. Since the adoption of the European Social Policy Agenda in 2000, which set forth common objectives establishing comparable ways to combat poverty and promote social inclusion, Mental Health Europe has been active in improving social inclusion of people with mental health problems by preparing guidelines, providing evidence of good practices and supporting its members to participate and provide input in the policy making process at the national level through the Open Method of Coordination.

In recent years, the necessity of recognising the needs of people with mental health problems with regard to their full integration into society has become evident. However, in order for adequate decisions and actions to be taken at all levels of administration and at the community level, a detailed assessment of the current situation of social inclusion of people with mental health problems is essential, including an evaluation of the challenges and needs that still exist and must be addressed.

An overall assessment of the current situation in the Member States of the European Union with regard to social inclusion of people with mental health problems reveals many similarities as well as differences between countries. The similarities refer to some structural issues that appear in almost all Member States when it comes to policies and practices in the field of mental health and mental illness. Differences between Member States become especially apparent in view of the measures that are being adopted in order to meet existing challenges and needs.

In the field of **health and social services** the most prominent issue emanating from all countries covered in this report is that a medical model of psychiatric illness prevails. The focus is almost exclusively on curing the mental illness, without much regard to other social needs. In some cases, mental health conditions can exist a lifetime and therefore demand solutions that allow for improving the quality of life of people with mental health problems and their re-integration into society. However, in almost all countries there is a lack of alternative community-based systems for mental health care and psychosocial rehabilitation, and a lack of legislation to support such initiatives.

Another point raised in the majority of national reports was the missing link between the health and social sector, which often results in the absence of a coherent strategy and continuity in the provision of services for people with mental health problems. Other related fields that would need to be integrated in order to ensure steps towards the promotion of social inclusion of people with mental health problems are those of insurance and pension systems, rehabilitation, education and training systems and labour and employment policies.

The health and social services sector has been described in many cases as lacking the participation of users and families in the decision-making process at the political and care level. Also, there seems to be a general lack of communication and interaction, between general practitioners and psychiatrists and social workers, and at another level, between state and federal or regional and local authorities.

Positive developments that can be mentioned in the field of health and social services include the cases of Denmark and Estonia, which guarantee full access to health care on all levels free of payment for people with mental health problems who are often facing poverty and are unable to pay for their treatment. A further achievement in these countries includes the fact that most of the psychiatric wards have been integrated into hospitals. In Germany, this step from psychiatric hospitals to de-institutionalisation has

also been successfully completed. However, the development has also lead to very specialised services for people with mental health problems that perpetuate social exclusion instead of being actually based in the community. An important factor to ensure developments that are directed towards social inclusion in the health and social services sector are legislative acts, as they have been achieved in Scotland and Sweden, which include a social inclusion agenda.

Recommendations for promoting social inclusion of people with mental health problems in health and social services:

→ Strengthen communication and interaction between the health and social sector and ensure more integrated actions

→ Ensure involvement and participation of people with mental health problems and their families in policy and decision making

→ Complement the de-institutionalisation process with increased development of alternative solutions for health and social services in the community

With regard to the area of **education and training**, school drop-out due to mental health problems is a major problem in all countries. Pupils or students experiencing a mental illness must usually leave school or university as a result of various factors including intolerance, fear/stigma, a lack of flexible education programmes or inexperience of teachers to deal with the illness. In most countries, the support provided by schools to excluded people is focused on disability. In Belgium/Walloon region, there are some special schools for pupils with mental health problems, however these are segregating in nature and promote further exclusion.

In almost all countries, there are no specific education policies which address young people and adults with mental health problems. The path from sheltered or supported to external job opportunities is largely dependent on the good will of employers, and the lack of opportunities leads to exclusion. Existing initiatives for vocational training or rehabilitation programmes aimed at social integration, which are mostly offered by NGOs, face problems of financial sustainability. In some countries, for example Cyprus, there are no programmes for professional education and employment of people with mental health problems at all.

Actions that have helped to promote the social inclusion of pupils who experience episodes of mental illness include the decision of the Belgium/Flemish government to include mental health as a factor for overall health and well-being in school evaluations. In the same region as well as in Austria, initiatives have been created to raise awareness of mental health and well-being and to promote early prevention of mental disorders in pupils at schools. However, these initiatives have often met with problems of scarce, or a stop of, funding. With regard to academic institutions, in Poland ten universities gathered and organised a network of assistance and information services for people with mental health problems. Similarly, in Slovakia there is a special programme for students who are older than 25 and live on pensions that has enabled many people with mental health problems to continue their education.

Recommendations for promoting social inclusion of people with mental health problems in education and training:

→ Promote early prevention of mental disorders in schools and develop specific education policies targeting pupils with mental health problems

→ Create information and support services in schools and universities supporting students with mental health problems to complete their education

→ Increase (financial) support for NGOs and other providers of vocational training and rehabilitation for people with mental health problems

In the field of **employment** people with mental health problems are among the largest group of unemployed in all countries, despite a sometimes very strong desire to engage in productive work. The situation is often especially hard for young people who experience mental illness and who are at the beginning of their careers. In cases where people have a job but lose it due to the occurrence of a mental illness they sometimes find no way to defend themselves (due to a lack of resources and information). However, in all countries there is a general lack of job opportunities for people with mental health problems; there is much stigma and discrimination, and myths about mental illness among employers are widespread. Most efforts directed at vulnerable groups are concentrated on people with disabilities, and employment agencies do not know how to deal with the specific needs of people with mental health problems.

In almost all countries, the only secure source of income is through social pensions or disability benefits, which in most cases are very low. The dilemma for people with mental health problems is always the same, once they find employment they lose their disability status and therefore their benefits. A negative result of this situation is that in some countries, for example Bulgaria, people with mental health problems have to fall back on short-term jobs, often without legalised contracts, no insurance payment from the employer, etc. Other problems, preventing people with mental health problems to become active on the labour market are a great need for relevant training as well as support in searching and applying for a job.

In several countries, there are sheltered or adapted jobs, even though there are few, but they do not meet the ultimate goal of re-integration of people with mental health problems in the open labour market.

Advances in the field of employment at national level can be noted for example in the Czech Republic where since 2005 people with mental health problems can have a salary and their disability pension at the same time. In Denmark, many private companies have expanded possibilities for "social responsibility" providing vulnerable people, also people with mental health problems, with job opportunities. A very common job opportunity for people with mental health problems, such as for example in France, Greece, Italy, Poland or Portugal, is within cooperative structures like social firms that allow people to be economically productive, earn money, without much stress, be empowered and therefore more confident and capable. Another good practice in the employment field can be found in Malta where the state employment agency has set up a partnership agreement with an NGO specialised in mental health to provide training, facilitate employment and provide support services for people with mental health problems who register for employment.

Recommendations for promoting social inclusion of people with mental health problems in employment:

- Raise awareness among employers of the employment potentials of people with mental health problems**
- Create decent job opportunities in sheltered/adapted employment or social firms as well as in the open labour market**
- Ensure a decent minimum income for people with mental health problems as well as a fair regulation of the compatibility between work and social benefits**

In terms of **housing**, there is a large number of people with mental health problems who are homeless in all countries. For this group it is very hard to find affordable and adequate housing; they often lack the financial resources to pay for rent and they also face stigma and discrimination. In many countries there are no existing regulations protecting people with mental health problems against direct or indirect discrimination in the area of housing.

In Cyprus, people with mental health problems are accommodated in homes for older people, where there is no family to support them and due to a lack of alternative solutions. In other countries, mostly in the EU-15 Member States, there are some sheltered living opportunities located in community settings which are targeted specifically at people with mental health problems. This is a relatively new concept for most of the newer Member States of the EU. In general, however, these opportunities are rare, they are mostly offered by NGOs and they are often faced with budgetary problems.

Some countries like Denmark have been able to develop a range of alternative housing opportunities for people with mental health problems such as flats in special housing units. However, the question remains whether these special social services create barriers for social inclusion. In Greece or Malta, governments have helped to support the provision of accommodation to people with mental health problems, mostly based on collaboration with NGOs and by providing rent subsidies promoting independent living. In Poland, legislation lays down social housing provisions inter alia for people with psychological problems.

Recommendations for promoting social inclusion of people with mental health problems in housing:

- Promote legal regulations promoting housing rights of people with mental health problems and prohibiting discrimination**
- Prevent homelessness of people with mental health problems by supporting the development of affordable and adequate housing**
- Provide (financial) support to NGOs and other providers of alternative housing solutions like sheltered living opportunities**

In the field of **transport**, participation in public transport often forms a barrier for people with mental health problems. In some cases, they decide not to travel (e.g. to therapy, day hospitals or for leisure activities) due to a lack of money, while in other cases they would need a person to assist and accompany them. Personal assistants are available in many countries for people with disabilities, but not for people with mental health problems. In some countries, mental health and social services are difficult to reach via public transport, which means that access becomes difficult for people with mental health problems, especially for those people living in rural areas.

For people with mental health problems, there are no special services and no price reductions in most cases. This is only available for people with disabilities, and in some countries people with mental health problems can benefit from it as well if they receive a disability pension.

Positive initiatives taken with regard to ensuring access to transport possibilities for people with mental health problems include a special pass issues in Luxembourg that allows for the use of public transport without charges. In Estonia, there are efforts to provide out-patient care services as close as possible to the patient's place of residence in order to avoid problems of transport. And in many countries, mental health and social care organisations organise transport for the users of their services themselves on a voluntary basis.

Recommendations for promoting social inclusion of people with mental health problems in transport:

→ Provide people with mental health problems, who rely on social assistance, with price reductions and support for access to public transport

→ Pay special attention to people living in rural areas with limited access to public transport

Regarding **leisure activities** in the community, in most countries, they are too costly for people with mental health problems to afford them (e.g. cinema, theatre, etc.). In some countries, even the disability status does not provide for discounts in ticket prices or cultural events. In addition, people with mental health problems generally fear judgement and rejection by others.

In most countries, leisure activities for people with mental health problems are provided by NGOs and self-help groups. These activities are facing financial pressures, which often lead to a limited service capacity. Moreover, these kinds of services are very specialised; in order for the leisure activities to be inclusive they should bring together people with mental health problems with other people in society.

To this end, Belgium has successfully been carrying out Buddy projects, where volunteers are twinned with a person with mental illness to give personal assistance and company in leisure activities. In Greece, housing initiatives ensure that people with mental health problems go out, enjoy summer vacations and socialise in the community. Leisure activities in Slovakia are mainly run by patient organisations that organise club meetings, trips, sports events, cultural and social events. Moreover, disabled people, including people with mental health problems, receive benefits in the form of discounts on theatre and cinema tickets.

Recommendations for promoting social inclusion of people with mental health problems in leisure activities:

→ Provide concessions and price reductions for social and leisure activities to people with mental health problems who rely on social assistance

→ Support the establishment and sustainability of self-help groups and social clubs for people with mental health problems as well as initiatives aimed at bringing together people with mental health problems with other people who live in the community

In view of the safeguarding of the **civil and human rights** of people with mental health problems the situation is very diverse in Europe. In some countries there is existing legislation referring to the rights of psychiatric patients (including right to information, informed consent, open files, etc.), while in other countries, legislation is missing. In some countries without legal provisions, for example in Latvia, there are many accounts of involuntary hospitalisation and human rights violations in psychiatric hospitals or social care homes in the form of physical and chemical restraint, physical and emotional coercion and control of a person's private belongings.

In most countries, people with mental health problems lack the knowledge about their rights, and as they are particularly vulnerable it is very difficult for them to defend themselves and to claim their rights. In many countries, there is existing anti-discrimination legislation (for example with regard to access to transport, education or employment); however, the legislation is mostly directed at discrimination on grounds of disability. For people with mental health problems there is mostly no specific legislation guaranteeing their rights.

Specific right-related problems in some countries concern the sentencing of mentally ill criminals, problems of accessing the same legal protection in court trials as other members of the society, and problems of guardianship law under which people with mental health problems lose their citizen's rights and are obliged to submit their life to control by another person, often within a complex system that does not have regard for people's individual needs.

Positive developments in this field include the example of Greece where there is a specific law protecting the civil and human rights of people with mental health problems. This, combined with programmes of awareness raising of the community civil society organisations, informs social services and the population in order to protect the human rights of this group. In Poland, positive changes include post-graduate studies for people with mental health problems at the university, the establishment of centres for civic counselling led by NGOs as well as the introduction of patient advocates in mental hospitals.

Recommendations for promoting social inclusion of people with mental health problems in civil and human rights:

- Ensure that people with mental health problems are informed about their rights**
- Enforce the implementation of anti-discrimination legislation in all areas**
- Support the creation of contact points for legal advice for people with mental health problems**

Other important areas that were repeatedly mentioned regarding their impact on the social inclusion of people with mental health problems include their involvement in policy and decision-making. In all countries, there is a need for good governance mechanisms and practices that allow and encourage an ongoing evaluation by users and their representatives. Good grass-roots involvement would ensure flexibility and sustainability of good practices at the local level. The role of the media was highlighted as a powerful tool to promote a realistic image of people with mental health problems and not to demonise them.

Loneliness and social isolation were seen as problematic and a main obstacle to social inclusion in many countries. Although the families of people with mental health problems are in many cases very supportive and provide needed help (for example housing), they are also often overprotective and do not encourage people with mental health problems to work and to integrate into society.

Financial aspects of social inclusion concern hospitalisation insurances that do not cover psychiatric illness in some countries, so that people with mental health problems cannot refer to their insurances for hospitalisation costs. Moreover, all countries, without exception are faced with very limited financial budgets for community psychiatric services and supply.

Recommendations for promoting social inclusion of people with mental health problems in other important areas:

- Ensure the involvement of people with mental health problems and their families in relevant policy and decision making as well as in ongoing monitoring and evaluation of services**
- Seek partnership with NGOs and other grass-roots providers of services in mental health to ensure adequacy, flexibility and sustainability at the local level**
- Provide an adequate financial frame for the development of sustainable community-based mental health services**
- Guarantee equal treatment for people with mental health problems with regard to insurance coverages**

The situation of particularly **vulnerable groups** such as women, children/adolescents; migrants or older people who are faced with several dimensions of stigma, discrimination and social exclusion simultaneously varies in the different countries. However, the group that is mentioned the most in all countries in terms of being at risk of mental ill health and social exclusion is that of migrants. In all countries, migrants tend to face many problems at the same time such as problems related to access to work, to decent housing, financial and legal security, etc. These problems can be excluding as such and often exacerbate existing mental health problems. In addition, migrants who experience mental health problems often lack access to adequate services that are culturally sensitive and provided at an early stage.

Another group vulnerable to mental illness and social exclusion are women. An observation across many countries is that there is a lack of a gender-based approach to mental health and social services. The impression is that disabled people lose their gender attributes and that they are only regarded as being disabled.

Most existing initiatives targeting vulnerable groups include those focused at children in general and migrant children in particular. A problematic aspect here is the labelling of children or young people as mentally ill, thus increasing the risk of social exclusion. In younger people a growing problem in some countries is the problem of drug abuse and addiction, which in the presence of psychosis result in a high risk for exclusion.

Older people are reported in all countries to face mental health problems. The cause or consequence of this situation is in many cases loneliness. In most countries, there is not enough health and social support for people to stay in their homes, and at the same time there is a growing need for spaces for meeting and living in the community.

Recommendations for promoting social inclusion of people with mental health problems in vulnerable groups:

→ Pay special attention to the mental health and social needs of migrants and invest in culturally sensitive approaches to mental health and social services

→ Adopt a gender-based approach in mental health and social support services

→ Invest in mental health promotion and early prevention of mental disorders and drug abuse in children and young people

→ Create spaces for meeting others and living in the community for older people and fight social isolation

General categories of **good practices** for improving social inclusion of people with mental health problems that were mentioned in most countries included all socio-psychiatric associations (drop-in centres, counselling, day centres, different forms of housing and rehabilitation, etc.). Necessary principles for the success of inclusive practices are person-centeredness, independence, empowerment and community-orientation. The effectiveness of these initiatives is largely determined by the extent to which people with mental health problems are included in the advisory boards and decision-making processes.

Other good practices that were mentioned in the countries can be classified into three broad categories, good practices concerning social activities such as projects addressing the social and training needs of people with mental health problems (music, arts, other skills), buddy/befriending projects connecting people with and without mental illness, but also de-institutionalisation processes that go hand in hand with the development of flexible community-based systems for mental health care, rehabilitation, support and alternative housing opportunities in the community. The other category concerns good practices aiming at the labour market integration of people with mental health problems for example through supported employment, rehabilitation initiatives, social firms, work opportunities in the community, in local cafés, etc.). Finally, the third group of good practices includes those aimed at the general population such as anti-stigma campaigns as well as efforts at the policy level to mainstream mentally healthy public policy and practice in all policies aimed at achieving social justice and closing the opportunities gap.

It should be stressed that the majority of these good practice that are being implemented across European countries are run by NGOs, mainly on a voluntary basis and with only very limited financial resources.

Recommendations for promoting social inclusion of people with mental health problems in good practices:

- Adopt the principles of person-centeredness, independence, empowerment and community orientation**
- Invest in social activities in the community as well as in initiatives promoting labour market integration of people with mental health problems**
- Fight stigma and prejudice in society through realistic messages in the media**
- Support NGOs and other voluntary providers of mental health and social services**

For the period 2006-2008, only 13 out of the 27 **National Action Plans on Social Inclusion** that have been developed as part of the National Reports on Strategies for Social Protection and Social Inclusion make a reference to the social inclusion needs of people with mental health problems. Whereas the issue is picked up in only five countries, Finland, Greece, Lithuania, Malta, Sweden, in a more extensive manner – taking into account the need to adopt a preventative approach, providing non-institutional services, long-term care, social care and social housing solutions for people with mental health problems, and with particular focus on children, young people and families with children – the eight other Reports mention the challenges and needs of people with mental health problems only very peripherally, mostly in one sentence.

In all other National Action Plans on Social Inclusion, people with mental health problems are either not considered at all, or no distinction is being made between people with mental health problems and people with disability or mental disability – two fundamentally different groups. In almost all countries, there has been no systematic involvement of civil society organisations, in particular mental health associations. And many countries reported about difficulties to identify, contact and talk to the responsible

units and officials dealing with the reports in order to become involved in the social inclusion process at the national level.

In several countries, the needs of people with mental health problems fall under the jurisdiction of the Ministries of Health and thus were reflected in the National Strategies for Health and Long-term care and not in the National Action Plans on Social Inclusion. This has far reaching negative consequences, as this group is being left out of the policy area that integrates and coordinates matters of social inclusion.

In order to make this instrument more effective, most countries agreed that national governments must adopt a serious and coherent approach towards the development of the Report as well as towards the effective implementation of all other instruments related to the Open Method of Coordination such as mutual learning and peer reviews.

Recommendations for promoting social inclusion of people with mental health problems in the National Action Plans on Social Inclusion:

- Include people with mental health problems in the framework for the National Action Plans on Social Inclusion in all countries as a separate group from people with other disabilities***
- Involve NGOs and other civil society organisations, especially mental health associations, in the discussion, drafting, implementation and monitoring of the National Reports on Strategies for Social Protection and Social Inclusion***
- Enforce an integrated approach to tackling the needs of people with mental health problems in all areas of the National Reports, Social Inclusion, Health and Long-term Care and Pensions***
- Assume and promote ownership and responsibility for the National Reports as well as for all other OMC related instruments, such as mutual learning and peer reviews***
- Ensure an effective implementation of agreed strategies and actions as laid down in the National Reports***

3.2. National reports on mental health and social inclusion

3.2.1. Austria

Health and social services

The existing dilemma in the field of health and social services with regard to people with mental health problems is a very high demand on the one hand and constantly decreasing budgets to meet the demands on the other hand. In the context of public financing of health and social services cost-benefit analysis become more and more important.

People with mental health problems who live on social benefits have only limited access to insurance claims. Total inaccessibility to complementary insurance is a major factor of social exclusion of people with mental health problems.

Generally, there is a missing link between the health and social sector. The interaction of federal and state authorities is with regard to people with mental health problems insufficient. Individuals are handled as "cases" rather than "persons". As a result of the Austrian federal system the level of support for people with mental health problems often depends on the place of residence. In addition, the health sector is characterised by a lack of transparency with regard to questions of competence and financing, which is similar in the social field.

With regard to allowances for nursing care, people with mental health problems are often discriminated against: they receive a very low level of allowance, if any. Despite of day-long nursing care, people suffering from dementia are not adequately graded. Moreover, the amount of nursing allowance is only a drop in the ocean.

Education and training

In the day centers and job training centers the financial scope is decreasing. The path from sheltered or supported to external job opportunities is still largely dependent on the good will of the employers. This lack of opportunities leads to exclusion.

In schools most support for excluded people is focused on "disability". In order to advance social inclusion of people with mental health problems, the issue has to be acknowledged also in this context of teachers' training and further education. The existing discrimination in schools reproduces social exclusion. However, schools which are ready for the 21 century have to start with the youngest in the frame of early prevention of mental disorders. Only this approach may help to break the vicious cycle of exclusion.

Employment

The lack of job opportunities for people with mental health problems is evident. A first step towards entering the job market is often through part-time work, adapted to individual capacities. The concept of flexicurity could become effective in the form of existential security over standard benefits and a flexible organisation of employment relationships. This requires a stage model, which offers the incentive to earn more on a job. The danger of social exclusion because of flexible labour agreements and the increasing number of working poor is especially strong for people with mental health problems.

In the field of employment, a further development can be observed, which is increasing in scale, namely that of "burn-out". This mental illness, which is related to depression, is especially prevalent among highly qualified professionals. In this way, the work environment "produces" people with mental health problems and afterwards excludes

these previously high performers from the economic process – this is the paradox of our times.

