C/2024/6868

28.11.2024

Opinion of the European Economic and Social Committee

Mental health community services

(own-initiative opinion)

(C/2024/6868)

Rapporteur: **Pietro Vittorio BARBIERI**

Advisor	Gisella TRINCAS (for the rapporteur)
Plenary Assembly decision	18.1.2024
Procedural basis	Rule 52(2) of the Rules of Procedure
Section responsible	Employment, Social Affairs and Citizenship
Adopted in section	4.9.2024
Outcome of vote (for/against/abstentions)	76/1/0
Adopted at plenary session	18.9.2024
Plenary session No	590
Outcome of vote (for/against/abstentions)	204/1/3

1. Conclusions and recommendations

1.1. The EESC shares the aims and objectives of the European Commission's comprehensive approach to mental health, in particular the actions chapter: integrating mental health into all policies; promoting prevention and early diagnosis services for mental health problems; boosting the mental health of children, young people and older people; helping those most in need; tackling and preventing psychosocial risks at work; reinforcing mental health systems and improving access to treatment and care; breaking through stigma and prejudices; and fostering mental health globally.

1.2. The EESC believes that mental health literacy for the whole of society is needed. In fact, prevention strategies must be able to deploy all their potential to increase awareness in the population so that stigma is fought in open communities, and so that it is made more possible to recognise and diagnose mental health conditions at an early stage for an early intervention.

1.3. The EESC considers cooperation among the sectors to be crucial in order to ensure that the education, employment, social care and mental health care sectors all work together to help people live life to the fullest potential. Policies should aim for an integrated mental health system, as a person's life does not depend on the expertise of any one specific sector. The goal is to reach the person's full potential with a view to supporting them in the pursuit of happiness, like everyone else.

1.4. The EESC supports empowerment and support for self-representation as the key to ensuring the full participation of people in what concerns them and to co-producing strategies and programmes to support people suffering mental health issues. This involves the planning, design, provision and evaluation of care. Inevitably this requires a programme of technical and financial support for forms of self-management, usually by means of non-profit organisations.

1.5. The EESC encourages the Member States, local communities, professionals, civil society organisations (including the social partners) and all state and non-state actors to build an ecosystem of community-based services to support people across Europe who experience mental suffering. In particular, the EESC draws attention to the essential elements of the environment which should be built according to the guidance already set out by the World Health Organization (WHO): reducing hospitalisations in psychiatric hospitals (as has already happened in Italy), abolishing coercive practices, countering power imbalances in care services, moving from segregating services to personalised practices, making available services and professionals capable of interpreting what changes are needed based on human rights starting from the dignity of each person, changing the fate of thousands of people (and their families) who live with these conditions, and fighting stigma also to trigger a positive mechanism oriented towards social inclusion and participation in community life.

1.6. The EESC believes it is crucial that the ecosystem be based on some precise guidelines: the personal budget as a driver of spending by states and communities; diagnostic and treatment services that are as close as possible to the person's place of residence, and at the same time are pleasant places to visit; the person's right to choose to be able to live in non-segregating settings, which never exceed 3-5 beds; employment, education and lifelong learning services that adopt adequate and personalised strategies and tools; professionals with adequate training, including the most advanced contribution from research; and peer counselling services since people learn more from those who have lived a similar experience. The EESC considers the objective of establishing clear guidelines to be fundamental so that reference standards can be determined.

1.7. The EESC is convinced that it is necessary to acquire disaggregated data and economic statistics so that Member States and communities are able to carry out national and community planning.

1.8. The resources chapter represents the greatest challenge. Cost-effectiveness must be taken into account. There is now specialised and consolidated international literature according to which the absence of actions or the existence of segregating services clearly represents a much higher cost than working towards inclusive services. The process is long and complex, and the EESC considers it mandatory to undertake it if we consider the Charter of Fundamental Rights to be a foundation of the EU. Therefore, investments need to be made at all levels to support a community-based approach and proceed with deinstitutionalisation.

1.9. The EESC calls for the European and international institutions, Member States, local communities and organised civil society (including the social partners) to take urgent steps forward to organise the transition. The EESC intends to support all initiatives that lead to a place of broad consensus that can overcome the persistent stigma in the decision-making process. The protagonists must be the people who experience mental suffering and the organisations that represent them. It is necessary to build a structured path by means of a 'consensus conference' that involves the institutions.

2. **General comments**

2.1. A recent Eurobarometer survey ([1]) reveals the increasing impact of mental health issues on Europeans and their growing concern regarding this issue: 46 % of respondents reported having experienced an emotional or psychosocial problem in the past 12 months, 89 % agreed that it was important to promote mental health, while 25 % reported that one of their family members had experienced problems in accessing mental health services.

2.2. The European Commission's *Comprehensive approach to mental health* ([2]) states that:

— mental health is an integral part of health;

— it is affected by a range of factors (personal, environmental, social and economic factors, as well as crises such as the COVID-19 pandemic, the war in Ukraine, inflation and the energy crisis);

([1]) https://europa.eu/eurobarometer/surveys/detail/3032.
([2]) https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/promoting-our-european-way-life/european-health-union/comprehensive-approach-mental-health_en.

— before the COVID-19 pandemic, mental health problems affected one in six people in the EU at a cost of more than 4 % of GDP;

— this cost is due both to the above-mentioned crises and to the political and organisational choices of governments;

— this issue involves the weakest sections of society, starting with young people, among whom suicide is the second leading cause of death ([3]).

2.3. The right to access care, including preventive care, is enshrined in the Charter of Fundamental Rights of the European Union and in the European Pillar of Social Rights, which states that it is necessary to uphold this right through good quality services, which respect human rights and involve those directly concerned.

2.4. The European Commission Communication is based on three principles: availability of adequate and effective prevention, access to high-quality and affordable treatment and healthcare, and reintegration into society after recovery.

2.5. In its opinion on *Measures to improve mental health* ([4]), the EESC:

— calls for a reform of the EU's health systems to ensure the prevention, early detection and screening of mental illnesses and the provision of a person-centred approach in the community;

— recommends that the EU's 'comprehensive approach to mental health' include a timeframe, be sufficiently funded, establish responsibilities and include indicators to monitor progress, including in the European Semester. The NRRPs ([5]) should include more direct investments in the health and social sector;

— supports the development of human-rights-based, person-centred, recovery-oriented, community-based mental health systems that prioritise the person's empowerment and active participation in their own recovery, with the ultimate goal of improving the quality of life of people with mental health conditions and in compliance with the principles of the UN Convention on the Rights of Persons with Disabilities (CRPD), while focusing on the needs of specific and vulnerable groups; and

— encourages the social partners to support and promote initiatives aimed at improving working conditions with a view to assessing and eliminating psychosocial risks in the workplace.

3. **Specific comments**

3.1. With this second opinion on this subject, the EESC is seeking to generate debate and proposals with a view to reducing the disconnect between what is said and what is actually done when it comes to providing mental healthcare and social services.

3.2. Flagship initiative No 1 of the 'comprehensive approach' communication is the 'European Mental Health Capacity Building initiative'. Through an EUR 11 million project that is currently being implemented with the WHO, the European Commission will support Member States in capacity building to strengthen and reform their mental health systems.

3.3. Under flagship initiative No 9, the 'Youth First Flagship', the Commission, in collaboration with UNICEF, is currently working with Cyprus, Slovenia, Italy and Spain (specifically Andalusia