Housing

The right to housing is a fundamental right. The inclusion into community structures combined with the sustainment or creation of public spaces for living together are basic requirements for the fundamental right to housing. Access to housing in terms of choice, transitional options and affordable social housing are a condition for inclusion. Without a roof over ones head the risk of mental health problems increases substantially.

Transport

Participation in public transport still forms a major barrier for people with mental health problems. In order to guarantee mobility, people with mental health problems are often in need of a person to assist and accompany them.

Leisure activities

Leisure activities can only be counted as leisure in the light of other activities, particularly employment. Without employment leisure activities become a meaningless activity. Only affordable possibilities to participate in leisure and social life can have an inclusive effect; high prices are an element of exclusion. In addition, for leisure activities to be truly inclusive they need to be connecting people with mental health problems with those who enjoy good health.

Civil and human rights

Article 7 of the Austrian federal constitution states that no one should be discriminated against on the grounds of disability and that equal opportunities for disabled and abled people must be guaranteed in all spheres of life. This is an ambitious goal and its realisation still depends on many inclusive measures.

Access to rights is particularly difficult for vulnerable groups. Legislation that concerns people with mental health problems contains many vague legal terms and only few stipulated legal claims. As a result people with mental health problems remain dependent on the good will of the authorities.

Situation of women, children/ adolescents, migrants, older people

The situation of migrants needs special attention. Exclusion, no access to work, etc. excludes them and can exacerbate existing mental health problems. Evidence shows a form of substituted suffering of second and third generation migrants. On the other hand, there are many older (first generation) migrants struggling with various mental health problems.

Today, there are for the first time mentally ill people reaching older age. In addition, there are many mental health problems appearing later in life (depression, dementia, anxiety, panic attacks).

With regard to children, adolescents and adults, social inclusion can only be effective if the personal situation of the individual is taken into account (case-management) and phases of transition are carefully supported. The statutory fixing of age limits only leads to unexpected ruptures and therefore exclusion.

Good practices for improving social inclusion of people with mental health problems

All social psychiatric associations working with people with mental health problems, from low threshold drop in centers over counseling-, day- and socio-economic centers to

different forms of housing and rehabilitation are rays of hope in the field of mental health care. The social inclusion of people with mental health problems relies on the premises of person-centeredness, independence and empowerment and community orientation. The contribution of social clubs is particularly important. Moreover, people with mental health problems must be included in all advisory boards and decision-making processes. The development of self-help groups and the interconnection of people with mental health problems are equally important elements of inclusion.

National Action Plans on Social Inclusion 2006-2008

Mental health issues are only peripherally mentioned in the Austrian National Action Plans. No clear distinctions are being made between people with mental illness and people with mental disability.

Other specific challenges and solutions

Mental health is the basis for overall health – there can be no health without mental health. The social exclusion of people with mental health problems leads to a vicious circle that can only be broken where there are interventions occur at different stages in a cooperative manner. It is only in this way that social inclusion can become reality.

People who enjoy higher living standards define health as “well-being”, whereas people who live in poverty and social exclusion define health as “the absence of illness”. A lot remains to be done for that people with mental health problems can claim a definition of health based on “mental health and well-being”. The point is not to achieve the absence of illness for people with mental health problems. The point is to consider the mental health and well-being of this group, which should be central to the design of adequate health and social services. This requires a person-centred approach with a focus on mental health and well-being for all – regardless of social status, gender, ethnic origin, etc. Social inclusion requires mental health and well-being as a fundamental right.

3.2.2. Belgium (Flemish and Walloon Region)

Health and social services

A special recommendation of the Flemish Health Council was published on 21 April 2006, with a chapter on social inclusion of psychiatric patients. In June 2006 there was a debate in the Parliament with the decision to include the discrimination of psychiatric patients as a topic for the institute. There are plans of the Flemish government to add a 6th goal to its programme: "Fighting depression and reducing the number of suicides".

In general, there seems to be a focus in the Flemish region on curative approaches and a focus on mental disorder prevention in the Walloon region of Belgium.

Education and training

The Flemish government decided that from 01 September 2006 onwards, every Flemish school has to evaluate mental health as a factor of overall health and well-being of their pupils and to define policies to deal with potential problems. However, the status quo is that most schools do not have any policy to deal with mental health problems of their pupils.

In the Walloon region, there exist special schools for pupils with mental health problems. However, the segregating nature of these schools is a source of further social exclusion. There have been previous projects in the Walloon region aiming to raise awareness of mental health and well-being among pupils by informing them and introducing them to former patients. These projects proved to be successful but were brought to an end due to termination of funding.

Employment

In the Flemish region, an Interministerial Conference, held on 29 November 2005 created a working group to study the question of job opportunities for disabled people, including psychiatric patients. At the present point, the outcomes of this working group are unknown.

In 2004, the association of Catholic Hospitals (VVI) published a paper on "Inactivity-traps for people with mental health problems". This survey of different kinds of legal barriers for people with mental health problems to enter the labour market did not lead to a change in legislation. Nevertheless, the document gained influence in daily practice as it became a working instrument for social workers in their battle to help people with mental health problems (back) into employment.

Most efforts in the field of employment in the Flemish region are concentrated on people with mental disabilities not people with mental illness.

The main sources of difficulty for people with mental health problems to (re-)enter the labour market, observed in the Walloon region, are stigma, discrimination and absenteeism.

There are sheltered or adapted job services; however, these do not meet the ultimate goal of re-integration of people with mental health problems in the open labour market.

Housing

On a symposium in May 2002, the Federation of Centres of Social Work (CAW) presented a survey on homelessness in Belgium. According to this survey, the number of people with mental health problems living in a situation of homelessness had increased from 23% in 1982 to 34% in 2002.

Experiences in the Walloon region confirm this observation. For people with mental health problems it is very hard to find affordable and adequate housing. However, there are some sheltered living opportunities, located in community settings, which are targeted specifically at people with mental health problems.

Transport

In the Flemish region of Belgium, some psychiatric institutions are not reachable via public transport, which creates difficulties for relatives to visit patients.

The same problem exists in the Walloon region, where services are sometimes not well-accessible. In cases where public transport is not available, access for people with mental health problems becomes very difficult.

Leisure activities

Most projects dealing with leisure and social activities that are provided by the Flemish Government have a focus on people with physical and mental disabilities.

Over the last years, some "buddy" projects were successfully initiated in Gent, Antwerp and Leuven. In these projects, volunteers are twinned with people with mental health problems to give personal assistance and accompaniment especially in the area of leisure activities.

In the Walloon region, the main difficulty for people with mental health problems related to participation in leisure activities is the high costs of these activities that people cannot afford. Also, people with mental health problems often fear judgement and rejection by society.

There are special initiatives such as club houses which exist, but these are only directed towards patients and do not have a real inclusive character. In general, leisure activities that include people with mental health problems are rare, and for those people who live in rural or isolated areas there are practically no chances of engaging in such activities.

Civil and human rights

The current Federal legislation on patients' rights (2002) includes, contrary to the original text from 1994, psychiatric patients. Patients' rights include: quality of treatment; right to information; informed consent; open files; access to a complaint system.

The official support of patients' organisations has not yet been regulated. Until June 2006, support to Flemish patients' organisations depended on voluntary support, for example through the Flemish Mental Health Association.

Evidence shows that in the Flemish region people with mental health problems lack the knowledge and access to their rights. The more vulnerable the people are the more difficult it becomes for them to defend themselves and claim their rights.

Other areas

Hospitalisation insurances, both public and private, do not cover psychiatric illness so that people with severe psychiatric problems cannot refer to their insurance for hospitalisation costs.

In their report on the costs of chronic illness, the Flemish Platform of Patients' Organisations emphasised that with regard to hospitalisation people suffering from a mental illness were amongst those who are facing most difficulties.

Good practices for improving social inclusion of people with mental health problems

In the Flemish region, there are many local good practices for people with mental health problems to be found, particularly in the field of local community activities such as art, re-integration and rehabilitation.

Likewise there exist good practices in the Walloon region, for example public restaurants where people with mental health problems can work or re-adaptation centres or initiatives involving social activities.

Another positive development in the Walloon region is an increasingly stronger growing users' movement.

National Action Plans on Social Inclusion 2006-2008

The concerns of people with mental health problems have been taken into account to some extent in the National Action Plans. However, there has been no systematic involvement of civil society, in particular mental health associations, neither in the Flemish nor the Walloon region.

3.2.3. Bulgaria

Health and social services

In 2004, a new Health Law with a separate Mental Health Chapter was adopted. The Chapter describes mainly the groups of people targeted by the Law, the rights of the mentally ill, the respective institutions and services which are responsible for their treatment and procedures for compulsory treatment. By including this Chapter as an element of the Health Law, the most urgent needs for changes in the existing mental health regulations were met.

The health system in Bulgaria consists of a primary and a secondary sub-system. The visits to medical specialists working in sub-systems are paid by the National Health Insurance Fund (NHIF) and the Ministry of Health, respectively. Nevertheless, each patient should pay a small fee per visit with the amount equivalent to 1 per cent of the minimum salary in Bulgaria. Only people who have a disability status (document issued by a district medical commission) are exempt from fees. Although small in total, the fee may be very large for a person with schizophrenia, thus preventing him to receive timely medical attendance for his physical problems. A crucial problem is that about 1.000.000 inhabitants (almost 20%) of the Bulgarian population is not insured for different reasons. This means that these people have free access to the health care only in emergency situations. In all other situations they have to pay out of their own pockets, i.e. not only the small admission fee, but the full cost of the doctor's visit. Usually, these people are poor, and also the prevalence of (undiagnosed) psychiatric disorders is higher among them than among the general population.

Communication between general practitioners and psychiatrists is rare, at an individual, institutional and guild level. According to the standards of the Ministry of Health and the consensus statements of the psychiatric guild the general practitioners can and should treat all kinds of psychiatric disorders except some difficult cases of severe mental illness (manic episodes, treatment resistant depression and schizophrenia). In reality GPs do not provide any treatment or consultation, referring patients with mental health problems automatically to the psychiatric office. This results in overcrowding of the latter with cases of both severe and common mental illness, less time spent with each patient and finally in a reduction of quality of treatment.

The government strategy "National Program for Mental Health of the Citizens of Republic of Bulgaria" outlines that the medical model of psychiatric illness prevails. Professionals dealing with mental health have mainly a medical background and focus exclusively on the curing of illness. However, in the case of severe mental illnesses, they can exist a lifetime and therefore demand solutions in the perspective of bettering the quality of life of persons with severe mental illness and their re-integration into social life. The current system cannot meet these requirements. The necessary capabilities are lacking to integrate contributions of the non-medical sectors and professions.

A weakness of the legislative system is that the formulated standards of social services do not comply with the users' needs, especially in view of the type and nature of their disabilities (physical or mental). This raises questions about the adequacy of the provided services against users' demands and needs.

The long-term consequence of the existing approach towards people with mental disabilities, no matter whether they live in an institution or in the community, is lasting social isolation, incompetitiveness on the labour market and lack of social skills.

In August 2004, the Bulgarian Helsinki Committee (BHC) issued its report "Archipelago of the Forgotten - Social Care Homes for People with Mental Disorders in Bulgaria". It was a report on the situation of mentally disabled people placed in state institutions in Bulgaria. In this book the following grim picture was outlined:

"People with mental disabilities in Bulgarian social care homes are still living in an inhuman environment, deprived of medical care and secluded from the rest of the world. Far from the eyes of society, forgotten by their families and friends, they die in these institutions which so far do not have any alternative. This is the main conclusion of the three-year monitoring of the social care homes for people with developmental disabilities, mental illness and dementia".

Since then, in line with the requirements for entering the EU, the Bulgarian government started vigorous initiatives for both improving the material basis in the social care homes, as well as enhancing the process of "deinstitutionalization", i.e. creating the means for community care services.

Currently, a small number of alternatives to the residential care for children and adults with disabilities exist. There are day care centers for children and adults with mental disabilities under the jurisdiction of Ministry of Labour and Social Policy, day care centers for children within the Medical and Social Care Homes of the Ministry of Health and day care and rehabilitation centers established and run by NGOs. Their efficiency and quality of work is unevaluated; their current capacity is extremely limited.

Education and training

A person experiencing a first psychotic episode in Bulgaria is usually compelled to leave school or university. This happens because of several unfavourable circumstances: the intolerance towards the symptoms of psychosis and/or the associated, socially unaccepted behaviour on the part of the classmates of the psychotic person; reluctance of the school or university management to organise a specific flexible education programme; inexperience of the school psychologists and educational professionals to deal with the needs and challenges of a mental illness.

With regard to vocational training, after the beginning of the socio-economic reforms in Bulgaria a number of rehabilitation programmes emerged, orientated at increasing the social integration of people with severe mental illness (via education and training) and therefore increasing their chances of finding and keeping a job on the competitive job market. Such programmes are implemented mainly by NGOs and make use of recovery and rehabilitation models. A variety of training courses are offered, ranging from training in technical skills, such as carpentry to education in the methods of designing and operating a small business enterprise. The sustainability of these programmes, however, often expires once the projects sponsored by international agencies come to an end.

Employment

The only secure source of income for individuals with severe mental illness is their social pension for disability (30-50 Euros per month). The economic and social status of these people is extremely low. As a result they count for their sustenance entirely on their families, which in fact increases the economic burden and can create seeds of conflicts and frustration.

There is a National Employment Agency with a well developed network of local offices (Labour Bureau) in almost every Bulgarian town, which offers free job services and consultation to unemployed people. However, the staff in these agencies is not trained to communicate with and answer to the specific needs of people with severe mental illness. Therefore, such clients are regarded as annoying; they are denied jobs and advised to be contented with their disability pension. The advice is associated with a certain real risk. The predominant emotion guiding people with severe mental illness in the process of a job search is fear that once the fact of their employment becomes known to government employees, they will lose their disability status (and pension) given to them by the respective authorities.

In cases, where people with mental health problems get a job the work is usually on a day-by-day and per hour basis and does not involve long-term engagements (e.g. painting of an apartment, help with the house work, translations, etc.). Such jobs are in the domain of the so called "grey economy", i.e. without legalised contracts, with no insurance payment on the part of the employer and so on.

Labour Bureau officials are of the opinion that although many employment programmes aiming at the integration of disabled persons (including those with mental illness) exist, they are poorly tailored to the specificities of employees with psychiatric conditions. The legislation provides for some tax concessions for businesses that employ people with partial or full incapacity for work (i.e. with a disabilities status). However, these benefits are not very esteemed by employers. A growing number of owners of small and medium sized enterprises are willing to employ people with severe mental illness on unqualified positions regardless of the possible challenges, absenteeism in times of crises, morning sleepovers, etc.

With regard to supported employment, the country lacks the tradition and trained specialists in these kinds of employment services. Occupational rehabilitation in the form of some kind of job search training activities is offered sporadically and in an unstructured way. The existing "occupational-rehabilitative communities" that are run in the frame of some of the large psychiatric hospitals, offer monotonous and low-paid occupation that does not contribute at all to the goals of psychosocial rehabilitation and hence to the social inclusion of mentally disabled.

The labour law does not entail special measures for protection against discrimination of people with mental health problems at the work place. Such measures are foreseen for the whole group of "people with disabilities" in the Law for protection against discrimination. It defines and forbids direct and indirect discrimination on the basis of ethnic origin, race, disability, etc. However, cases against employers charged with discrimination are extremely rare.

Housing

The legislative framework does not include any regulation against direct or indirect discrimination against persons with mental health problems in the area of housing. The legislative framework regulating the accommodation of people in state-owned or municipality-owned houses provides for additional living space when a family member suffers from a condition requiring additional premises or the continuous support of another person. The lists of such conditions include most of the serious mental illnesses.

Cases of fraud and misappropriation of the homes of mentally ill by people who make use of their disorientation are quite common.

Supported housing for people with mental health problems is a new practice for Bulgaria. Several supported homes/halfway houses began to function in the second half of 2006. They are run by municipalities and NGOs; there is a budget for rent, utilities and food. These homes were organised and financed in the context of the "de-institutionalisation" process – people who had spent years in psychiatric homes or social homes were supposed to live there, after being assessed by a special commission made up of psychiatrists and social workers, that measures the capacity for independent living. In reality however, most of the supported homes were populated by people with mental retardation – those with schizophrenia being considered too dangerous and unpredictable to be offered the benefit of independent living. The management and personnel of the facilities largely does not understand the paradigm of supported homes. There is a tendency of restricting the inhabitants of the homes from leaving and returning to their residences at their own will. The daytime is organized in structured educational and occupational activities by the personnel "for the good of the beneficiaries".

Transport

No exclusion except for economic reasons.

Leisure activities

People with serious mental illness are generally excluded from participating in cultural and sports life because they are not able to afford such activities. The disability status does not provide for any discounts in ticket prices for cultural events, nor the perusal of sports equipment.

According to the regulations, social services provided in specialist institutions and in the community have to meet certain standards and criteria for organisation of leisure time and personal contacts such as the possibility for the users of social services to organise their spare time independently or the planning of cultural, sports and other activities for the users of social services. To achieve the standards related to the organisation of leisure time and personal contacts several factors are essential: available financial resources, recognition of the various interests of the users as well as their financial capabilities to meet these demands. It is not clear how the standards for independent organisations of leisure time as regards people with more severe mental disabilities will be achieved.

A weakness of the regulatory system is that the family of the patient is not included in the process of organising their leisure time. Taking their opinion into consideration, upon available informed consent of the user, would create preconditions for the organised activities to become more adequate to users' needs, wishes and interests. As recognised by BHC, in its report on homes for mentally disabled people, in the process of organising leisure time and personal contacts "the emphasis is placed on the strictly medical model of their mental disease, which prevents the formulation of adequate targets while treating and rehabilitating mentally disabled people". The scanty regulatory system with this purely medical approach towards mentally disabled people results in their isolation from the organised forms of social activity in the institutions.

Civil and human rights

The constitution grants basic human and civil rights to all citizens, except to those placed under guardianship (declared incompetent by a court). However, surveys of public attitudes reveal that it is very difficult to think of people with mental health problems in the context of human rights. In the following, there are some illustrations from a focus group survey of the general public, made by the Public Health Association (June-July 2006), illustrate the problems:

"Of course crazy people are also humans. They have the right to receive medical and other cares on part of the society. Or, more precisely put, the state is obliged to take care for them".

"These people are very unlike each other. Some of them could easily work in the agriculture or as artists...but I would not let such people in the police, the army or the parliament, although these institutions are flocked with persons like this.

"I am sure that some of them can have the right to work, to marry, but others should be renounced."

"In these cases the approach should be individual."

"The rights of these people should depend on their capacity to act in a responsible manner...If he has the brains of a three year old child, why should he have the rights of a normal citizen?"

"In some respects these people enjoy more rights than the rest. And these rights turn into a privilege. If such a person commits a murder, he is not convicted because he's deemed mentally irresponsible....he has murdered a human being, and no one is guilty. The newspapers report such cases every day."

"If it depends on me, I will put him in a mad house right away, and in his place I will convict the state which is guilty that it has left in the open a dangerous lunatic."

Other areas

The analyses of the situation focuses mainly on social exclusion issues regarding people with serious mental health problems, psychoses, mental retardation, etc. In Bulgaria, these people fall under the category "people with mental disabilities". To date, there are no effective mechanisms to promote the social exclusion of people suffering from the so called "common" psychiatric disorders.

National Action Plans on Social Inclusion 2006-2008

People with mental health problems are mentioned in the National Action Plans on Social Inclusion 2006-2008 in the context of programmes, work-plans and grant schemes, but together with other people with disabilities, not as a separate group of vulnerable people.

Good practices for improving social inclusion of people with mental health problems

The integration of people with chronic mental disorders in the social and the economic life of the country is a complex problem concerning amongst others local Bulgarian communities, the regional organizations of people with severe mental illness, organisations of helping professions, the local and the global business entities, the national and the local institutions and authorities engaged with social policy making. The complexity of the problem implies that all these are responsible for its solution. It is not possible to develop a model of social inclusion that would exclude any of these groups.

The users of mental health care in Bulgaria have a proven need for rehabilitation that involves possibilities for equal participation in the basic social activities that guarantee inclusion and equality. Among them is the independence guaranteed by income. Despite the existence of unfavourable psychosocial factors associated with life with a severe mental illness, the studies in the EU Member States undoubtedly present evidence that the new developments in employment, for example supported employment, which envisage coordinated communication among the employer, the employee and the professionals, is a source of new hope for employment of a larger number of people with severe mental illness in the context of the competitive labour market. Bulgarian businesses must develop social attitudes to respond to the needs of the respective communities to integrate the unemployed members of the group of disabled and mentally ill.

3.2.4. Cyprus

Health and social services

People with mental health problems are faced with a number of problems that consequently marginalise them and lead to social exclusion:

- there is no community care legislation for the provision of community psychiatric care;
- the necessary and appropriate medical structures do not exist;
- psychosocial rehabilitation of people with mental health problems does not exist;
- socio-economic support for mentally ill patients and their families that provide care does not exist;
- a large number of patients were removed from the mental hospital and placed in homes for older people, although they were not old themselves.

In 2004, in a reply to the state of absence of legislation for the care in the community of this group the ombudsman pointed out that there is no coherent and legally regulated policy for the out-of-hospital care and rehabilitation of people with mental problems, and that existing practices are ineffective and/or inconsistent. In the same report the ombudsman also pointed out that state practices did not include any programmes to promote public sensitivity to the problem of prejudice against mental illness.

There is a lack of cooperation between various Governmental Departments and relevant Ministries involved in treatment and psychosocial care for coordination and implementation of a continuous service. Too often, the consequence is that not only do results not meet the inclusion needs at the level of the individual, but it also results in the absence of a coherent strategy for people with mental health problems that may create the basis for good practices. It is not recognised that a lack of coordination and communication is a fundamental obstacle and an aspect of exclusion in itself. It disconnects practices, while practices are fed by misinformation and stigma. The consequence of this vicious circle is an exclusion of people with mental health problems.

To an extent, de-institutionalisation, which is still incomplete, has substituted one kind of exclusion for another. Former patients of the psychiatric hospital are increasingly becoming inmates of homes for the aged where the family is not capable to provide care, with minimal opportunities for work or education and minimal resources for mobility and recreation.

People with psychiatric illness today, who cannot have a decent life, are facing uncertainty and isolation, just as their families who carry a substantial psychosocial and financial burden and who are replacing the obligation of the services that should have been developed.

Education and training

There is an absence of interim institutions to prepare people with mental health problems for full social and professional integration. Intensive programmes for professional education and employment do not exist. Due to this and other reasons the great majority of people with mental health problems are unemployed (source: research carried out by the Mentally Ill Supervising Committee. Report for Commissioner for Administration No A/Π 763/2000).

Employment

The Ministry of Labour and Social Insurance has not included people with psychiatric disability in its 2nd Scheme Providing Incentives for the Employment of Severely Disabled Persons in the Private Sector. The Scheme provides subsidies to employers of up to 40% of the annual wages, subject to a maximum of CY£3.200, for the installation of facilities

for severely disabled employees. In addition, it subsidizes the employment of such persons up to 60% of their annual salary, subject to a maximum of CY£4.800.

Housing

In cases where the families of people with mental health problems are not in the position to provide care, due to a lack of support for their new needs/role, or where there is no family to take over the care, they are placed in homes for the aged. Research carried out by the Mentally Ill Supervising Committee showed that 66% of people in the Homes are between the ages of 30 and 60. Former inmates of the psychiatric hospital are increasingly becoming inmates of homes for the aged.

Transport

People with mental health problems and their families experience important difficulties in mobility (public transport is deficient). As a result of the fact that their needs are not addressed under the schemes of the physically disabled persons (with benefits/exemptions for public transport) it is not possible for them to have easy access to areas of community participation which could enable inclusion.

Leisure activities

Opportunities for people with mental illness for leisure and integration are limited. This includes difficulties to reach any existing care centres or programmes as well as difficulties in financial resources for mobility which could enable inclusion.

Civil and human rights

People with mental health problems in Cyprus are living in various environments of compromised freedom, confronted with difficulties, and in financial dependence leading to social exclusion.

The mass media show little sensitivity towards protecting people with mental health problems and their families from stigma. Projections of mental problems are often determined by fear, aversion and pity. There is a need to investigate the role of education in younger people's knowledge of mental problems and the role of the media in relation to the public's knowledge of mental illness.

The report by the Mentally Ill Supervising Committee (Report for Commissioner for Administration No A/Π 763/2000) pointed out that there is no coherent and legally regulated policy for the out-of-hospital care and rehabilitation of people with mental problems, that existing practices are ineffective and inconsistent and that state practices do not provide any programme to encourage public sensitivity towards the problem of prejudice against mental illness and dealing with stigma.

Other areas

The prerequisite for the identification and provision of intermediate practices that may ensure the psychosocial inclusion of people with mental health problems is that people are able to make their own rightful choices. Policy and decision making cannot be in the interests of users if they are centralised. Good governance mechanisms and practices should allow and encourage an ongoing evaluation by users and their representatives.

There is a need to formulate policies with adequate grass-root involvement that would empower practices with flexibility and potential for organic development. Currently, emphasis is placed on what is being achieved from above and not in what is missing at the individual level.

Situation of women, children/ adolescents, migrants, older people

The needs of young children, women and older persons for support are even greater because they are more vulnerable to abuse (e.g. battered women, children with mental health problems and their failure to continue education, specific concerns of older persons, etc.)

Social exclusion is also faced by children, women and older people in their role as family members and carers of people with mental health problems. The outcomes of the pilot programme "Support for relatives of people with mental health problems", which was carried out by KIPRODIPSA/AGMI in 2003, reveal the feelings of helplessness, guilt and isolation expressed by families of people with mental health problems in their attempts to provide care to their beloved family members that often lead to feelings of depression resulting from the burden of extreme responsibility.

Good practices for improving social inclusion of people with mental health problems

A good practice can be seen in the policies and plans of the Ministry of Employment Department regulating the affairs of other groups of disabled people, with allowances for their specific needs (subsidised benefits, petrol, transportation, special allowances for their specific disability needs etc.) – if these regulations would also apply to people with psychiatric illness.

Other forms of good practices include the supported employment for people with mental health problems.

National Action Plans on Social Inclusion 2006-2008

Under the National Action Plans on Social Inclusion 2006-2008 people with mental health problems have been identified as a special target group. However, even though mental disability is recognised under the law for disabled people, there is not any specific policy measure to reduce the marginalisation of people with mental health problems in this legislation. Consequently people with psychiatric illness are not included in provisions of other groups of disabled that aim at securing a decent life and combating their poverty.

In the policies and plans of the Ministry of Employment Department regulating the affairs of other groups of disabled people, allowances for their specific needs (subsidised benefits, petrol, transportation, special allowances for their specific disability needs etc.), there are no regulations responding to the needs of people with psychiatric illness. The question remains as to how the actions declared in the National Action Plans 2006-2008 for this group of mentally ill will be implemented – under which law and which regulations?

The needs of people with mental health problems are under the jurisdiction of the Ministry of Health (Mental Health Services) and as such they are reflected more in the National Strategies for Health and Long-Term Care than in the National Action Plans on Social Inclusion. This distinction and isolation promotes stigma and prejudice for people with psychiatric illness. This group is being left out of the policy area that integrates and coordinates matters concerning social inclusion.

Mentally ill and mentally disabled are two different concepts.

In the National Action Plan's section on the implementation of policy measures and institutional arrangements with the aim to develop integrated policies that coordinate all matters concerning people with disabilities people with mental illness are not included. Consequently there are no references to the needs of people with psychiatric illness within the rights of people with disabilities. And where no regulation is defining the specific group as beneficiaries whom it is going to serve, it is not difficult to understand the existing inequalities in the delivery of services.

The National Action Plan refers to a Unit of Occupational Rehabilitation of the Mentally Ill. However, it remains unclear how this Unit is for example related to the policy measures and institutional arrangements of the Ministry of Labour and Social Insurance that coordinates all matters concerning people with disabilities.

Other specific challenges and solutions

The process of de-institutionalisation needs to go hand in hand with public awareness raising and promotion of a positive image capable of combating stigma, prejudice and exclusion.

There should be action plans targeting the media. Currently, the mass media in Cyprus shows little sensitivity in protecting people with mental health problems from stigma as projections of mental health problems are often related to fear, aversion and pity.

The social policy of the state with regard to people with mental health problems must be strengthened. Isolated efforts of good practices do not replace an integrated policy approach. Essential elements of a policy, which is backed by a statutory framework, can secure quality, the continuity of responsibilities of the state, an improvement of services and support in ensuring a decent life far from social exclusion. The emphasis must be on life inside the community, promoting integration and combating and eliminating stigma attached to mental illness.

Finally, what is needed are action plans with policy decisions resulting in drastic measures, and the closure of the resource gap which is depriving those affected by mental illness from receiving adequate mental health care and social support.

3.2.5. Czech Republic

Health and social services

People with mental health problems are excluded because of difficult access to health and social services. The Czech Republic allocates only about 3,5% of GNP to psychiatric care. Most of this budget goes not to institutionalised care, which is generally given preference.

There is a lack of crisis services. In some regions, there is a lack of psychosocial services altogether. Generally, it is an exception to open any new health or social services even though the Czech Republic has many "gaps" in its psychosocial services network. There is also a lack of cooperation between actors, especially between the Ministry of Health and Ministry of Labour and Social Affairs. Most psychosocial services are provided by NGOs. Their income is not guaranteed by any official source (government, other state institutions, local authorities...).

Since January 2007, the Czech Republic has a new law on social services. This law was expected for several years as a solution for problems in this area. Unfortunately, it is not targeting people with mental illness, but rather only addressing people with physical or mental handicap.

There are some strategic documents dealing with mental health and social inclusion, for example Health 21, Article 6 focusing on mental health and support, prevention of suicide, etc.; Conception of psychiatry; National Action Plan on Social Inclusion; WHO/Euro Declaration and Action Plan for Mental Health; European Commission Green Paper on Mental Health. These documents are not obligatory, but they are conceived as recommendations and guidelines. In the case of Health 21, Article 6 some commitments are mentioned with dates for implementation. But reporting about the document highlights that there are serious problems and obstacles to implementation.

Education and training

There is a lack of education opportunities for people with mental health problems, especially adequate courses for higher education.

There are some isolated educational programmes led by day-care centres and the few existing users' organisations offer some training services too.

Employment

Employment is very hard to obtain for people with mental health problems who are on social disability pensions. There is also much fear and not enough understanding on the side of employers about mental health issues and the employment of people with mental health problems.

NGOs sometimes offer certain kinds of employment to people with mental health problems such as sheltered workshops. However, this does not provide support to them to get a job in the open labour market.

A welcome development is that since January 2005 people with mental health problems can have a salary and their disability pension at the same time. Previously, this presented a very big obstacle to people with mental health problems as they were afraid to take a "normal" job and consequently lose their pension, i.e. the only money they had. Nevertheless, there is a need to find more ways how to support people with mental health problems in their job search and to ultimately integrate them into mainstream employment.

Housing

Housing is a problematic issue for people with mental health problems. In most cases, they do not have enough money to pay rent so they live mostly with their parents, which quite often inhibits their move towards independence. There is a lack of supported housing or similar services for this target group – day centers, crisis centres, services helping with finding housing, etc. This situation – hardly any or no possibilities to get a job, no services or centres where to spend time with other people, no money for leisure activities, no money for living and being independent – leads to feelings of resignation and hopelessness.

Transport

It seems that transport is not a very problematic issue for people with mental health problems. If people have a right to full disability pension they can travel for lower prices by bus or train; however, with “restricted” disability pension there is no such advantage.

The issue of transport is in fact related to the financial situation. Given the lack of money people with mental health problems have to think twice before they decide to travel somewhere, be it for therapy, to visit a day hospital, etc. In many cases they simply have to stay at home.

Leisure activities

The situation of social exclusion with regard to leisure activities depends on the region. Some regions have a lot of resources, with many offers for people with mental health problems, some are very poor.

In general, leisure time activities are provided by NGOs and self-help groups. Usually, NGOs run day-activity centres. There are some problems with financial issues as well as with the qualification of staff. Another risk factor is the exclusion of new clients as a result of the small service capacity.

There are some advantages for people having a physical handicap, e.g. a document, which allows for obtaining benefits (lower prices for travelling, culture, sports, etc.), but there is nothing similar for people with mental illness.

Civil and human rights

People with mental health problems are experiencing exclusion with regard to access to their civil and human rights in the following areas:

- involuntary hospitalisation;
- no informed consent for care/therapy;
- use of restrictive instruments;
- exoneration to perform legal acts;
- access to information, especially access to the personal file.

Situation of women, children/ adolescents, migrants, older people

There are some projects targeting children as well as many programmes focused on Roma people with mental health problems in the Czech Republic.

Good practices for improving social inclusion of people with mental health problems

There is still a lack of services for people with mental illness. This means, that in fact each community service of this kind is very desirable. In some regions, there are larger institutions, which aim at providing services and activities for this target group. There are also some self-help organisations, a few communities for people with this kind of

experience, and also some social firms. Most of these initiatives have adopted models taken over from institutions abroad that they attempt to organise with the aim to achieve a high level of social integration and cooperation.

National Action Plans on Social Inclusion 2006-2008

People with mental health problems are not specifically mentioned in the National Action Plan on Social Inclusion. There is mention of socially vulnerable groups, which however are often facing very different problems and social situations.

The main challenges for people with mental health problems include the expansion of services and activities, including day hospitals, service for people in crisis, clubs, leisure time activities, job centres, supported and sheltered housing, supported and sheltered jobs, assertive teams, employment and/or support for the creation of part-time jobs, support for employers hiring people with mental illness, changes in the financial system, changes in the attitudes of psychiatrists and the number of personnel in psychiatric care.

These changes need to be pursued by the local and national authorities. People working in the administrations who would take ownership for the implementation of concrete measure could be helpful as well. But it is first and foremost necessary to change the system itself.

Other specific challenges and solutions

A very fundamental issue to be addressed is the information and awareness raising of the general public about mental health problems. There is still too much misunderstanding, fear and anxiety related to people with mental illness. Generally, people associate mental health problems with aggressiveness or violence. What is needed are educational campaigns that inform the society about the real situation of people with mental health problems and their social exclusion.

3.2.6. Denmark

Health and social services

People with mental health problems have full access to somatic health care in the same way as all Danish citizens, i.e. free of payment on all levels of health care. The psychiatric system is covering treatment in hospitals, in outpatient-services and outreach services.

The majority of the psychiatric wards are integrated as parts of the somatic hospitals; only a few of the traditional big mental hospitals remain, and they have the same standards as other parts of the health system. Both mental health services and somatic health services are included in the same political and administrative system at both national and local level.

People with mental illness can, depending of the severity of the illness, obtain permanent health pensions on the same premises as people with chronic physical handicaps. Moreover, people with mental health problems can receive social security benefits if they are unable to work for a certain period of time. The sections within social legislation concerning financial help to people who are unable to earn their money apply to people with somatic and mental health problems equally. This is not the case when talking about personal support. People with physical disabilities are offered more comprehensive personal assistance than people with mental health problems.

Apart from the general social services, the social service system in the municipalities offer a particular service for mentally ill people called "social psychiatric service". It is a service developed during the last 15 years consisting of a wide range of different services such as special housing, professional staff who are in contact and give support in the home of the mentally ill person, day-centres, work and education opportunities. The number of flats in the special housing units is not known precisely but is about 3.000 – 4.000. The number of mentally ill people having regular contact with a "contact-person" is near to 5.000. The question remains whether this special service is both a cheap and a discriminating service, not giving mentally ill people the real help they need and at the same time keeping them out of the general services. It is argued – especially by the user-organisation – that offering a special social service is a way to create barriers for truly including mentally ill people and to treat them in the same way as other people with a disability.

Education and training

The social-psychiatric system is offering special education services.

Employment

Over the last years, many private companies have focused on their "social responsibility" by providing many vulnerable people – also people with mental health problems – with the opportunity to find a job in the open labour market.

The alternative job market – such as for instance represented by the so-called social cooperatives – seems to be poorly developed in Denmark. The Council for Socially Marginalized Groups has in November 2007 ordered an evaluation of existing alternative-based companies.

Housing

Besides the ordinary housing market there is a comprehensive range of alternative housing opportunities for mentally ill people – as described above.

Transport

No special services are offered to people with mental health problems.

Leisure activities

No special services are offered, and no discrimination seems to exist in access to the general leisure activities.

Civil and human rights

The number of patients who are sentenced to psychiatric treatment due to committed criminal activities is growing. This could be due to rising criminality among people with mental health problems or due to the penalties that are more severe and are often sentenced for longer periods of time. Where penalties are sentenced to people not having a mental health problem they are usually proportional to the severity of the crime; however, this is different when people with ill mental health are sentenced. In autumn 2004, the Council for Socially Marginalized Groups asked the Danish Institute for Human Rights to prepare a report on the use of special measures on mentally ill criminals, viewed from a human rights perspective. The report shows that the type of offences committed and the sentence rendered do not always correspond when it comes to mentally people. In the vast majority of cases, the offences are misdemeanors such as theft and assaulting a public servant in connection with, e.g. a compulsory admission. Even so, the sentence can be treatment with anti-psychotic medicine in a psychiatric hospital or as an outpatient with the option of treatment up to five years or an unlimited period of time. It has to be concluded that the principle of proportionality in sentencing mentally ill criminals is not truly implemented in the law and tradition.

There are 2000 forensic psychiatric patients and 200 beds in the forensic psychiatry. Ninety-five per cent are men and sixty-six per cent of the inpatients have no home (are homeless). Thirty-five per cent of the inpatients are migrants (compared to 9% of the population).

Situation of women, children/ adolescents, migrants, older people

The total number of homeless people in Denmark, as mapped in 2007, was 5300 people (1 homeless/1000 inhabitant). Of them 1600 (30%) had a mental health problem, and of those people suffering from a mental health problem 800 (50%) had no contact to a mental health service. As a result of a very restricted procedure to obtain contact to outgoing mental health services and no investigative outreach functions in the outgoing teams people are easily left alone in the streets and in shelters for homeless people.

The immigrant population is 9% of the total population. But in the wards for sentenced, criminal mentally ill the quota of migrants is 35%. This can be due to less intensive services provided to migrants with mental health problems at an early stage.

Good practices for improving social inclusion of people with mental health problems

The possibility to live in a home of your own, whether in the ordinary housing market or in "special housing" for people with ill mental health combined with social problems, can certainly support the social inclusion of mentally ill people and their integration in the community, especially when housing is combined with a system of outreaching professionals offering a differentiated degree of personal support.

National Action Plans on Social Inclusion 2006-2008

People with mental health problems are mentioned, but only very briefly, in the National Report on Strategies for Social Protection and Social Inclusion/ National Action Plan on Social Inclusion.

In order to make this instrument more effective, the national government must adopt a serious and consequent approach towards the Report as well as to all other instruments related to the Open Method of Coordination, for example mutual learning and peer reviews.

Other specific challenges and solutions

Over the last 10–15 years, a strong social-psychiatric movement has developed, based on a mostly humanistic and community-based paradigm. The municipalities are responsible for this service and it is therefore close to the citizens and related to the neighbourhood. Social-psychiatry is developing its own methods for work and research, and it is more and more user-involving and even user-lead.

3.2.7. Estonia

Health and social services

For people with mental health problems equal rights and opportunities to use health care services are guaranteed. The Estonian health insurance is based on the solidarity principle, i.e. in case of illness the availability of services and compensation for expenses on health care do not depend on the amount of social tax paid by a particular patient. It also means that the treatment of people who are not working or are not economically active is covered by the social tax paid for by employed people. In Estonia 6% of the population does not have health insurance. It is not known how high the percentage is among people with mental health problems.

There are 178 psychiatrists, 93 psychiatric nurses and 709 psychiatric beds in Estonia (31.12.2004); differences between regions are significant. Psychiatrists are overwhelmed with work and out-patient waiting lists are quite long. There is a lack of child psychiatrists. A problem in recent years is that young doctors leave Estonia for better work conditions and salary and find a job in well-developed EU countries. Talking therapy (psychological counselling) is not well available for people with mental health problems. There is a lack of clinical psychologists. Psychological help and psychotherapy is mainly available in the private sector and therefore most of the people can not afford it.

Three types of services can be differentiated in the welfare support of people with special mental needs: (1) associating services to increase a person's ability to cope (case management and rehabilitation); (2) supporting services (supported living, supported working, everyday life support, living in the community); (3) special services (different twenty-four hour nursing services).

Day centres are available in some local communities, but not everywhere, and they are not flexible in working hours and location. They support people in everyday life by providing knowledge and skills and creating possibilities for washing, hairdressing, manicure/pedicure, food, cooking, laundry etc. Traditionally, day centres are not focused on social inclusion, but rather on providing a place to be, to communicate with other people with mental health problems (unfortunately not so much with people outside services) and to be involved in meaningful activities. The "bridging" function of day centres – creating and maintaining a linkage with mainstream society – should be strengthened. Centres should not reinforce social exclusion, even they are voluntary.

A field that needs to be developed is carers' (mainly family members') support and empowerment. Carers of people with mental health problems need better training, counselling and guidance to increase their ability to cope with the situation. Carers need also more flexible working hours, better support services and a fair tax and benefit system. Closer attention should be paid to promoting carers' health, well-being and security as carers experience frequently themselves mental health problems (psychological distress and depression).

A further challenge in Estonia with regard to people with mental health problems is the promotion of self-help approaches and non-stigmatisation. A good example in this field are the Estonian Association of Mental Health Organisations' activities targeted at counselling persons with mental health problems and offering them a possibility to work together towards good mental health.

Overall, the Estonian health care system is still too hospital-centred. Improvements are needed with regard to primary care, providing physicians with the resources, knowledge and confidence to deal with people with mental health problems, and with regard to the availability of quality nursing care and rehabilitation services.

Education and training

Children with behavioural and conduct disorders are threatened by falling out of the educational system. They are frequently placed on individual training schemes, which can in turn generate social exclusion.

A significant problem in Estonia is the drop-out from schools, amongst other reasons due to mental health problems. There is a high overall drop-out rate at basic school level (1500 students in academic year 2003/2004, 80% of them boys).

Employment

There is a lack of possibilities in the labour market for people with mental health problems. Stigma around mental health problems is high, and employers prefer "normal" people irrespective of the nature of work that should be done and the nature of mental health problem a person has. Awareness is low, and the myths are wide-spread.

It has been planned to facilitate the entry of disabled persons to the labour market through providing necessary services: professional and vocational rehabilitation, assisted work, protected work, personal assistants, support persons, transport opportunities.

A new method that has been introduced is the preparation of an individual action plan, which is prepared in cooperation between the unemployed person and the consultant of the regional office of the Labour Market Board. The task of consultants is to identify problems that prevent unemployed people from getting work, prepare action plans for tackling the problems in cooperation with job-seekers and coordinate and monitor the performance of the action plan by networking with other institutions and local governments. The results of the practical implementation of these principles for providing assistance are yet to be seen.

The increase in employment also presupposes an improvement in the availability of flexible forms of work, which can increase the employment opportunities of people for whom full-time or regular work is not always suitable, such as people with mental health problems.

The activities planned with regard to welfare services that support employment are: (1) the elaboration of a vocational and professional rehabilitation system for disabled people; (2) the development of welfare services enabling the disabled person to maintain his or her position in the labour market (e.g. personal assistant or support person, social transport, sheltered and supported employment); (3) training for social workers, aimed at a development of the knowledge and skills necessary for supporting the discouraged and long-term unemployed to the labour market.

The activities planned within social benefits system supporting employment are: (1) to ensure more efficient coherence between the provision of subsistence benefits and participation in welfare and active labour market measures; (2) the reform of social benefits system for disabled people to support disabled people who work or study.

Housing

People with mental health problems frequently have housing problems, such as rent arrears or poor accommodation. Decent and stable housing is critical for providing a sense of security. In Estonia, the main responsibility in the field of housing is put on families and relatives, but also on local communities.

There is a lack of institutions like nursing homes, in addition to psychiatric institutions. Homeless people with mental health problems sometimes commit suicide attempts in order to get access to hospital admission (for food, hygiene, overnight).

In the case of persons who are socially and economically incapable to get housing or to manage to maintain it on their own it would be helpful to provide them with the opportunity to rent a subsidised municipal rental dwelling. Implementation of the subsistence benefit system is organised on the local government level.

Transport

People with mental health problems experience difficulties accessing mental health services as a result of an inability to pay for public transport. Furthermore, transport is crucial for access to any kind of services, for example employment, leisure etc. Especially in rural areas the social exclusion is magnified by long distances and reduced frequency of public transport.

Efforts have been made to provide family physicians and specialised out-patient care services as close as possible to the patient's place of residence, thus avoiding transport costs for reaching help. Some local communities have organised transport for people who are interested in participating in day centre activities.

Leisure activities

Some sports activities, art, music, etc. are organised in day centres. Contacts with people outside the mental health system are limited. People who are not paid for taking care of persons with mental health problems are usually not interested in dealing with them.

Volunteering is a resource for social inclusion, which should be promoted and empowered in Estonia – volunteering for people with mental health problems and volunteering by people with mental health problems.

Civil and human rights

Involuntary psychiatric treatment of people with mental disorders is regulated by the Mental Health Act, which needs to be updated. Estonian law does not separate involuntary detention and treatment issues and does not meet the European Convention of Human Rights standards. A new act has been planned to come into force in 2008.

Protection of civil and human rights in court trials is sometimes problematic. People who use mental health services can encounter difficulties in accessing the same legal protection as other members in the community. The state provides necessary minimum legal protection by attorney in criminal trials, but mostly it is only a formal procedure. A non-profit organisation, the Bureau of Legal Services, has developed a free legal aid system in Estonia to protect the rights of marginalised and/or at poverty risk persons in civil (private) cases. Still, the system does not function on the national level, but regionally.

The most active patients' organisation is the Estonian Patients Advocacy Association (EPAA), established in 1992. The activities of EPAA are focused on helping people with health problems and the protection of their rights. The objective of EPAA is to safeguard the interests of patients and disabled people in organising the social and health care system to execute patients' rights in case of practical problems, and to distribute information concerning the rights of social and health care consumers. The state has provided the activities of EPAA with financial support from the budget of the Ministry of Social Affairs for counselling psychiatric patients.

Other areas

Estonia has made considerable progress during its transition to an information society, which facilitates also the life of people with mental health problems (people with special needs) and promotes their social inclusion. Estonia has a well-developed communication

network and good accessibility of Internet. Citizens can communicate with the state and use its services. Although the general supply of computers and internet access in Estonia is good and improving, home use of computers (47%) and internet (36%) is rather low when compared to the public and private sector. Still, there is easy access to the internet in public libraries.

National Action Plans on Social Inclusion 2006-2008

The National Report on Strategies for Social Protection and Social Exclusion/National Action Plans on Social Inclusion 2006-2008 does not handle separately the problem of social exclusion of people with mental health problems, but only mentions disability.

3.2.8. Finland

Health and social services

Rehabilitation services are almost completely lacking for outpatients. About 1500 people use the rehabilitation course services of the Finnish Central Association for Mental Health (FCAMH) and Finnish Association for Mental Health (FAMH), annually. This is a low number, considering the needs of the 200 000 to 300 000 working people suffering from psychological symptoms.

Following the dismantling of psychiatric institutions, about 9 000 people now live in so-called rehabilitation homes of varying quality. These homes are maintained by various associations, trusts, businesses and the public sector. Good and bad practices are encountered in all of them, especially those in the private sector. In the worst cases, patients are incarcerated in ways similar to those of old mental hospitals, and even in good homes there are shortages of rehabilitation services.

Psychological counselling is still too medical-science and treatment orientated. Social work is almost completely lacking from mental health work. There are, for example, three times as many psychiatric nurses in Finland than there are in other Nordic countries, but Finland has remarkably less social work.

In Finnish mental health treatment too much coercion and isolation is used, which increases patients' feelings of inferiority. The discharge and debriefing following the use of various methods of coercion is almost totally lacking. Thus people resort to using various alternative treatments, because rehabilitation services are lacking and effective rehabilitation is not sufficiently available. Disappointment in their ineffectiveness causes further marginalisation.

Generally, there is a lack of faith in the rehabilitation of those that are severely mentally ill. Schizophrenia is often still considered to be an incurable disease, even though new research in the field, and subjective experiences of recovery, has been published. Moreover, stigma brands all mental health work and the patients themselves. Shame is the greatest obstacle to rehabilitation. The stigma of the mental health branch hinders both the development of services and weakens the patients' faith in their own recovery.

Employment

In Finland, the patient group with approved disability pension having "mental health and behavioural disorders" constitutes the largest main-diagnosis group. People in this group make up 43,2% of all people on disability pension, i.e. altogether 111 673 people.

The Pellervo Economic Research Institute PTT published in July 2007 a study "Vammaisten työkyky vuonna 2007: vertailua työttömiin" (The Working Capacity of Handicapped Persons in 2007: Comparison with Unemployed Persons, Holm-Happonen), which highlighted handicapped people's willingness to do work. According to this study, about 40% of all handicapped people considered employment as very important for their well-being. Half of the respondents had done some work during the preceding 24-month period, which also included voluntary work. About 30 % of all respondents considered their own working ability to be excellent or good. The responses of people with mental health problems did not in any way deviate from the general trend. Their desire of to return to work and to society is strong. The administrator, Mika Vuorela, appointed by the Minister of Labour, Tarja Cronberg, reported that about 40 000 people on pension for psychological reasons wanted to return to work.

Housing

The Minister of Housing, Jan Vapaavuori, appointed Deputy Mayor of Helsinki, Paula Kokkonen, to lead a working group to carry out the project "Reduction of long-term

homelessness programme 2008-2011". The working group will start their work on 9th November 2007, and it is expected to present a proposal for action on 10th January 2008 to the Minister and subsequently to the Council of State. The working group will be paying special attention to people with mental health problems in their work.

Leisure activities

The cost and the limited availability of cultural services prevent people with mental health problems from making use of such services. Institutionalised patients have little art to look at, even though research has proved the therapeutic affects of art. The dry environment of an institution marginalises the patient into a gloomy daily life.

Civil and human rights

No change has been realised so far with respect to the excessive use of coercion in mental health treatment, but the issue has been observed widely in Finland, e.g. in studies presented in the media in 2007.

Other areas

The worst problem faced by the mentally ill and their families is loneliness, and many also suffer from insufficient income. Preconceived ideas about one's own chances for rehabilitation prevent it.

Situation of women, children/ adolescents, migrants, older people

Family members of people with mental health problems may be ashamed and not dare to demand adequate services for the patient. Family members, and especially children, of the mentally ill person are also susceptible to mental illness. Up to 40% of the children of depressed parents become ill before the age of 20 years. In therapeutic work, it is nonetheless possible to take children into consideration and to offer them the opportunity to share their rehabilitative experiences in peer groups.

Good practices for improving social inclusion of people with mental health problems

In Finland, actors working in the field of mental health have increased their cooperation. In 2005, the key actors in the field (NGOs, professionals and expert organisations) established a Mental Health Pool. This Mental Health Pool raises common concerns in the field. In 2006, the Mental Health Pool took a stand on the European Green Paper, and in Finland on the infectivity of the treatment provision guarantee. In 2007, the Mental Health Pool influenced the new government's programme with a joint proposition.

A joint anti-stigma campaign has had a direct effect on the fight against stigma. In addition, the Finnish Psychiatric Association has launched its own awareness raising campaign to disseminate relevant information on mental illnesses. The effect of stigmatisation on people with mental health problems was measured using the Mental Health Barometer launched on 10 October, the international Mental Health Day. The barometer revealed that the attitudes of Finns, across the board, have relaxed. The organisations consider it a consequence of consolidated and more visible co-operation.

National Action Plans on Social Inclusion 2006-2008

The challenges and needs of people with mental health problems, particularly mental health risks at the work place, are given attention in the Finnish National Action Plan on Social Inclusion 2006-2008. A very welcome approach adopted in this report is the emphasis on a preventive approach as the most effective way to reduce poverty and social exclusion. Particular attention is also paid to early intervention in the problems of children, young people, and families with children. In the prevention of health problems,

the promotion of mental health and the management of substance abuse have a clear connection with reducing the risk of social exclusion.

Other specific challenges and solutions

Parliamentarians are not familiar neither with mental health problems nor their treatment. According to a joint survey by FCAMH and Astra Zeneca Oy (2007) on parliamentarians' perceptions of schizophrenia and mental health treatment in Finland, the people that pass laws have poor knowledge of mental health treatment. In parliament, health policy decisions are made based more on beliefs than on facts.

Respondents' estimations of the cost on society of mental health problems were wide off the mark. The median response of the whole group was €470 million. The true costs, for example in 2004, were €1,7 billion. Candidates that had already served as parliamentarians were more accurate than others were, but their median response was €1 billion. Candidates estimated medical costs to represent about 40% of total mental health costs, while the true proportion was 16%.

3.2.9. France

Health and social services

Care services are focused too often on the psychiatric hospitals that provide treatment in a specific geographical sector of residence of the patients, to the detriment of the choice of doctor and the patients. The health and social sectors still work very rarely together. A person who has left psychiatry and who makes a social request is referred back to psychiatry. The two sectors are separated. There is no culture of common practice for the professionals.

Hospitalisation is too often under constraint and is often the only available solution for people with mental health problems, due to a lack of crisis centres. Programmes of prevention of mental disorders are little developed and it is difficult to seek support or care without fearing stigmatisation.

Education and training

The psychiatric handicap has been recently recognised by the law of February 11/05 and is not sufficiently taken into account in mainstream education opportunities. There is psychological consultation for students and some few places in psychiatric structures allow people to continue their studies, but people who experience greater difficulties are quickly excluded from the education system.

Employment

Centres of protected work are numerous but generally relate to other types of handicap such as mental disability. The people working in these protected centres do not have the status of workers and remain sometimes in these centres for all their lives.

There are only few inclusive practices. There are contracts supported by the State which offer a solution to entering the labour market, but without taking into account the particular needs of people with mental health problems (concentration problems due to medication, proneness to stress and fatigue, etc.).

Many people who experience mental health problems are without a job. As there is much stigma that persists in the labour field, the need for new ways of ensuring access to work has increased. Cooperative structures, for example, can allow users to be economically useful and to earn money, working without any stress (or less stress), be empowered and therefore more confident and capable.

Housing

Many people with mental health problems are without housing due to the stigma attached to mental illness that can frighten house owners. Moreover, the incomes of people with mental health problems are weak whereas the prices of rents in France are very high.

People with mental health problems who are not married or are single are thus not priority candidates for social housing (which is scarce). There are some homes for people with mental health problems, but only few of them and they are often very constraining (for receiving visitors; living space shared with several people). The homes often operate under the principle of trusteeship (guardianship) in order to ensure financial security, much to the detriment of the autonomy of the individual.

Transport

People with mental health problems are treated as other handicapped people without holding specific account of need.

Leisure activities

People with mental health problems are often isolated and excluded from leisure activities as they are either too expensive or too difficult to access in light of the perceived discrimination by others.

Civil and human rights

Too many people are under guardianship law and lose their citizen's rights, the direct contact with the community, are obliged to submit their life to control by another person, often within a complex system that ignores people's wishes and/or their projects in life.

There is a new law (March 4, 2002), which reaffirms the rights of the patient; however, for people who are hospitalised in psychiatry there are always possible exceptions to directly consult a medical file, for example. The grounds for an appeal are difficult to reach. The testimony of people with mental health problems is often discredited and there is no (official) system of advocacy. Users' associations and family associations are sometimes implicated in local decision but mainly in a consulting role.

Situation of women, children/ adolescents, migrants, older people

With regard to vulnerable groups, the immigrant group is particularly vulnerable. The problem here is firstly political: to tackle this problem effectively, as well as to simply act in a humanistic way, the state has to be welcoming. Without legal authorisation to live in France, many persons (men, women and child migrants) can develop mental health problems, facing many problems of living conditions (housing, precariousness, fear of being arrested by the police). In France, much more mental health services are needed that reflect cultural diversities, with professionals coming from foreign countries and available translators.

Regarding the situation of women, a gender-based approach is still rare and particularly disabled people lose their gender attributes, they are nothing more but disabled. Sterilisation of women is legalised; it is restricted to special cases but nevertheless practised in spite of the progress of other forms of contraception. Women with mental health problems still have difficulties to keep their child after the birth; a large mistrust remains and one discourages the women to have children.

As for children and older persons, one of the main sources of mental health problems is the situation of loneliness and individualism of modern life. Prevention and promotion, as well as care whenever necessary are needed as well as solidarity and building convivial spaces of meeting and living in the community.

Good practices for improving social inclusion of people with mental health problems

Advocacy practices have developed over the last years and have highlighted the usefulness and need of actions to support people with mental health problems so that they can speak up when faced with worries such as discrimination or rights-based problems, issues of hospitalisation under restraint, guardianship as well problems of neighbourhood, labour, leisure and all other problems where stigma is the main issue.

With regard to good practices, users' advocacy groups must be considered. Yet, most financial support goes into the experimental self-help groups of users that have been mainstreamed as GEM (Mutual Self-help Groups) and considered as useful by the Government. To date, it is unclear whether the grants will be renewed, even for those groups, which have existed for the 2 past years. Users' organisation must insist that these groups should not be new services set up by administrations but must be created by users' organisations themselves. What needs to be supported and financed is first of all the empowerment of users, so that they can set up their proper self-help groups and not

some pseudo-groups created by professionals or parents, where users remain dependent of others.

National Action Plans on Social Inclusion 2006-2008

The social inclusion of people with mental health problems is only marginally mentioned in the National Action Plan on Social Inclusion for France. This could be the result of a very medical approach to policy and practice in this area.

Moreover, it has proven very difficult for civil society organisations to meet the persons responsible for the Report in French government/Social and Health ministry and to become involved in the social inclusion process. Nowadays in France, the Health Ministry is separate from the Ministry of Social Affairs which belongs to the Labour Ministry. There is an urgent need for increased cooperation in health and social affairs.

Other specific challenges and solutions

In France, there is no holistic approach to mental health and well-being that takes into account the totality of human needs and problems from childhood to old age. The approach is rather medical than social. The model is based on cure not care and on treatment not rehabilitation, prevention or an inclusive approach.

Many good practices can develop, also in collaboration with civil society associations, but as the financing is allotted according to an administrative logic and according to specific problems or disorders many associations work around a specific problem and are prevented to work in an inter-associative way. The networks which manage to exist are either formal around strong institutional actors (with means, procedures), or very abstract, without means, professionals and sustainability.

3.2.10. Germany

Health and social services

The period of de-institutionalisation of the long-term wards in German psychiatric hospitals ended at the end of the 20th century. In 1970-2000 around 130.000 hospitalised long-term patients lived in a situation of often overcrowded long-time care. One part of the long-term patients lived after discharge inside the community in own apartments or flats, having in some cases access to work, mostly dependent on professional assistance, and having sometimes good and sometimes not so good contacts to other people from the community. At the same time many specialised community-based psychiatric services were created. More than 400 NGOs were established in the last 30 years, creating the "Gemeindepsychiatrie". On the other hand, there were those long-term ex-patients who lived after discharge often outside the community in homes, or asylums, not integrated, having isolated contacts, if any, only to other nursing homes residents. This development was termed "Re-hospitalisation".

To manage the process of de-institutionalisation German social policy started to finance this transition under the term "Eingliederungshilfe", which means mostly assisted living with the support of social workers and based on welfare benefits. However, in many cases the contrary of inclusion occurred. People with mental disorders lived very often in isolation from the community, in a status of social exclusion, using the offers of highly specialised services, which protect them and their professionals against the reality of society. Today, 30 years later, the process of de-institutionalisation has largely been concluded. Many of the ex-long-term patients are today very old or died. But what is still left are the community-based services and institutions as a part of the social welfare-system, and too often they are the reason for the manifestation of exclusion, poverty, social isolation and limited social rights.

The main challenge and need related to the social exclusion of people with mental health problems in Germany is to integrate the right to ambulant care and therapy for mentally ill people into the normal system of health insurance, just like for everyone, who is sick or has a health-problem. People with mental health problems first need a doctor or a nurse, and secondly a social worker. The overspecialised welfare-system for people with mental health problems, which is very often isolated or separated from the society, should be replaced by a system of good integrated ambulant treatment and care. To be involved and to participate in the system of health insurance should be the first and most important decision for a new health-policy and therefore for a chance for more social inclusion in Germany.

Employment

The problem of unemployment is one of the greatest and most severe reasons for social exclusion, also for younger people with mental health problems or other people with handicaps. They depend too much on welfare benefits only because they are ill or handicapped. The social welfare system on the other hand demands from the user to be poor, if he or she wants get assistance. This social assistance creates a system of compensation and dependency, too often resulting in a life outside of common society. The answer to this problem would not be to reduce or cut the benefits. On the contrary, people with mental health problems should be given the same benefits and rights just like all other people and outside the psychiatric system.

Moreover, German NGOs must adapt to new objectives: treatment comes first, rehabilitation second. Work places inside the normal industrial world are more inclusive than sheltered workshops. Instead of long-term rehabilitation, the focus must shift towards prevention, mental health education, and treatment instead of cure.

Other areas

Most German NGOs working in the field of mental health are in the same way dependent on the welfare system as the users of mental health services. In addition, people with mental health problems must fight for financial support from health insurances. To have access to adequate health insurance and to be a user of services financed by the health insurance is an important step towards inclusion.

Situation of women, children/ adolescents, migrants, older people

Patients or users of mental health services who are especially vulnerable to exclusion are people with a forensic history and homeless people. Also younger people with addiction and psychosis have a high risk for a long-term exclusion career. A further problematic issue is the labelling of children and teenagers with demonstrative behaviour (Attention-Deficit Hyperactivity Disorder) as psychiatric ill patients. The danger to be excluded from society in a very short time is very high.

Good practices for improving social inclusion of people with mental health problems

Examples of good practices for promoting social inclusion of people with mental health problems can be found in the area of outpatient psychiatric care (e.g. www.gapsy.de). This kind of services offers ambulant psychiatric care and other outpatient services that can help in many cases to avoid clinical admissions.

Another example of a good practice in Germany is represented by associations who offer outpatient aid for housing, work and treatment, together with the involvement of ex-users of mental health services (www.pinel.de).

National Action Plans on Social Inclusion 2006-2008

People with mental health problems are not mentioned in the German National Action Plans on Social Inclusion 2006-2008, and only peripherally in the National Plan on Health and Long-Term Care.

Other specific challenges and solutions

In Germany, there are many papers, resolutions, statements, actions plans and other publications at all levels of society that want to promote social inclusion of people with mental health or other problems and handicaps. Inclusion of people with mental health problems is increasingly becoming a target for policy, churches, welfare organisations and community psychiatry. But what must always be taken into account is the other side of society: discrimination and stigmatisation happens in the newspapers, in television and in the everyday-life of people.

3.2.11. Greece

Health and social services

In Greece, the psychiatric reform is under way. A great number of people with mental health problems have already been de-institutionalised. Around 60 hostels are created all over Greece, but these have to fight with financial problems due to insufficient funding from the Greek Ministries (Finance and Health). The organisations cannot pay the salaries of their employees and the quality of life of people with mental health problems is deteriorating. Also, the units of primary care are few and consequently not able to cover the needs of the population.

According to the current state of the art, a community-based system for mental health care should consist of psychiatric units in general hospitals or centres for mental health, daytime hospital centres, supervised community housing structures, mobile units and, last but not least, possibilities for gainful employment. However, practical experience has shown that not only the quantity and quality of the community-based mental health services is inadequate, but that there is also a lack of adequate coordination between the individual services.

The services themselves often have problems in dealing with the wide variety of needs and difficulties of people with mental health problems. Severe mental health problems often appear in parallel with additional individual handicaps such as drug abuse and social disadvantages, and in particular a significant part of the homeless population suffers from mental health problems.

What is urgently needed is a better coordination of the relevant policies for health care, social protection and social affairs, insurance and pension systems, rehabilitation, education and training systems, and of course labour and employment policies.

Education and training

The number of day centres where people with mental health problems can receive education and/or training, are very few. Normally, there should be at least 30 day centres (1 for every 2 hostels), but there are only 15.

Employment

Despite the existence of the law 2716/1999, article 12 on the establishment of social cooperatives as an alternative form of employment all over Greece, they are not functioning on their full capacity due to a lack of subsidies. People with mental health problems are, if at all, employed either under unemployment conditions, or as people with special needs. The percentage of people with mental health problems in employment is low.

The only way to meet the complex needs of this group of people whilst respecting their dignity is via a multi-dimensional, holistic approach. These needs have a medical, a psychological and a social dimension. This includes integration into the labour market, since far more is associated with work than just the earning of a personal income. Work gives a feeling of belonging to society, it confers social status and a sense of identity, it allows interaction with other people, and imparts the sense of being empowered, being responsible for one's own life and (re-)gaining a degree of control over one's life.

The greatest barriers towards full citizenship for people with mental health problems exist in the field of vocational integration, since the general growth in unemployment has had a particular impact on physically and mentally handicapped people, especially of course on those least fit for work or suffering from additional problems of social exclusion. Employment opportunities, never easy to find for people with mental health problems, and even less so for those leaving psychiatric hospitals and being re-integrated into local

environments, have become increasingly rare in the present circumstances. Still, promoting and supporting re-integration into the labour market is considered a crucial factor for eliminating the various labels and prejudices and the stigma attributed to people with mental health problems.

Housing

Under the "Psychargos" programme, many residential houses have been created. The number of protected apartments is limited though.

Transport

There is no law that gives people with mental health problems the opportunity to travel at no or reduced costs. Some organisations provide mini-buses for the transport of their service users when needed.

Leisure activities

All hostels in Greece make sure that people with mental health problems get out, enjoy summer vacations, and socialise in the community. Unfortunately, there is no legal provision for these persons for financial support to visit museums, go to theatres or cinema, etc.

Civil and human rights

In Greece, there is a law protecting the civil and human rights of people with mental health problems. Moreover, with programmes of awareness raising of the community civil society organisations try to inform social services and the population in order to protect the human rights of these persons.

Other areas

Awareness raising of the society is very important in order to change the attitudes of the population towards psychiatric illness, and to prevent the social exclusion of people with mental health problems. This sector must be a main target of the Greek State as well as of the European Community in order to achieve positive results.

Good practices for improving social inclusion of people with mental health problems

De-institutionalisation of people with mental health problems has been one of the most desirable developments in Greece. This includes efforts to close, or at the very least to downsize, psychiatric asylums, to avoid re-admission of new patients and to transfer the current inmates to settings in the local community. However, this process will have to go hand in hand with the increased development of flexible community-based systems for mental health care, rehabilitation and support as an alternative to institutional segregation.

National Action Plans on Social Inclusion 2006-2008

The Greek National Action Plan on Social Inclusion makes reference to strategies for social protection and social inclusion of people with mental health problems through the "National Plan on Psychiatric Reform 2000-2010 – Psychargos". The reform concerns the de-institutionalisation and creation of modern, community-based mental health services. Among the actions geared towards social re-integration is the development of social cooperatives of limited liability, making significant advances in the vocational rehabilitation of individuals suffering from severe psycho-social problems.

However, the project concerns mainly people who live in the big psychiatric hospitals of the country and have the right to be moved into hostels. There are no provisions for

people with mental health problems, especially young people, living in the community. There are no units that can accept them if they have not been hospitalised. Also, there are no units that can accept older patients who have in addition to psychiatric problems, pathological problems too. The general hospitals or the nursing homes do not accept them due to their psychiatric condition.

3.2.12. Hungary

Health and social services

Social exclusion of people with mental health problems is an old, serious problem in Hungary. In the last two years the problems have worsened. There is a radical reduction of hospital beds, without adequate development of the community care system. Effective psychiatric rehabilitation programmes are lacking, putting the emphasis on acute psychiatric care only. The out-patient services and primary care services are also in a very bad situation because of lack of financial resources.

Access to mental health services has become more difficult for people due to the introduction of the so called "visitation fee" (even for homeless people) and a "medicine box fee" (the patient has to pay for the box of the free of charge medicines).

Education and training

For people with mental health problems there is a possibility to take part in recently introduced re-education programmes. However, most of these people are not able to take part in them because they are not re-habilitated.

Employment

People with mental health problems have a strong desire to work, without any real possibility to find a work place.

It is more and more commonplace for people who experience mental health problems to lose their work. Nobody is there to defend him. The result is that they become poor, may loose their family and live excluded from the society.

All of these factors make the life situation of the large population of people with mental health problems even worse.

Other areas

Since some years, there has been a shift by the national government of the social department to local governments, providing them with the task of community psychiatric supply. This could have presented a good solution since the field of community psychiatry did not belong any longer to the traditional and institutional psychiatric system. However, after the reform the financial resources for community care became dependent on the local government's intentions and priorities. The result is that there has been a significant financial withdrawal from the local government's social budget, so the social sphere is no longer able to effectively provide community services.

Good practices for improving social inclusion of people with mental health problems

There are existing good initiatives in Hungary, but they are sporadic and usually depend on individual efforts and organisations (e.g. Soteria Foundation, Awakenings Foundation, Psychiatric Forum of Interest, Way-Out Association, etc.). These initiatives are also often not strong enough, they have limited financial resources and they are often rivalling.

National Action Plans on Social Inclusion 2006-2008

There is no mention of the social situation and social exclusion of people with mental health problems in Hungary in the National Action Plan on Social Inclusion 2006-2008. Only the part on health care and long-term care states in one sentence that "mental health problems are growing extensively".

Other specific challenges and solutions

A positive development is the beginning of the reform of the health and mental health system in the last years. Hopefully, it will be possible to learn from the lessons of the past and create based thereon a new system. For this, Hungary needs the support of the European Union and the European Union needs to speak with one European voice.

3.2.13. Ireland

Health and social services

The share of the health budget for mental health services has declined year on year to about half, in proportionate terms the level it was in the early 1980s. Mental health funding has been cut from 13% of the overall health budget to 6.5%. This in turn impacts on health and social services and contributes to social exclusion of people with mental health problems.

Education and training

Responses to exclusion from education and/or training as a result of mental health problems vary. Higher education institutes offer student support and flexible procedures. Rehabilitative and vocational training may be provided by the statutory or voluntary agencies.

Employment

It is prohibited under the Employment Equality Act (1998) to discriminate on grounds of disability (including mental health related conditions) in access to employment. Most people return to their work or studies on recovery. Others may require gradual re-introduction. Options provided by statutory, voluntary and private providers include sheltered work, supported employment, community employment, voluntary work and open employment.

Housing

There is a section of the Irish community who live in appalling conditions and some are homeless. A considerable number of people who fall into this category are mentally unwell. Some are in poor accommodation because of their mental health problems and in many cases their poor accommodation has exacerbated their mental ill health. Housing responses are provided by the health services, the local authority and by a number of voluntary organisations including local mental health associations affiliated to Mental Health Ireland.

Transport

A number of options are provided on a voluntary basis to meet the transport needs of people with mental health problems to access day activities or for social outings.

Leisure activities

Those with mental health problems can often find themselves very isolated with no way to interact with the community around them. A number of social clubs and befriending projects have been initiated by local mental health associations to provide supportive relationships in an effort to reduce isolation and exclusion.

Civil and human rights

The Mental Health Commission and the National Disability Authority in conjunction with the Irish Human Rights Commission are discussing equity in mental health as a basic human right.

Good practices for improving social inclusion of people with mental health problems

There seems to be a fragmentary approach by a range of Government Departments and NGOs in relation to identifying the issue of social exclusion and addressing it. Current projects addressing aspects of social exclusion include:

Cara House – a members led activity based project to cater for the social and training needs of the members. This is based in the North West of the country and has expanded to cater for the needs of elderly members of the community in isolation. They offered the facility on Christmas Day also. This is self funded and self regulated.

Le Cheile – a similar members led activity based project based in a large city in the Mid West of the County. Members determine the content and focus of their own progress and activities have included ethnic music, art as well as skill base and care needs being met.

The Dublin North Befriending Project – a new service initiated to address social exclusion by bringing people together for positive supporting relationships which will reduce the isolation often felt by those with mental health difficulties.

National Action Plans on Social Inclusion 2006-2008

The Irish Government's National Action Plan for Social Inclusion, setting out a programme of action to address poverty and tackle health inequality, was launched early in 2007. Health and well-being are determined by a range of factors, including adequate income and access to education and housing. Therefore, social inclusion is vital for good health and requires a cross-sectoral approach, as proposed by the new NAP/Inclusion.

Complemented by the social inclusion elements of the Irish Government sponsored National Development Plan (NDP) 2007-2013, the NAP/Inclusion sets out how the social inclusion strategy will be achieved over the period 2007-2016 and focuses on the four lifecycles of children, people of working age, older people, people with disabilities and communities. The plan singles out topics such as education, income support, community care and housing as issues that can have an impact on an individual's ability to be part of society, and rightly proposes that a multidisciplinary approach is required if these problems are to be addressed.

Complex factors contribute to health inequality and consistent poverty is perhaps one of the most damaging. The NAP/Inclusion recognises this at the outset by setting out its overall poverty goal: "To reduce the number of those experiencing consistent poverty to between 2 and 4 per cent by 2012, with the aim of eliminating consistent poverty by 2016, under the revised definition."

The definition of poverty and social exclusion, which the Irish Government first adopted in 1997 and on which the NAP/Inclusion is based, states "People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society."

The report identifies a number of targets in relation to child health, which focus on the development of healthy behaviour and attitudes, particularly in relation to exercise, eating habits and the avoidance of alcohol and other substance abuse. As already seen in the Government approved mental health policy document 'A Vision for Change', the NAP/Inclusion pledges the delivery of one child and adolescent Community Mental Health Team (CMHTs) per 100 000 of the population by 2008, with this to increase to two teams per 100 000 by 2013 and also the promise of two General Adult Community Mental Health Teams (CMHTs) per 100 000 of the populations by 2013.

The NAP Inclusion pledges that by 2016, "every family should have access to health and social care, affordable accommodation appropriate to their needs and a well functioning public transport system." However, no real tangible goals are set out in the plan to ensure that every family will have access to health and social care. Instead it seems to reiterate much of what has already been said in the past. For example, it outlines one of

its measures to ensure equitable access as “ensuring people who are not able to meet the cost of GP services for themselves and their families are supported appropriately either by means of a medical card or GP visit card, depending on their means.” However, what the plan fails to highlight is the fact that the number of people with access to a full medical card has been decreasing and according to a medical representative organisation, the percentage of the population covered under the scheme is currently at its lowest (26 per cent) in the ten years since the last Government came into office.

In pledging support for mental health services and suicide prevention, the plan points to initiatives and developments already in the public domain, such as the ‘Vision for Change’ Report and the ‘Reach Out’ national strategy on suicide prevention. However, the recommendations in both reports have not been implemented and funding for suicide prevention has actually been reduced from 3.6m to 1.8m.

While health is an integral part of the NAP/Inclusion it is limited somewhat as the plan does not include implementation and performance measurement and monitoring. The plan does not contain any targeted health initiatives for people with disabilities, yet it does concentrate on increasing employment and participation of this sector in society.

3.2.14. Italy

Health and social services

The consequence of the national law 180 (totally incorporated in the general health reform, law 833, 1978) has been the closure of the psychiatric hospitals and efforts to include people with mental health problems in the community. Since the beginning, there have been difficulties in putting the law in practice mainly due to a lack of resources to establish new services in the community and to improve the culture of inclusion in the society.

The change process has not been easy at all also for the strong opposition on the part of the general society, of the professionals and of relatives associations. It can be said that this change has been successful in some parts of Italy; however, in other places there are few community services and sometimes too many big private organisations. In general the closure of the psychiatric hospitals in 1978 has been realised through the admission of new patients in special areas of the general hospitals (if in acute crisis) or in different services in the community.

Among the regions where the law 180 has been put in practice, Tuscany plays a special role. Regional laws on mental health, according to the law 180 philosophy, allow for a good integration between the health and social sectors, e.g. the constitution of the so called "Health Society" at local level. The "Health Society" is a statutory organisation responsible for the community services at county level. The mental health services are considered community services; also the beds in the general hospital are considered community service as part of the mental health service.

The social services situation is different in the different regions of Italy: in some places the social workers are part of the mental health services, in other places the social workers belong to a different and autonomous organisation. In the last years the user and relatives associations are more involved than in the past in the mental health policies at different levels.

Education and training

There is a discontinuity of projects against stigma and prejudice towards people with mental health problems. These projects are generally organised by statutory organisations and supported by relatives associations. User associations are more involved in these projects than in the past. Positive messages on mental health are few; negative messages through the media, on the other hand, are frequent. There are only few education initiatives in high schools.

Employment

The growth of the economy in Italy is very slow. The national government has implemented a number of jobs, but these are only temporary jobs and the right of people to have more continuity in their jobs is not protected. For people with mental health problems it is much more difficult to find a job. There are some possibilities to have some socio-therapeutic bursary for part-time jobs, but very difficult then to move on to a normal job. A good solution appears to be the creation of new jobs through the establishment of integrated cooperatives

Housing

In Italy most people own their house. It is difficult to find houses to rent, and especially difficult for a person with mental health problems. Public housing is also difficult to obtain for people with mental health problems as families with children have more rights to this kind of housing. As for the rest of the population, people generally avoid living near persons with mental health problems because of fear and feelings of insecurity.

Transport

Public transport possibilities are generally good. There are different projects to pick up users from their houses. However, it is important to encourage people with mental health problems to use public transport with the aim to make them more and more autonomous. It could be convenient to offer tickets at lower price for people with low income or without a job.

Leisure activities

There are inclusive initiatives both in public and in private sectors. It is necessary however to organise self-help leisure initiatives to better facilitate the approach with people with mental problems.

There is prevalence of a paternalistic attitude in big organisations for social activities, which leaves people with mental problems in a dependent position as a result of which they often decide not to participate.

Civil and human rights

The national law 180 has been a kind of cultural revolution due to the closure of the psychiatric hospitals and to the consequent inclusion in the community of people with serious mental health problems. People with mental health problems in theory have access to the same rights than other people. This is not very simple in many cases. The general culture is paternalistic and authoritarian. Very often the relatives associations fight for the rights of users, but once again the risk of paternalism is very high. Advocacy schemes run by users or citizens are not very usual.

Other areas

The media generally depicts a very negative image of mental health.

At national level there are plans on the safety of the general population, which stress the importance of avoiding outside dangers (migrants, people with mental problems, homeless...). This prejudiced and stigmatising approach risks producing more social exclusion.

The closure of psychiatric hospitals does not automatically lead to an acceptance of people with mental problems. It is necessary to spread examples of good practice of social inclusion.

Situation of women, children/ adolescents, migrants, older people

Women in mental health services are very prevalent. There is a lack of special services for women, especially residential services.

For adolescents, there are more and more problems related to drug abuse. The medical model is going to be adopted also for problems of minors. More psychosocial interventions are needed.

Immigration is a relatively new phenomenon for Italy, especially with people from the Maghreb, China and Eastern European countries. There is a lack of preparedness for this event that has very big dimensions. More cultural mediation is needed.

Older people have a lot of mental health problems. General practitioners and geriatrists are involved at basic level. There is not enough health and social support for people to stay in their homes.

Good practices for improving social inclusion of people with mental health problems

Good examples for improving social inclusion of people with mental health problems in Italy include the Mental Health Month, held in October every year to raise general awareness of mental health, successfully involving mass media and big organisations; self-help groups, a combination of activities with individuals and their social context; housing projects, at local level there are some houses run by the service or in collaboration with cooperatives, recently some associations propose to use private houses, in collaboration with services, for small groups of people with mental health problems; work, creating new jobs and new cooperatives; local Mental Health Systems, combination of activities with users groups, relatives groups and local community organisations.

National Action Plans on Social Inclusion 2006-2008

The National Action Plan on Social Inclusion for Italy does not take into account mental health issues or the challenges and needs of people with mental health problems.

At the national and regional level there is existing legislation, especially in the field of mental health, but often these laws are not put in practice. Civil society associations are going at great lengths to stimulate politicians to apply the laws.

Other specific challenges and solutions

It is important to take into consideration that Italy is a large country with very different cultures. The northern part of Italy is more similar to central Europe; the southern part is very Mediterranean. But there are also large differences between cities for historical reasons. It is important to analyse the different cultures and to create instruments for mental health problems that focus on the different local realities.

3.2.15. Latvia

Health and social services

According to the 2000 Population and Housing census, Latvia has 2.331.500 inhabitants. According to the Mental Health State Agency, in 2003 there were a total of 64.198 people in Latvia with registered mental illness or behavioural problems. Each year, around 6.000 new patients are diagnosed as having mental illness.

In Latvia, there is one long-term psychiatric hospital for children, Ainazi. There are also three specialised social care homes for children with severe mental disabilities, from the age of 4 up to the age of 18. Also five child care centres for orphans and 48 orphanage-shelters for children.

There are 31 specialised State social care homes for adults with "disorders of a mental nature" in Latvia. There are 72 social care homes for the elderly managed by local governments or municipalities. There are also eight psychiatric hospitals in Latvia, most of which provide long-term care for patients, including people with intellectual disabilities. Although it is recognised that institutional care is not the best solution for people with intellectual disabilities, or, more generally, people with mental disabilities, there is a lack of alternative residential services in the community for people with mental health problems.

At present, community-based services are available mainly in Riga (day centres, out-patient medical care centre) and Jelgava which is relatively close to Riga (day centre and mobile treatment team). It can be said that in Latvia there are practically no community-based services, the process is in the very beginning: there is one "Training flat" in Akniste, one day centre for schizophrenic patients and their relatives in Riga, one group house in Jelgava and one mobile team in Jelgava. All mentioned services are not financed by state.

The vast majority of hospital patients do not know about the availability of the above mentioned community-based services at their place of residence. Most patients have to live in the hospitals not because they need constant treatment, but because there are no places where to go outside of the hospital.

There is no support for the family of the people with mental health problems. All the problems and heaviness of the situation is carried by the family's own resources.

Education and training

There are no programmes for life-long learning education available, and no special training for people with mental health problems. It means that those people who have to change their profession, usually can not do it because of a lack of a training and support system. The result is invalidity, unemployment and social exclusion and falling deeper into the symptoms of depression.

Most hospital patients (53%) have secondary or secondary professional education, 11% have incomplete secondary education, 17% have primary or incomplete primary education, and 19% of patients have higher or incomplete higher education (N=266). Similarly most residents of social care homes or 45% have secondary or secondary professional education, 6% have incomplete secondary education, 13% have incomplete primary education, 8% has higher or incomplete higher education, 22% have primary education, but 6% have no education (N=142) (Leimane-Veldmeijere, & Veits, 2006).

Employment

In analysing the employment situation of users of mental health care services it was found that most respondents, or 352 users of mental health care services, did not have

paid employment. The employment situation was a little better in the care of hospital patients, 29 of whom had a full-time paid job, 3 had paid employment at a state subsidised place of employment, and 12 had paid odd jobs. Of the interviewed residents of social care homes (N=142) only 3 had full-time paid employment and 9 had paid odd jobs. Most of those hospital patients who had paid employment or 19 persons had found it with the help of friends or relatives and only 4 persons had found work with the help of the State Employment Agency. Ten persons had found a job with the help of hospital personnel and social workers.

When asked about needed assistance in finding employment, users of mental health care services indicated that the most necessary assistance would be additional training and courses (23% of hospital patients and 25% of residents of social care homes); moral support and encouragement to look for work (16% of hospital patients and 19% of residents of social care homes); assistance in looking for work, for example, information on vacant jobs (17% of hospital patients and 13% of residents of social care homes) (Leimane-Veldmeijere, & Veits, 2006).

Housing

Seven per cent of respondents interviewed at psychiatric hospitals were located at the time of the interview in a 13 bed ward, and 11% of respondents at hospitals stayed in 9-12 bed wards (N=266). The situation of residents in social care homes is better because only 2% of the interviewed respondents lived in rooms containing more than seven beds (N=142).

Results of the interviews show that most hospital patients and residents of social care homes are satisfied with existing living conditions in the units. The interviewers, psychiatric nurses, were surprised at the high percentage in certain facilities and explain it by the fact that some of the users of mental health care had not had the opportunity to experience better living conditions and so they are satisfied with the existing situation. 36% of hospital patients and 43% of residents in social care homes indicated that they do not have easy access to a telephone, and 45% of hospital patients and 42% of residents at social care homes indicated that the location of the telephone does not ensure privacy of conversations. 12% or 32 patients and 7% or 10 residents at social care homes stated that letters must be opened, when handed over to personnel for sending, which is considered a violation of human rights (Leimane-Veldmeijere, & Veits, 2006).

There are almost no group houses and half-way houses in Latvia.

Transport

When asked about the transport situation, workers who work with people with mental health problems say that this is not a problem for them because only some of drivers of public transport do not want to carry them.

People with invalidity can access transport free of charge, but transport is not always available, for example, in some smaller cities. There is lack of budget for it.

Leisure activities

According to workers who work with people with mental health problems there is a very limited offer for leisure activities in Latvia. People with mental health problems also have a financial problem which may prevent them to go out.

Civil and human rights

Of the 408 interviewed users of mental health care services 163, or 40%, of the respondents remembered cases when they had been involuntarily hospitalised at a

psychiatric hospital. 127 users of mental health care services, or 78% of those involuntarily hospitalised mentioned that the physicians' council had not examined them within 3 days after admission, as it should have been done according to the Medical Treatment Law. Of the 36 users examined by the council only 20 remembered that they had been informed about the decision of the council.

Altogether 15% of respondents (N=265), users of mental health care services, indicated that they had suffered violations of human rights during their stay at a psychiatric hospital or a social care home. 20%, or 53 interviewed hospital patients stated having suffered violations of human rights, mentioning physical and emotional coercion, use of physical and chemical restraint, control of a person's private belongings without the presence of a patient, prohibition to use private belongings, not providing access to a telephone to contact relatives, not providing information, involuntary hospitalisation and treatment, prohibition to have walks in fresh air, unsatisfactory living conditions, not providing information concerning medical treatment related questions, etc.

The results of the interviews show that 43% of hospital patients and 27% of social care homes' residents do not know where to turn for assistance if quality of medical care, attitude of personnel or conditions in psychiatric facilities do not satisfy them. It may be explained partly by the fact that there is practically no information in facilities on complaint mechanisms, providing an explanation where users of mental health services may turn for assistance in case of human rights violations or inadequate care. A total of 39% of respondents admitted that units of hospitals or care homes do have information on patients' rights, 28% indicated that such information is not available, but 33% of respondents did not know whether information on patients' rights was available (Leimane-Veldmeijere, & Veits, 2006).

Other areas

In assessing monthly income, the average income of residents of social care homes is LVL 21.04 (or EUR 29.93) per month. Average income of hospital patients is LVL 64.67 (EUR 92.01) a month (Leimane-Veldmeijere, & Veits, 2006).

Assessing the level of users' knowledge of their diagnosis can be considered low, because about half of respondents did not have sufficient knowledge of their mental illness (ibid).

Many people with mental health problems and their relatives are afraid and dependent on medical staff, they do not know their rights and are afraid to stand for them.

National Action Plans on Social Inclusion 2006-2008

In the Latvian National Action Plan for reduction of poverty and social exclusion (2004-2006) social inclusion for people with mental health problems is mentioned. Apart from that, there are only the following references to the situation of disabled people, without making a specification as to the nature of disability.

In chapter 1.10. Situation of Social exclusion risk group/Disabled people, it has been listed that an important group at risk of social exclusion are disabled people. This social group is subject to several risk factors depending on the particular type of disability. Disabled people have difficulties in obtaining qualitative education, since the majority of educational institutions of all levels are not adapted to persons with functional disorders. Another risk factor of social exclusion for disabled people is the low employment level. The number of social services for people with disabilities and their families aimed at the compensation of disability (assistants, attendants, etc.) is insufficient. The factor, which creates the social exclusion of those groups, is an unadapted physical and informative environment.

Chapter 3.8. Development of Social Services mentions that to reduce the risks of social exclusion and to improve the choice and quality of social services provided to inhabitants,

several policy documents have been elaborated, for example, The Concept Paper "On Development of Provision of Social Care Services" (2002), which anticipates promoting the development of new and multiform social care services in order to create an alternative to the long-term social care services provided by the state institutions. To improve the quality of services provided to persons with mental disorders who live in social care institutions, 6 institutions in five regions of Latvia will be renovated. To facilitate the reintegration of the clients living in these institutions into society, municipal alternative care services (group-homes, day centres, and special workshops) will be improved by attracting the financing of the national budgets of municipalities and the EU funds.

Chapter 3. Policy measure/Special State Support Measures for groups at risk of social exclusion/Disabled people. The Concept Paper "Equal Opportunities for All" will adopt an integrated approach and intends to implement an overall set of measures to eliminate barriers for the independent living of disabled people and their full participation in social life.

3.2.16. Lithuania

Health and social services

The social inclusion question is mentioned in Lithuania's Mental health strategy approved by the Parliament of Lithuania in 2007 and is foreseen to be concretised in the form of an action plan.

Education and training

For successful integration of children with intellectual disabilities and mental health problems into mainstream schools municipalities should provide sufficient funding to ensure the transport of children with disabilities to schools, especially in rural areas and in winter. Qualification and training of all teachers working with children with disabilities and mental health problems should be improved also. Special pedagogical and psychological assistance, learning measures should become more available.

Employment

Despite the fact that a legislative basis was very developed during the last years, there are many problems of daily life related to social inclusion themes. Stigmatisation and negative attitudes toward the people with mental health problem prevent employment possibilities.

Housing

There is lack of supported housing services for people with mental health problems (only in some towns and mostly for people with intellectual disabilities). The rise of realty prices make the implementation of safe housing programmes very difficult.

Transport

Transport is problematic especially for children with mental health problems who live in rural and remote geographic areas.

Civil and human rights

Lithuania has created a legislative basis to highlight the social inclusion of people with mental health problems, and this foundation has been strengthened in recent years. The main legislation creating the basis for social inclusion of disabled people policy in Lithuania includes the following:

- The Law on the Social Integration of People with Disabilities (2004) is the most important legislation regulating social integration of people with disabilities. It applies to people with disabilities of any level or type. The purpose of this law is to secure equal rights and equal opportunities for people with disabilities in all spheres of life within society, to establish principles of their social integration.
- The Law on Mental Health Care (1995) prohibits discrimination based on an individual's former or existing mental disabilities. It guarantees all political, economic, social and cultural rights to patients with mental disabilities.
- The Law on Equal Opportunities (2003) includes a specific prohibition against discrimination on various grounds, including disability. Provisions of this law explicitly regulates the implementation of equal opportunities in such areas as: 1) state and municipal institutions' and offices' activities in adopting legislation, preparing various programmes and means for guaranteeing equal opportunities; 2) education; 3) employment; 4) access to goods and services.
- The Law on Social Enterprises (2004) and the Law on Support for Employment (2006). These laws assign people with disabilities (including mental disabilities) as

- a target group to make use of additional help and support means for their employment.
- Social exclusion of women, migrants and elderly people with mental health problem are not discussed separately. For children and adolescents the Law on Special Education (1998) establishes the basis for the inclusive education of children with intellectual disabilities.

Good practices for improving social inclusion of people with mental health problems

NGO's and some non-profit organisations are very active in fighting social exclusion in Lithuania. For example the NGO "People with mental disorder care association" established eight round table meetings, "Mental health-our objective" focusing on coordination between municipalities, health institutions and NGOs in the context of the realisation of the law of social care in the community.

Some of the good practices of the NGO "Viltis" (Hope) include: establishment of new groups and classes in general education schools as well as specialised schools to educate children of pre-school and school age with developmental impairments; establishment of day activities centres intended to develop social and occupational skills of youth with developmental impairments; execution of long-term legal programmes with a view to creating a new conception of human rights of people with disability; expansion of residential and community-based social services to individuals with developmental impairments and their families in their local communities; organising parent support groups in order to overcome possible crisis in the family, when the family members learn of the disability of the child; creation of experimental transportation services network for people with developmental impairments, who cannot use public transport services due to the nature of their disability; providing opportunities to individuals with developmental impairments and their family members to rest and learn in the summer leisure and psychosocial rehabilitation camps by the Baltic sea.

The public non-profit organisation "Vilnius centre for psychosocial rehabilitation" provides psychosocial rehabilitation services, including employment rehabilitation programmes, vocational rehabilitation, engagement, etc.

The public non-profit organisation "Global initiative in Psychiatry" organised on 3-9 April 2006 a "Destigmatisation week". The main activities during the week were: press conference, video and radio clips, social advertisement in the streets, etc.

National Action Plans on Social Inclusion 2006-2008

The Lithuanian National Action Plan for Inclusion mentions people with mental illness with regard to the following challenges/needs:

- Develop the facilities of non-institutional social services targeted towards the disabled with heavy impairments or with mental (psychic) disorders and social risk children, supporting family members of such persons in returning to the labour market.
- Long-term care
- Social care institutions, especially for children and older people
- Strengthening of mental health through promotion of individual-friendly social environment.

3.2.17. Luxembourg

Health and social services

Exclusion of people with mental health problems in the area of health and social services does not seem to be an urgent problem. Services are open for these people and have often an outreaching attitude.

Education and training

The education system is not very flexible and young people with mental health problems are often excluded. There are great needs and challenges in this area. The number of school drop-outs is relatively high and a lot of these children go abroad for further education.

Employment

In Luxemburg, competition is high in the area of employment. People with mental health problems often have no chance to find a job on the open job market.

In September 2003, the law for "persons with disabilities" was passed. The idea was to move to more inclusion for those people, also for people with mental health problems. But so far the results are rather negative.

Housing

Apartments and houses are very expensive and people with mental health problems have often difficulties to find a place to rent.

Transport

The transport situation is quite favourable for people with mental health problems who can often get a pass to use public transport without charges.

Leisure activities

People with mental health problems often do not make use of the existing possibilities.

Situation of women, children/ adolescents, migrants, older people

There exist very few possibilities for children, adolescents or older people with mental health problems. Often they have to be sent to other countries to find appropriated help.

Good practices for improving social inclusion of people with mental health problems

A very good practice is "Ateliers Therapeutiques de Walferdange", where 150-200 people with mental health problems are integrated in several workplaces.

Different projects of sheltered living exist in Luxemburg, and will probably get more financial support from 2008 on.

Other good practices in Luxemburg include daycentres, an "open house" and creative ateliers.

National Action Plans on Social Inclusion 2006-2008

The situation of social inclusion of people with mental health problems is only referred to in one single paragraph of the National Action Plan for Luxemburg, with regard to plans for social housing for this group.

3.2.18. Malta

Health and social services

Mental Health Services are autonomous. They are still mainly institutional. There still exists a large psychiatric institution from where mental health services are mainly provided. There is a psychiatric unit with ten beds in the general hospital but this is far from adequate. Within the new general hospital which has become functional in November 2007 a psychiatric unit has been planned but the number of beds is again far from adequate. Community mental health services are not well developed. Out-patient clinics are held in the general hospital. There are some services in the community being provided by a non-governmental organisation. User groups and associations have begun to appear but somehow the existent culture does not facilitate their development.

Health and social services are not integrated to provide seamless services for people experiencing mental illness. There are social workers working for the psychiatric hospital falling under the responsibility of the health sector whilst other social workers belong to different organisations.

State support with regards to medication for chronic illnesses is only available to those with a diagnosis of schizophrenia. This increases tremendously the financial burden on people who experience other chronic mental illnesses and their families. Again, only people experiencing schizophrenia who are unemployed are provided with some financial support from the state and this is far from adequate to facilitate inclusion.

Education and training

There are no specific educational policies which address the needs of youth and adults who experience mental health problems. Neither are there specific training services.

Children who are severely emotionally and behaviourally challenged are provided with personalised support in schools.

Employment

The Employment and Training Corporation which is the State organisation responsible for employment, has a partnership agreement with a non-governmental organisation that specialises in mental health to provide training, facilitate employment and provide follow on support services to persons with a mental illness registering for employment. Whilst this is a positive step forward it has to be acknowledged that incentives to support employers in order to facilitate the inclusion into employment are very rudimentary, still making it difficult for people with a mental health problem to find employment that is suitable for them.

There are hardly any structures which ensure that persons who are already employed and who experience mental health problems are supported to retain their employment in order to avoid their exclusion from employment and possibly increase their risks to poverty.

Housing

In the last few years, the Government is supportive of providing accommodation for persons with mental health problems. There are a number of incentives which help people to access housing. There is collaboration with NGOs and the provision of rent subsidies to facilitate that persons with mental health problems can access also the private housing market.

Transport

Whilst public transport is generally good, there are no projects or support targeting people with mental health problems. It would be helpful if transport subsidies are provided for those with low income or people who are unemployed.

Leisure activities

There are no initiatives either of the public or the private sector to integrate persons with mental health problems into mainstream leisure activities. There are a couple of initiatives taken on by non-governmental organisations to facilitate opportunities. However, the challenge for these initiatives is to avoid the increase of stigmatisation.

Civil and human rights

People with mental health problems in theory have access to the same rights as every other citizen. However, this is not so straightforward in many instances. The reason is the general paternalistic and authoritarian culture of Malta. Advocacy is still in its infancy.

National Action Plans on Social Inclusion 2006-2008

In the first National Action Plan on Social Inclusion mental health was not included. However, as a result of increased lobbying of NGOs mental health has now been included throughout the report. Best practices provided by NGOs working in community mental health have also been identified and included.

3.2.19. Netherlands

Health and social services

The quality of mental health care in psychiatric hospitals seems to decrease. Mental health problems seem to be increasingly treated as mere biological diseases. Treatment is often reduced to the prescription of drugs. There is even a tendency to oblige people to take drugs, which is very worrying. As a result, patients often report that they do not feel safe in psychiatric hospitals; they are not given much attention and are being too much drugged. Moreover, a big problem is that people are put on a long waiting-list before they receive needed treatment. This affects their overall amelioration and participation in a negative way. In addition, caretakers do not seem to be aware of the importance of social participation and sometimes even discourage patients to work.

Sometimes physical diseases are overlooked or not taken seriously when they are presented by people with mental illness. There have been reported cases of people with a "major depression" who turned out to suffer from cancer.

As for the social services, in the Netherlands around 30% of the people receiving benefits are people with mental illness. In general, there seems to be less and less tolerance towards people who are "different" or "behave strangely". Whereas a couple of years ago people with mental disorders were usually referred to as "people who are sick" nowadays they are often referred to as people who ought to "pull themselves together". Dutch society is becoming more and more individualistic and people are supposed to take full responsibility of their lives. There is a tendency to exclude people with mental health problems from the benefits of our social security system. Stress, burn-out, depression and anxiety disorders are considered not so much to be illnesses, but to be mere individual coping problems.

Due to recent reforms many people who were considered being ill – and therefore used to receive wage replacement benefits – are now considered to be 'healthy' and to earn their income in regular jobs. In reality, it is very difficult to participate for people who have (had) mental problems. In comparison to people with physical handicaps people with mental illness participate far less in the labour market.

Employment

As mentioned above, people with mental disorders have great difficulties in finding or keeping regular jobs. They are generally considered to be less reliable, less productive and difficult to handle.

They are participating more and more in sheltered workshops. The problem here is that these jobs are often industrial (which provokes reactions such as "I may be crazy but I'm not retarded") and supervisors are often not aware how to deal with people with mental illnesses.

Housing

The number of easily accessible shelters is decreasing. Among the group of homeless people, the number of people with major mental illness like schizophrenia is increasing.

Civil and human rights

This year, Dutch legislation was changed in order to make it easier to impose compulsory admission to a psychiatric hospital and compulsory administration of drugs. This undermines the right of self determination.

On the other hand, since 2003 there is an act of non-discrimination of people with disabilities concerning transport, education and employment.

Situation of women, children/ adolescents, migrants, older people

Intercultural mental health care is still in its infancy; it should be developed and stimulated.

Good practices for improving social inclusion of people with mental health problems

Amongst existing good practices there are wholly or partially consumer-run projects to be mentioned, of which there are almost 200 in the Netherlands.

National Action Plans on Social Inclusion 2006-2008

In general, the importance of including people with disabilities is clearly stated in our National Strategic Reports/National Action Plans on Social Inclusion. The first objective is to increase the number of people with disabilities on the regular labour market. Regular work is considered to be the most effective way to ensure social inclusion. The Pandora Foundation, a leading Dutch civil society organisation, emphasises that a big effort should be made to support people with mental problems on the labour market, but that we must not forget that there is a group of particularly vulnerable people who are not able to participate in that way.

One of the recent reforms in the Netherlands is the decentralisation of the exact measures to be taken to achieve social inclusion. Measures are being taken on municipal level as the local situation can differ substantially. It has been arranged that representatives of local groups can have a say in this matter. The problem here is that it can be hard to find qualified representatives of people with mental illness.

3.2.20. Poland

Health and social services

In Poland, health and social services operate under separate ministries. Co-operation between these ministries in the field of mental health has developed since the early nineties, when the Mental Health Protection Act was being prepared. However, a desirable result of such co-operation, e.g. a comprehensive, inter-sectorial programme on mental health, has not been achieved. Social services have taken up a leading role in introducing some innovative solutions in community care. But social workers are very rarely acknowledged by physicians as partners in psychiatric teams and in community social service facilities.

Long-term mentally ill persons are mainly cared for in large regional hospitals. This is itself a factor of social exclusion, due to the distance between these hospitals and the patients' homes, families, friends or local communities where they could be accepted as family members, neighbours, etc.

The Polish Mental Health Protection Act (implemented since 1995) stipulates for the right to treatment and the right to less restrictive treatment as an alternative. However, neither community care nor crisis intervention networks were ensured to the extent needed.

The current focus of public debates on health care at the moment is on adequacy of health care expenditures and low salaries of health care personnel. Members of consumer organisations and professionals in the area of health and social services are involved in discussions, concerning topics such as diminishing regional inequities in access to mental health care, development of integrated, high quality health and social services and overcoming social exclusion.

Education and training

There are significant differences between regions and even within the same region, as concerns educational possibilities and assistance for children and young people with mental health problems. In the case of serious problems, assistance and education are integrated with treatment. However, there are some "privileged" and "under-privileged" health and educational facilities, applying such an approach, the former offering good quality and the latter unsatisfactory services. There are some innovatory initiatives in this area organised by non-governmental organisations and run by parents and by mental health professionals.

Organisations of parents of children with learning disabilities or other intellectual disabilities have been successful in implementing many effective solutions in this area. However, for children, youth and young adults with mental health problems, Poland is at the very beginning of finding some constructive solutions.

There is a relatively small number of young people with mental health problems with completed higher education. Ten universities in Poland organise assistance and information services for disabled students. The universities create a network and promote exchange of experience and good practice. A great part of students who make use of such services are persons with mental health problems. However, university graduates with psychiatric history are usually older than average students. So they cannot take advantage from some of the special programmes for graduates, for example, helping them to find a first job (accessible for persons under 25 or less than 27). The process of negotiations has started to change this regulation.

According to published declarations and programmes of the government, new regulations enhancing opportunities and support for disabled persons who want to acquire education (and especially higher education) should be prepared in a short time. This also concerns

legal regulations relating to different forms of life-long, extramural learning (e.g. distance learning). These are especially important for people with mental health problems from rural areas and small towns who are interested in open-market employment.

Employment

It seems to be very difficult for persons with psychiatric history to overcome barriers of social exclusion in the area of employment, especially on the open labour market. Even in the framework of new programmes of so-called "transitional employment", employers appear sometimes prejudiced and not able to develop an attitude of respect to employees. Without such an approach people with mental health problems do not find good working conditions.

According to widely spread opinions, a person with a psychiatric diagnosis can find employment on the open market only when he/she does not reveal this diagnosis and psychiatric history. Psychiatrists usually support their patients in maintaining the impression of a healthy person in front of the employer and co-workers.

There are certain measures aimed at integrating people with mental health problems in the labour market, such as the Law on Social Employment of 2003 that created the possibility of so-called Centres for Social Integration aimed at social integration and adaptation or re-adaptation as well as vocational education and preparation to work; the possibility of creating social co-operatives have been introduced by the Law on promoting employment and labour market institutions of 2004; people with psychiatric history and formally acknowledged status of the disabled person can be employed in enterprises, classified as "sheltered workshops"; according to the Law of 1997 on employment and occupational and social rehabilitation of the disabled it is also possible for any person with legally acknowledged disability to receive meaningful financial support when starting (for the first time) his/her own business.

In Poland, high unemployment rates go together with relatively high economic development indicators. It is supposed that in such a situation, greater flexibility of working conditions (part-time work, flexible working hours, etc.) and better education can stimulate improvement in the area of employment. Such solutions and especially flexible work conditions seem to be favourable for people with mental health problems.

Housing

In the programme of the government entitled "Solidarity State", the current situation in the area of housing in Poland was described as alarming. According to the National Census 2002, the number of households in Poland exceeded the number of housing units by 1,5 million. Many tenants are indebted (in 2004 it was about 1/5); some of them are in arrears with rent for a flat for no longer than 3 months. They are threatened with eviction. Among them there are people with mental health problems.

Social houses represent about 0,3% of all houses resources in Poland. In July 2003, the governmental programme of building flats for people requiring social aid was adopted. The law on financial support for creating social housing, lodging houses and homes for the homeless was adopted in April 2004. According to this law, social housing, including "protective apartments" (sheltered accommodation), should be available in particular: to "people with psychological problems" and to "people who need help in daily life due to disability, illness or age, but do not require day and night care".

According to estimates made by non-governmental organisations (on the basis of surveys) there are about 30.000-80.000 homeless people living in Poland. It is assumed that homelessness coincides with mental illness in many cases.

There are examples of "good practices" in the area of sheltered accommodation for people with mental health problems. Sheltered accommodation is organised by local

governments or by local mental health associations with support and co-operation of local governments, State Rehabilitation Fund, etc. Better co-operation is needed to make a comprehensive analysis and assessment of such initiatives and to prepare a strategy of expanding best practices in this area.

Last but not least, the long-term residents of mental institutions must be mentioned, who stay in them because they lost their own homes for the sake of their families, neighbours or local communities. Shortages of housing resources and high prices of the houses in Poland have a great impact on such a situation. It is possible to prevent losses of flats or houses by people with mental health problems, but to achieve this goal, better co-operation between health and social services is needed as well as high quality mental health care in community settings.

Transport

People with legally acknowledged disability pay a lower price for public transport. People legally acknowledged as severely disabled can travel with an accompanying person who is entitled to travel without paying for a ticket. In bigger cities, reduced prices for transport services are available for disabled or chronically ill persons. However, public transport is not equally accessible in different regions of Poland.

The same is true for mental health care facilities. Sometimes it is necessary to travel more than 100km to a mental health centre. This may become extremely difficult because of poor transport possibilities. Some local governments and self-help community centres organise transport for users of rehabilitation services – especially in rural areas and small towns.

Leisure activities

Self-help groups and organisations as well as some centres of psycho-social rehabilitation, day care centres, and social clubs run by mental health associations organise leisure and sport activities for their members/users, sometimes under the aegis of social rehabilitation or integration. Such activities are usually supported by local governments, social services and the State Rehabilitation Fund as well as by different private foundations and individual persons. Sometimes leisure activities are added to educational courses and vocational training.

Apart from these specialised activities, there are different forms of leisure activities in the mainstream. Some of them are rather expensive and inaccessible for people with low income. However they may join some activities organised for example by public libraries, open universities, so called local or community cultural centres, churches, etc.

People with mental health history have a greater choice in towns, in more differentiated, multi-cultural societies than in small local societies. Some people after a mental crisis spend much of their leisure time helping others. Some are involved in painting, poetry, reading, studying, hobbies, etc. In Poland there are about 1 million people having their own internet pages where they describe their psychiatric histories.

Civil and human rights

As it is being emphasised in the Polish National Action Plan on Social Inclusion, implementation of civil and human rights as defined by international and national law, and especially implementation of social rights, is costly. The conclusion drawn in the NAP with regard to those rights is that financial, personnel, office, material and other resources should be ensured for institutions responsible for the implementation of these rights.

Examples of positive changes in the area of civil and human rights are: post-graduate studies for people with mental health problems at Warsaw University, the network of centres for civic counselling led by non-governmental associations, the last changes in

the Mental Health Protection Act, introducing patient advocates to mental hospitals. However, there is a need for better support for self-advocacy and family-advocacy, wider information and attractive forms of education and social dialogue on mental health and human rights. If negative social stereotypes and prejudices concerning mental illness and mental health are not discussed in an open way, different action programmes and institutions protecting human rights and aimed at social inclusion (even those sufficiently subsidised) cannot do much and are pushed out to social peripheries.

Other areas

There are many difficult problems concerning mentally ill offenders. Among them there are persons who committed small offences as well as offenders detained because of crimes. The problem of inclusion activities in relation to persons in conflict with the law is also discussed in the Polish NAP on Social Inclusion. However, the problem of mentally ill offenders was completely neglected.

Mental health problems should also be discussed in the next NAP on Inclusion in relation to small ethnic minorities and groups of refugees. It is necessary to take into account special needs of these groups as well as other vulnerable groups with multiple problems, for example deafness and mental health, etc.

Situation of women, children/ adolescents, migrants, older people

There are many interesting and effective programmes concerning vulnerable groups, realised mainly by non-governmental organisations in co-operation with local governments and state administration. However, a consistent and effective policy in this area remains to be developed in the near future.

It is important to mention some interesting initiatives in this area, for example a social action "All Poland needs to children" (related to children's emotional and intellectual development and better relations between children and the other members of the family); gradual replacing of great and alienating welfare institutions by "Family Children's Homes"; studies concerning participation in work, especially of young, disabled people; studies concerning needs of the older population; introducing methods used in Denmark to solving social problems of marginalised people and the imprisoned.

Good practices for improving social inclusion of people with mental health problems

Although the inclusion policy is not universally accepted in Poland and some people consider the idea of social inclusion of persons with mental problems as utopian, there exists a kind of social movement gathering a relatively large group of different stakeholders, interested in promoting such a policy and developing effective strategies in this area. Such strategies in Poland continue to go through a period of spontaneous development. It is hard to say, how strong the movement is at present, but it seems that it has a great development potential. The number of registered mental patients in Poland exceeded one million a few years ago; and the number of registered non-governmental organisations of families and patients or ex-patients and professionals who co-operate with them is increasing systematically.

Other existing innovative good practices include components of information and education in non-institutional settings. Some of them represent cases of transformation of old institutions or creating new solutions, especially in community care, vocational training and employment. All of them have a component of self-help/mutual assistance or supporting and developing self-help. Examples of these good practices include:

- From information to empowerment and supporting active participation in social life (Wroclaw)
- Self-help community centre and "Fountain House" in Kielce – integrated system of supporting people after mental crisis

- "Spark" – preventing and combating social exclusion of people with the experience of depression (Warszawa)
- Meetings at Murzasichle – education in non-institutional setting and a meaning of self help (Krakow)
- "To understand and to help" – preventing and combating social exclusion of people with mental health problems as the most important task of the family association (Poznan)
- From institutionalisation to life in the family and community – adaptation and rehabilitation centre for children and youngsters in Gliwice
- "Alternative" - from asylum to a new centre of social life (Warszawa- Ursus)
- Theatre against social exclusion (Wroclaw)
- "Theatre of social life" and social inclusion (Lublin)
- "Language of psychiatry in everyday life, marketing, media and politics" - towards knowledge society (Warszawa)

National Action Plans on Social Inclusion 2006-2008

In the Polish NAP on Inclusion as well as in the National Reform Programme the question of employment of people with mental health problems is mentioned in the context of social employment and social co-operatives.

In addition, mental health problems (in a broad sense, including alcohol and drug addiction) are mentioned in chapters on health care (however, only problems connected with alcohol and drug addictions are discussed), on homelessness and on social housing. People with mental health problems are also taken into account, implicitly, under such labels as disability and long-term illnesses.

3.2.21. Portugal

Health and social services

The mental health system in Portugal still is a system very much centred on psychiatric hospitals. A new national mental health plan, approved last month by the government, aims at changing this situation. The objective of the plan is to develop community mental services, promote the creation of psychiatric units at general hospitals and to create rehabilitation services and programs for the severely mentally ill.

The participation of users and families in the decision making process, both at the political and the care level, is still very limited. There are not many associations representing these groups and self-help groups are also very few.

People with mental health problems have the same rights regarding care delivered by the National Health Service as people with other problems. However, mental health services are often very distant from the places where people live. For this reason and also because stigma is very strong, many people with mental disorders do not receive the care they need. It is estimated that only a small part of those with mental disorders have access to services that respond to their needs.

With regard to social service, in Portugal, there is a lack of residential and occupational facilities and programmes in the community. An official agreement between the health and social sector, which allows financial support for NGO's providing these kinds of services, exists since 1998. A new and more comprehensive programme in this area was included in the Mental Health Plan and is expected to start before the end of the year.

At the present time, relatives continue to have a crucial role in the provision of long-term care for the severely mentally ill, thereby experiencing a significant burden.

Mental patients are often excluded from services, programmes and benefits addressing the needs of people with disabilities. There is a lack of awareness regarding the needs of people with mental disorders. The social pension and a special pension for people with significant social handicaps are the only available social support for them.

Education and training

A significant investment in vocational rehabilitation was made since the 90's with the support of public funds. Many NGO's started working on vocational training, supported employment and development of social firms. These programmes contribute to the improvement of professional competencies of people with mental disorders but they rarely result in a real integration in the open labour market. Regarding academic training, frequently interrupted by psychoses, there are no established practices to support patients to restart their studies. A very small number of NGOs are preparing projects in this area.

Employment

People with mental disorders have great difficulties in finding and maintaining a regular job, as a result of the lack of incentives given to employers and of several bureaucratic constraints. For that reason, supported and protected employment and social firms have been privileged, but the success attained with these projects has not been sufficiently evaluated.

Housing

Since 1998, it became possible to develop residential facilities based on a specific legislation created for this purpose. Many patients without social support are institutionalised. Some NGOs are investing in projects supporting individual residential

facilities but there are no official measures to support these kinds of programmes. The new Mental Health Plan includes measures to support housing for people with mental disorders.

Transport

There are no special measures related to support for transport or mobility of people with mental disorders.

Leisure activities

There are programmes that allow for the financing of day centres as well as projects aiming at the developing of leisure, cultural and sports activities. These activities are usually developed by NGOs.

Civil and human rights

The national Mental Health Law passed in 1998 regulates compulsory treatment and defines the rights of people with mental disorders. The law defines the rights of users of mental health services, regarding privacy, access to information, refusal of treatment, access to care, etc. The law also defines in great detail the organisation of mental health services, emphasising the importance of community care and psychosocial rehabilitation.

In 2006, the law 46/06, on non-discrimination was adopted, prohibiting all kinds of discrimination of people with disabilities but does not mention the mentally ill as a group of people with special problems in this area.

Situation of women, children/ adolescents, migrants, older people

With the exception of children and adolescents, that have access to special services, the situation of vulnerable groups has not been specifically addressed in Portugal. There are very few services for older people and no services for migrants or women.

Good practices for improving social inclusion of people with mental health problems

The development of projects by NGOs in the area of psychosocial rehabilitation all over the country has been an important support to patients and families.

A multidisciplinary and intersectoral project on domestic violence was created by a mental health team in the region of Coimbra.

National Action Plans on Social Inclusion 2006-2008

The National Plan of Action for Inclusion does not specifically mention the inclusion of people with mental disorders. There is a reference to the group of people with disabilities but it does not specify that this group include people with mental disorders. Some form of positive discrimination would be necessary in order to make sure that people with mental disorders benefit from the same measures to promote inclusion as other people with disabilities do.

Other specific challenges and solutions

Participation of users and families in policies and services development is one of the major challenges at the present time. The difficulty is to find qualified organisations representing the people's interests. It is necessary to promote their empowerment in order to change the situation.

A national advocacy campaign raising the attention to problems related to mental health and rehabilitation is needed, with the support of the media.

3.2.22. Romania

Health and social services

In Romania, people with mental health problems, especially people with severe mental illnesses, are not easily accepted and treated in the non-psychiatric health services. In the last years, social services have started to take the problems and needs of these people more into account and offer some support. However, more attention must be given to the difficulties these people are confronted with so that their socially integration can be ensured.

Mental health problems are primarily treated as biological diseases. Community services are just starting to develop and they are not yet functioning as they should. As a result, people are treated mainly in psychiatric hospitals and very few have the opportunity to access after-hospital services.

Overall physical health is not often taken into account in the treatment of people with mental health problems.

At the moment, social services for people with mental health problems are very limited. Stress, burn-out, depression and anxiety disorders are considered not so much to be illnesses, but to be mere individual coping problems.

Education and training

Low levels of education are the main cause for hindering the work integration of people with mental health problems.

In order to effect a shift towards a more inclusive approach to education, resources must be allocated to change attitudes, behaviour, teaching methodologies, curricula and the environment, so that educators can better meet the needs of all learners.

Employment

People with mental disorders have great difficulties in finding or keeping regular jobs. There are no specialised support services for these people and as a result very few of them are employed.

The legislation allows people with severe mental illness to work and still receive 50% of the "handicap allowance". In reality, it is very difficult to get a job on the open labour market for people who have mental problems and there are no protected shelters for these people.

Housing

The number of protected accommodation is very low, in fact it is still at the experimental level, and they are supported by NGOs. At present, the number of people who benefit of protected accommodation is under 100.

Transport

As a result of decentralisation it depends on the local authority what type of transport benefits are given to people with disabilities.

Leisure activities

There is no special support for leisure activities.

Civil and human rights

The Romanian mental health legislation establishes standards for respecting the human rights of people with mental health problems who are admitted and treated in a psychiatric hospital on a compulsory basis. The implementation of this legislation is inadequate in some places of the country.

Other areas

Families are often overprotective and do not encourage people with mental health problems to work and integrate into society.

Situation of women, children/ adolescents, migrants, older people

In Romania, more attention is given to children at risk of mental health problems but not as much to other vulnerable groups, elderly being the least favoured.

Good practices for improving social inclusion of people with mental health problems

There are NGOs that offer good practice examples through their services offered to people with mental health problems.

National Action Plans on Social Inclusion 2006-2008

The importance of social inclusion of people with disabilities – not specifically people with mental health problems – is stated in our National Strategic Reports/National Action Plans on Social Inclusion. An important objective is to increase the number of people with disabilities on the regular labour market that is why the disability legislation has changed so that people with severe and medium disabilities could retain 50% and 30% respectively of the disability benefits if they are employed. People with mental health problems can also benefit from this.

The decentralisation of the exact measures to be taken to achieve social inclusion leads to big differences between counties and even regions in Romania.

Other specific challenges and solutions

The biggest challenge is the lack of an existing system through which the person with mental health problems could go through, so that after hospitalisation he/she could be supported towards social integration. For most people who get out of the hospital there are no such services available.

3.2.23. Scotland

Health and social services

Around 16% of the population have common mental health problems. A Scottish study of children "Looked After and Accommodated (in Local Authority Care)" found rates of depression and conduct disorder five times higher than the average rates (Dimigen et al, 1999). Poverty, unemployment and social isolation are associated with the first incidence of schizophrenia. First admission rates to specialist psychiatric care for people in this group are higher among those resident in deprived areas. In Scotland, twice as many suicides occur among people from the most deprived areas.

Depression, anxiety and phobias can affect up to one in six of the population at any one time with the highest rates in deprived neighbourhoods. GPs spend a third of their time on mental health issues.

A group made up of a wide range of organisation including the Scottish Executive, NGOs, Nursing, Social Services and Policy Makers drafted Guidance on Section 26 of our new Mental Health Act which encompasses the whole social inclusion agenda. In drafting guidelines the group made specific recommendations in a range of areas in an attempt to raise the issue around social exclusion and mental health. The group continues to meet and actively promote issues in this field.

Education and training

People with mental health problems face barriers in engaging with education and training, with establishments often unaware how they could make their services more accessible to this group. Just fewer than one in three people with common mental health problems have no qualifications. The National Programme for Improving Mental health and Well-being funded the Scottish Further Education Institute to develop a website to improve information to staff on this issue www.ssmh.ac.uk.

Employment

There are high levels of unemployment among people with mental health problems. Only 24% of adults in the UK with mental health problems are in work - the lowest employment rate for any of the main groups of disabled people (Social Exclusion Unit, 2004). Fewer than four in ten employers would recruit a person with a mental health problem and most people fear disclosing their condition even to family and friends. 35% of people with mental health problems who are currently inactive would like to work. Two thirds of men under the age of 35 with mental health problems who die by suicide are unemployed. It was estimated that mental health problems cost the country £77 billion a year and early intervention to keep people in work could significantly reduce these costs. Once a person reaches crisis point it is much more costly and difficult to restore their employment and social status. It must be acknowledged that there is suspicion among many users that the social inclusion agenda is an attempt to take away their existing Social Security Benefits and this is one of the challenges we are attempting to tackle in Scotland.

Housing

People with mental health problems are three times more likely to be in debt; one in four tenants with mental health problems has serious rent arrears and is at risk of losing their home. People with mental health problems are four times more likely to say that their poor housing has damaged their health. In Scotland, people who experience mental health problems are allowed to access Tenancy Support Services funded by Local Authorities which provide them with support with a range of issues to enable them to manage their tenancies.

Transport

Social isolation is an important factor for deteriorating mental health and suicide. Particularly in rural areas, people with mental health problems report that poor transport facilities increase their isolation and access to services. A MIND Report in 2004 reported that 84% of people with mental health problems feel isolated compared to 29% of the general population and nearly 60% of people with mental health problems felt that isolation was linked to discrimination on the grounds of mental health.

Leisure activities

The Social Exclusion Unit identified a lack of clear responsibility in promoting vocational and social outcomes among many health and social care staff and reported that Professionals have too low expectations about what people with mental health problems can achieve. There is limited recognition about the value of overcoming social isolation. 40% of people living in the community have little or no contact outside mental health services. There has been evidence of improvement recently in this field with local Recreation and Leisure Department staff being willing to look at creative ways of engaging people with mental health problems.

Civil and human rights

The overall social inclusion agenda in Scotland has been taken forward in several Executive Departments and policy areas and the Scottish Executive's Equalities Strategy (2000) is based on the principle of "mainstreaming". It is suggested that to achieve mentally healthy public policy and practice there is a need to mainstream mental health improvement goals in policies aimed at achieving social justice and closing the opportunities gap (and in ways that take into account the unequal distribution of mental health risk factors across and within social groups). The new Mental Health Act has a Section 26 which aims to embrace social inclusion for people with mental health problems.

Good practices for improving social inclusion of people with mental health problems

In Scotland there is a National Programme for Improving Mental Health and Well-being www.wellscotland.info/mentalhealth/nationalprogramme.html which has produced an Action Plan and has as one of its key aims- the achievement of social inclusion (and improved quality of life) for those experiencing mental health problems.

The National Programme has also produced a paper on Addressing Mental Health Equalities in Scotland called Equal Minds (Scottish Executive, Edinburgh 2005). The work of the National Programme forms a key part of the Scottish Executive's work on improving health in Scotland and in achieving greater social justice by working to address mental health inequalities and reduce the opportunity gap experienced by people with mental health problems.

The Scottish Executive's anti-stigma programme is called "see me" (www.seemescotland.org.uk). It aims to tackle stigma around mental health. The Scottish Recovery Network (www.scottishrecovery.net) promotes the concept of recovery for people with mental health problems. "Delivering for Mental Health", the mental health delivery plan for Scotland, sets out targets and commitments for the development of mental health services in Scotland and states in its first Commitment "We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010".

National Action Plans on Social Inclusion 2006-2008

The National Action Plan is a UK central government document. Although adults with mental health problems are one of the most excluded groups in society according to a report published by the Office of the Deputy Prime Minister into Social Inclusion and Mental Health in 2004, there is hardly any specific mention of mental health and social exclusion to be found in it, although the Plan does refer to disabilities.

3.2.24. Slovakia

Health and social services

The majority of professionals in Slovakia are strongly focused on psychiatric hospitals. There is no training in community services. According to recent statistics there are 28 patients per one psychiatrist a day in Slovakia; one patient comes approximately 6,5 times for examination to his doctor a year; this examination lasts 12,7 min. and thus the time for one patient in one year is 82 min.

Adequate social support is lacking.

Education and training

Discrimination in the labour market is amongst others caused by inappropriate educational attainment, either unfinished or very elementary. Access to the labour market depends on level and type of education. A large number of people with mental health problems do not finish their higher education due to hospitalisation. In universities there is only one special programme that exists: University of Third Age where students can apply if they are older than 25 and live on pensions. The studies are not for free but they are not expensive.

Mental illness is undoubtedly a barrier for higher education in many cases. But the users of psychiatric care are usually very keen to taking on various trainings. As it appears the most frequent way to enter any course or training is to apply for it through patient organisations. They are the main "institutions" that, based on their own sources or supported by grants, organise seminars on various subjects such as PC and internet skills, handicrafts, project management and another very useful training "Patient's rights and patient advocacy".

There are 2 work-rehabilitation centres in Slovakia that provide work skills training.

Employment

In Slovakia, employment for people with mental illness is very sensitive issue like in many other Eastern European countries where unemployment is very high. With the restructuring of the Slovak economy, since 1991, the income imbalance among the population has also risen. Users are among the groups with the lowest income, unfortunately. It is especially difficult for disabled people that receive pensions (pensions in health disability).

There are only 3 sheltered work places in Slovakia – one is in Bratislava where the League for Mental Health is supporting a NGO run café with 3-4 working places for users since 2002; another one, a restaurant, is in Michalovce; and the last one is in Trnava where both people with mental health problems and people with intellectual disability work. However, this is just a drop in the ocean compared with the needs of potential workers.

Opportunities for agreement with employers for reduced working hours are completely missing in Slovakia. In terms of legislation there is "space" and support for it, but corporations and employers choose rather to pay a fine for not employing people with mental health problems. Disabled people are trying to solve this situation in these various ways:

- using services of different agencies of supported employment (but those are strongly oriented towards clients with intellectual disabilities)
- using private information from other members in patients organisation
- taking various part-time jobs, inappropriate for their profession; usually manual work

- in "strong and active" patient organisations they are applying for different types of grants and they are creating coordination and manager positions (disabled people)
- there are professional social workers in day-stationeries who should help users with this difficult tasks but the problem is that after hospitalisation, this service is no longer applicable.

Housing

In this field, Slovakia is in a very alarming situation: there are only 2 sheltered housing opportunities. Both are run by patient organisations. Some patient organisations are negotiating with representatives of their Self-governing Regions. So far they did not receive any help on this issue although it is recognised as an activity of Self-governing Regions.

Transport

There is no especially designated budget for a support with transport of people with mental health problems. Only if someone has an invalidity status he/she has the right for a price reduction of 50% for both city, intercity and international transport.

Leisure activities

Leisure activities make up for the main activities in which patient organisations are active and this is also an issue which is best taken care of. However, there are patients' organisations in less than 50% of big Slovak cities. Members of patients' organisations can meet and socialise in regular club meetings, they organise trips, sports events, cultural and social events, recreations, celebrate holidays together, etc. Above all patients' organisations are the ones which support talented artists, among them people with mental health problems.

Disabled people, including people with mental health problems, are approved by a special commission to receive some benefits: they receive a 50% discount in chosen theatres and cinemas and they also receive a discount for travel expenses all over Slovakia.

Civil and human rights

In many cases, the problem is a very low level of awareness of the civil and human rights of people with mental health problems. Moreover, the lack of information about psychiatric diseases and their treatment or prevention results in a passive approach to these problems.

Other areas

Although mental health problems occur in almost every fourth family in Slovakia, people who experience them still meet fear and prejudice from others citizens and are often made to feel ashamed and excluded. Feelings of social distance from the general public are very common among people with mental health problems, especially in rural areas.

Situation of women, children/ adolescents, migrants, older people

There are no appropriate social care services for women who have to leave their jobs due to illness of members of their family, or social care for older women who are receiving very low pensions and have problems with their mental health. Mental illness is also a great complication in the life of single mothers.

With regard to homeless people with mental health problems, the problems is that there are no existing statistics of homeless people, which poses the greatest problem for the provision of (financial) support for this group.

Good practices for improving social inclusion of people with mental health problems

In Michalovsce, a town in eastern Slovakia, 16 places of sheltered housing exist. Over the last decade an integrated system of community mental health services has been created there, based on a functional recovery model. In other words, services adapt to the needs of service users instead of the other way around. The Slovak National Programme for Mental Health recognises Michalovsce as the model region for Slovakia in the field of mental health care services.

Other good practices in Slovakia include an information campaign, organised by a national NGO, that takes place every year. The aim of this campaign is to raise public awareness on mental health promotion, mental diseases prevention, on civil and human rights among users organisations, organisations of relatives, health professionals and the public. Volunteers from local mental health services user organisations as well as professionals (psychologists and psychiatrists) and other volunteers usually join the various campaign activities. There is also close cooperation with students from high schools all over Slovakia who help with delivering the message. In 2007, the campaign's headline was "Social Inclusion of people with Mental Health Problems".

National Action Plans on Social Inclusion 2006-2008

The Slovak National Action Plan on Social Inclusion does not refer to people with mental health problems at all.

Other specific challenges and solutions

The laws in the social sector are changing so rapidly in Slovakia that there would be a need to establish an information centre. Users would give the consultations, where they could offer their own experiences with treatment, psychotherapy, psychiatric health services, etc.

There is a need for comprehensive data and surveys about needs, problems and expectations of people with mental health problems and their family members. The outcomes should be presented by and to the media and authorities responsible for the planning of psychiatric health and social services.

3.2.25. Slovenia

Health and social services

The most discussed theme in the field of mental health in Slovenia is currently the legal vacuum. Part of the old act, which dealt with hospitalisation against a person's will is no longer in force (since 2003) and there is still no new law. There are discussions about a proposed Mental Health Act that will hopefully be accepted beginning 2008, after 14 years of debate around different proposals. The new law is far more extensive than the old one. A National Programme for Mental Health is to be prepared one year after the new law will be operative.

Education and training

Students with mental health problems do not have any special status or special rights due to their mental health problems. There are no specific prevention programmes.

Employment

People with mental health problems are excluded mostly due to the stigma attached to mental health problems, the lack of understanding of problems connected with mental health problems and due to uncertainties regarding the course of mental health problems. Employers do not have enough information about mental health issues.

There are specific forms of vocational rehabilitation and programmes for people with lower vocational competences available.

Housing

People with mental health problems are not included in the group of disabled persons who have special legal rights, including easier access to housing. After successful accomplishment of psychosocial rehabilitation they cannot move on to their own/rented apartments due to their social economic situation and status. There are not enough flats available for people with lower social economics status, and no flats specifically for the group of people with mental health problems.

Temporary housing programmes offer often the only available way of helping people with mental health problems with regard to housing. Most housing groups, all for people outside social services institutions, are run by NGOs working in the mental health field. Currently there are more than 25 housing groups all over Slovenia, which is not sufficient.

Transport

People with mental health problems do not have any special rights like other groups of disabled people do (e.g. discounts, tax relief, special provisions).

Leisure activities

For people with mental health problems, there are no special opportunities or rights. There are some isolated leisure activities for this target group mostly provided by NGOs working in the mental health field. Also, there are some profit organisations offering vacation for specific groups and promoting tourism for people with special needs.

Situation of women, children/ adolescents, migrants, older people

From a legal and civil rights point of view, people with mental health problems, Roma people and migrants are the most excluded groups in Slovenia. There is lack of good

social inclusion programmes and a lack of money and political will devoted to solving these problems.

Good practices for improving social inclusion of people with mental health problems

Existing good practices in Slovenia promoting the social inclusion of people with mental health problems include social firms employing people with mental health problems and other hard-to-employ people (60-70% of all employees).

Moreover, there are several initiatives that make use of modern communication technologies (e.g. internet) to publish relevant information about mental health problems, alternative psychiatric medicine, legislation on mental health in Slovenia and educational lectures about harmful side effects of psychiatric drugs.

National Action Plans on Social Inclusion 2006-2008

The National Report on Strategies for Social Protection and Social Inclusion/National Action Plan on Social Inclusion mentions people with mental health problems as part of the vulnerable group. Also housing groups for people with mental health problems are listed under the good practice programmes in National Action Plan on Social Inclusion.

Other specific challenges and solutions

There is still a lot to do in the field of mental health in Slovenia. Currently, NGOs working on mental health issues are informally connected through a coordination network and are acting together on all important mental health issues. Still, most of the psychosocial rehabilitation is done in NGOs and there is not enough supportive legislation and financing for these activities. There is a hope that the new Mental Health Act and National Programme for Mental Health will support cooperation between the social and health sector.

3.2.26. Spain

Health and social services

As in many countries in the world, mental health issues are not receiving the needed attention. In 1986, the General Health Law established the equity of mental health in relation to other health issues, which involved the closing of large psychiatric hospitals and the provision of mental health services at the community level. However, health and social services for people with mental illness are nowadays still not sufficient, even if they are based on accurate models, and they do not receive the needed resources.

Despite the psychiatric reform, a survey published by the IMSERSO revealed that only 4,34% of the respondents with severe and enduring mental illness had received care from day-hospitals and only 6,88% had received social or health care at home, compared to 48,8% of the services received in psychiatric hospitals.

In health services, people with mental illness experience exclusion because of stigma and the insufficiency of resources. Moreover, primary care and non-psychiatric medical facilities very often overlook the health of people with mental illness. At the same time, people with more acute and chronic mental illness in many cases do not receive the needed holistic treatment because the systems are not able to ensure needed follow-up.

A better coordination with social care services is needed at all levels and recognised in the National Strategy on Mental Health as a pending issue. This affects especially the provision of rehabilitation services where they are not provided through the health system, and the access to housing initiatives, employment and social benefits.

Mental illness does affect, in different degrees, the social functioning of the people who suffer it. Meanwhile, the people who have a recognised level of disability higher than 65%, have access to pensions, which are insufficient as regards the amount.

Education and training

In general, people with severe and chronic mental illness do not have too many difficulties to follow primary level studies at school. In many cases, they reach higher academic levels than people with other disabilities. However, we do know that at university level, when mental illnesses do usually appear, the educational institutions do not accommodate people's needs.

After being diagnosed with a mental disorder, there is only a low number of people who follow training programmes. There is a need therefore to disseminate information on available training options, and to promote the accommodation of the specific needs of people with mental illness.

Employment

In Spain, between 60%-90% of people affected by mental health problems are unemployed. According to the survey developed by IMSERSO published in 2003, only 15% of people with mental illness surveyed were working at the time or had worked before. People with mental illness usually find occasional jobs whereas people with other disabilities are more likely to have more stable contracts. This information reveals a major instability and vulnerability of people with mental health problems on the labour market. The work they can manage to find is mainly non-qualified, in the services sector, agriculture or fishing and industries. A percentage of 31,78% people stated that they wanted to do any kind of work as long as they would be able to work.

In Spain, there are currently specific measures for the promotion of the employment of people with disabilities. However, people with mental illness do not benefit of these initiatives to the same degree as other disabled groups. In the survey published by

IMERSO, people affected by most severe and enduring mental illness did not have access to these measures. For people with less severe mental illness the measures most used are special employment centres (8.99%), specialised mediation services on disability (8.08%), reserved quotas for people with disabilities in the private sector (5,68%), contracts for training or practices of people with disabilities (6,75).

Specific measures for the positive discrimination of people with mental illness need to be promoted and efficiently implemented as they share the same difficulties than other people with disabilities but experience the aggravating factor of stigma.

Housing

As a consequence of the insufficiency of community support services that should have accompanied the de-institutionalisation process, most people with mental illness in Spain, live with their families. About 88% of the care received by people with mental illness in Spain is provided by family members. This has prevented many people from social exclusion, but other means for promoting autonomy and independence of the people affected need to be implemented. Moreover, a big concern is that the families, especially parents, are getting older and may not be able to provide support for long time.

In Spain, it is a constitutional right to have access to some kind of house or home. Although most people live in a permanent place (94,01%), around 10.000 people in Spain still use long stay placements in hospitals. Alternative housing initiatives in the community centred on autonomy are needed that can offer the kind of support people need.

Transport

There is not much available information on the special needs of people with mental illness regarding transport. One issue that emerged was that in one specific case a group of people with mental illness have had problems to travel by plane. They needed to present a report from their doctor stating that they are able to travel and that they would understand the instructions from the crew in case of an emergency. This situation reveals the existing stigma, which on the other hand may be a necessary requirement for the establishment of special transport and travelling rights for people with disabilities.

Leisure activities

Generally, people with mental illness have access to leisure activities and services. However, at the individual level, people often have to face discrimination and stigma as in many other areas of life.

Civil and human rights

The above mentioned items are examples of difficulties for people with mental illness to exercise their full citizenship. Stigma is a major issue that affects all areas of life and that causes discrimination for legal protection, access to services, information on health and treatment, etc. Also the right for health protection is very often overlooked, and people receiving treatment do not receive it with the needed continuity and quality.

Situation of women, children/ adolescents, migrants, older people

In Spain, women, migrants, people with multiple disabilities, dual diagnoses, and children and youth have special difficulties for integration and accessing the already insufficient resources.

Special measures to attend to these situations include:

- promoting the employment of women with mental illness

- improving the coordination between the services
- strengthening the current services addressed to children and youth and create new ones
- accommodating in current services the special needs of migrants (cultural adaptation).

Good practices for improving social inclusion of people with mental health problems

Some examples of good practices on social inclusion include psychosocial rehabilitation services, employment initiatives (programmes of employment with support, special employment centres, employment rehabilitation services), housing with support, leisure programmes, training, home care assistance programmes, multidisciplinary teams, family support, etc. These good practices are developed in different places of the country by public and private institutions as well as NGOs.

Another example is the inclusion of people with mental illness in the System for the Attention to Dependency which is being created by the "Ley de Promoción de la Autonomía y Atención a las Persoans en Situación de dependencia". This appears as a new dimension of the welfare system in Spain, which however it is still very new and its results still need to be examined.

National Action Plans on Social Inclusion 2006-2008

The National Action Plan for Social Inclusion (2006-2008) included the elaboration of the Strategy on Mental Health of the National Health System. This is the only direct reference made to mental health.

In the Social Inclusion Report (2005-2006) there was a mention of the creation of a Committee to redact the Strategy referring to the cooperation of scientific associations and FEAFES. However, in Spain mental illness is mainstreamed in the different actions targeted at people with disabilities. Public authorities have had some other means of collaborating with the mental health sector (launching of an awareness campaign by the health Ministry in 2005, inclusion of people with mental illness needs in the law for dependency, etc.). Still, mental health needs to be made more visible and included in policy agendas in order to change its historic role of "Cinderella" in the health and social systems.

3.2.27. Sweden

Health and social services

Since the Mental Health reform of 1995, there has been a changed view of mental illness. A shift has taken place involving the closing of mental hospitals. The aim was to achieve social integration and the best life possible for people with mental health problems, on equal terms with the rest of the population.

With the change in legislation funding resources were transferred from county councils to municipalities. As a result the number of beds in psychiatric hospitals decreased in the years 1994-2002 from 10.000 to 4.000, while the number of community-based houses increased in the same time from 2.000 to 8.000.

The Swedish Government appointed in 2003 a national psychiatry coordinator with the task of reviewing issues concerned with forms of work, collaboration, resources and personnel in psychiatry. In response to the coordinator's proposal, the Government has invested a total of 700 million Swedish kronor in 2005 and 2006 in care, employment, accommodation and the development of activities for people with mental health problems or mental disabilities. One of the aims of this initiative has been to strengthen the collaboration between the responsible authorities in relation to these target groups. In addition, 250 million Swedish kronor per year is being invested in 2007 and 2008 in targeted support for increased accessibility in child and adolescent psychiatry.

Special measures have been taken to improve the way in which the responsible authorities work together. In 2003 and 2004 municipalities and county councils were given greater opportunities to cooperate, firstly through the Act on Financial Coordination of Rehabilitation Measures, which makes it possible to make effective use of resources for persons who are in need of coordinated rehabilitation measures, and secondly through the Act on Joint Committees Within Health Care and Nursing, which enables municipalities and county councils to collaborate in a joint committee on issues relating to health care and social services.

Education and training

Most children and adolescents attend "regular" schools, although there are special types of schooling for pupils with disabilities. The Education Act states that children in need of special assistance at school are to be provided with it. Also, the law says, there must be equality in education for all children, wherever they may live in Sweden and regardless of any disabilities they may have.

Employment

In Sweden, unemployment is slightly higher among disabled people than among the rest of the population. There are now around 90 social firms employing 1.400 workers, a third of whom have disabilities or mental health problems. However, overall the number of sheltered work places is declining in Sweden.

The incidence rates of work related disability are high and rising throughout much of Europe. For example, in Sweden approximately 6% of the labour force is classified as being disabled.

Housing

Homelessness is a serious problem in Sweden. A large proportion of homeless people have substance abuse problems and/or mental health problems. Personal representatives are an important initiative for people with mental health problems. The personal representative is to represent the individual in contacts with various authorities, for instance, and make arrangements so that the measures taken by various responsible

bodies are planned, coordinated and implemented in such a way that the individual's own wishes, needs and legal rights are respected.

Civil and human rights

Patients' rights with respect to mental health care and treatment are nowadays guaranteed on the basis of the principles of informed consent, individual information and the possibility to appeal. However, involuntary treatment may occur if it can be defended with respect to the aim of the treatment. The challenge that remains is to find a balance between the right to freedom and citizenship and the right to health and protection.

Sweden has four laws prohibiting discrimination, one of the grounds cited being disability. The first, the Prohibition of Discrimination in Working Life of People with Disability Act, was adopted in 1999. This was followed in 2002 by the Act on Equal Treatment of Students at Universities and in 2003 by the Prohibition of Discrimination Act, which applies among other things to trading in goods and services. In 2006, a law was added prohibiting the discrimination of children with disabilities, etc, at preschool and school.

Other areas

A group that finds it difficult to have its needs met is that of people with substance abuse problems who also have mental health problems. The Office of National Drug Policy Coordination and the psychiatry coordinator have jointly presented a ten-point programme for the care of people who have a mental illness/disability and are also substance abusers. The programme was distributed to all the municipalities and county councils during the autumn of 2005. A total sum of 500 million Swedish kronor has been earmarked in 2005 and 2006 to improve accessibility and quality of care for people who have both mental disabilities and substance abuse problems.

Situation of women, children/ adolescents, migrants, older people

For a number of years, attention has been drawn in Sweden to conditions for children at risk. The work of the social services and other authorities in this area is undergoing continuous development. This group of children includes children who grow up in homes in which physical or psychological violence takes place, children who are neglected, children who have been subjected to sexual abuse, children of substance abusers, children of people with mental disorders and children who live in conditions of economic vulnerability.

For older people with mental health problems and mental disabilities, it is particularly difficult to have their housing needs met. There is a lack of special types of housing or special support in their homes.

Good practices for improving social inclusion of people with mental health problems

Examples of good practices promoting social inclusion include especially initiatives aimed at assisting homeless people with their health problems, including psychological support, and establishing contacts with other social services and NGOs (Hållpunkt Maria).

National Action Plans on Social Inclusion 2006-2008

The Swedish National Action Plan on Social Inclusion 2006-2008 presents an overview of the main challenges related to the social exclusion of people with mental health problems, with a particular focus on the special needs of children, older people and people with both mental health and substance abuse problems.

The report presents existing problems such as homelessness among people with mental health problems as well as future challenges including the need to strengthen

collaboration between different levels of actors as well as the need to develop preventative measures.

Other specific challenges and solutions

Persisting challenges in the field of mental health and social inclusion in Sweden include the gaps between community treatment and health care.

It is particularly important that the municipalities, in collaboration with the organisations in the network, make a commitment to draw up local action plans for social integration. Policy for social integration must be adapted to the needs of each group of socially vulnerable people such as people with mental health problems who want to break their social exclusion and so on. There is also a need for individually adapted measures as the problems of exclusion differ.

With the aim of creating a framework for collaboration between the public sector and the organisations, a clear framework and clear rules of play are required which establish joint objectives and define roles, responsibilities and financial resources to attain the established aims. These rules of play are to guarantee clarity, transparency and a long-term approach.

4. Recommendations for promoting social inclusion in Europe

Over the last years, there have been many achievements in the European Union in the field of mental health and well-being, the opening of psychiatric hospitals and the start of a process of de-institutionalisation, a stronger emphasis on social psychiatry and community-based solutions for mental health and social services and a growing recognition of the social inclusion challenges and needs of people with mental health problems, to name only some. However, despite the increase in attention of this issue in policy and practice, mental health and well-being and the promotion of social inclusion of people with mental health problems is still not receiving the acknowledgement it deserves, given the number of people experiencing or at risk of developing mental health problems and given the vicious circle of mental ill-health, unemployment, poverty, housing problems, social isolation and worsening mental health problems, from which it is only very hard to escape.

In all European countries, even where policies and initiatives to break this vicious circle exist, there still seems to be a low level of support when it comes to the implementation of solutions. The main reasons for this includes, insufficient communication and interaction between all levels, sectors and actors, a lack of funding especially for NGOs and other voluntary providers who provide most of the services but with only very limited financial and human resources. This together with a reluctance to involve the people who are affected, i.e. people with mental health problems and their families, in policy and decision making process hamper the move from political interest to action all over Europe.

The present report aims to remedy the situation by providing concrete information about mental health as well as mental illness and the risk of social exclusion. National reports from 27 Member States of the EU gave a detailed overview of the specific challenges that exist in each country, and the following recommendations based on the analysis of all national reports are addressed to policy makers and practitioners alike to support developments towards achieving mental health and well-being as well as social inclusion for all in Europe.

The key issues that were repeatedly highlighted in all the countries and national reports include the urgent need for strengthened communication and interaction between the health and social sector. Today, mental health and mental illness are still too often considered from a medical point of view, largely ignoring the social challenges and needs faced by people with mental health problems. Increased efforts are needed to develop alternative solutions for health and social services outside secluded hospitals and wards and inside the community. A decent minimum income as well as a fair regulation of the compatibility between work and social benefits is key to the integration of people with mental health problems in society. However, this requires adequate education and training opportunities as well as the safeguarding of their civil and human rights. People with mental health problems must therefore be included in the framework for the National Action Plans on Social Inclusion in all countries, as well as in all other policy initiatives aimed at social inclusion, as a separate group from people with other disabilities. Support must be guaranteed for the establishment of users' organisation and forms of self-representation to facilitate the involvement and participation of people with mental health problems and their families in relevant policy and decision making.

Finally, some concrete examples of good practices for social inclusion of people with mental health problems should be mentioned that have been identified in the frame of Mental Health Europe's transnational exchange project "Good Practices for Combating Social Exclusion of People with Mental Health Problems" - 2005-2007. The good practices are intended to serve as a source of inspiration for everybody who wants to learn about small, local initiatives that can help to promote the social inclusion. They can be found in a database on the project website (www.mentalhealth-socialinclusion.org), together with MHE's conclusions and recommendations for policy and practice.

Recommendations for promoting social inclusion of people with mental health problems

In health and social services:

- Strengthen communication and interaction between the health and social sector and ensure more integrated actions**
- Ensure involvement and participation of people with mental health problems and their families in policy and decision making**
- Complement the de-institutionalisation process with increased development of alternative solutions for health and social services in the community**

In education and training:

- Promote early prevention of mental disorders in schools and develop specific education policies targeting pupils with mental health problems**
- Create information and support services in schools and universities supporting students with mental health problems to complete their education**
- Increase (financial) support for NGOs and other providers of vocational training and rehabilitation for people with mental health problems**

In employment:

- Raise awareness among employers of the employment potentials of people with mental health problems**
- Create decent job opportunities in sheltered/adapted employment or social firms as well as in the open labour market**
- Ensure a decent minimum income for people with mental health problems as well as a fair regulation of the compatibility between work and social benefits**

In housing:

- Promote legal regulations promoting housing rights of people with mental health problems and prohibiting discrimination**
- Prevent homelessness of people with mental health problems by supporting the development of affordable and adequate housing**
- Provide (financial) support to NGOs and other providers of alternative housing solutions like sheltered living opportunities**

In transport:

→ Provide people with mental health problems, who rely on social assistance, with price reductions and support for access to public transport

→ Pay special attention to people living in rural areas with limited access to public transport

In leisure activities:

→ Provide concessions and price reductions for social and leisure activities to people with mental health problems who rely on social assistance

→ Support the establishment and sustainability of self-help groups and social clubs for people with mental health problems as well as initiatives aimed at bringing together people with mental health problems with other people who live in the community

In civil and human rights:

→ Ensure that people with mental health problems are informed about their rights

→ Enforce the implementation of anti-discrimination legislation in all areas

→ Support the creation of contact points for legal advice for people with mental health problems

In other important areas:

→ Ensure the involvement of people with mental health problems and their families in relevant policy and decision making as well as in ongoing monitoring and evaluation of services

→ Seek partnership with NGOs and other grass-roots providers of services in mental health to ensure adequacy, flexibility and sustainability at the local level

→ Provide an adequate financial frame for the development of sustainable community-based mental health services

→ Guarantee equal treatment for people with mental health problems with regard to insurance coverages

In vulnerable groups:

→ Pay special attention to the mental health and social needs of migrants and invest in culturally sensitive approaches to mental health and social services

→ Adopt a gender-based approach in mental health and social support services

→ Invest in mental health promotion and early prevention of mental disorders and drug abuse in children and young people

→ Create spaces for meeting others and living in the community for older people and fight social isolation

In good practices:

→ Adopt the principles of person-centeredness, independence, empowerment and community orientation

→ Invest in social activities in the community as well as in initiatives promoting labour market integration of people with mental health problems

→ Fight stigma and prejudice in society through realistic messages in the media

→ Support NGOs and other voluntary providers of mental health and social services

In the National Action Plans on Social Inclusion:

→ Include people with mental health problems in the framework for the National Action Plans on Social Inclusion in all countries as a separate group from people with other disabilities

→ Involve NGOs and other civil society organisations, especially mental health associations, in the discussion, drafting, implementation and monitoring of the National Reports on Strategies for Social Protection and Social Inclusion

→ Enforce an integrated approach to tackling the needs of people with mental health problems in all areas of the National Reports, Social Inclusion, Health and Long-term Care and Pensions

→ Assume and promote ownership and responsibility for the National Reports as well as for all other OMC related instruments, such as mutual learning and peer reviews

→ Ensure an effective implementation of agreed strategies and actions as laid down in the National Reports

5. About Mental Health Europe

Mental Health Europe (MHE) is a European level non-governmental organisation (NGO) and network committed to the promotion of positive mental health and well-being, the prevention of mental disorders, the improvement of care, advocacy for social inclusion and the protection of the human rights of people with mental health problems and their families and carers.

MHE's vision is of a Europe where mental health and well-being is given high priority in the political spectrum and on the European health and social agenda, where (ex)users of mental health services live as full citizens with access to appropriate services and support when needed, and where meaningful participation is guaranteed at all levels of decision-making and administration. MHE's values are based on dignity and respect, equal opportunities, freedom of choice, non-discrimination, social inclusion, democracy and participation.

Membership of MHE is open to NGOs, individuals, professionals, volunteers and others, including people with mental health problems, who are active in the mental health field at local, national, regional or European level and who share and who support MHE's vision. MHE represents the common interest of these organisations and lobbies and advocate for it at the European level.

For further information about MHE, please contact the MHE Secretariat:

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Website: www.mhe-sme.org

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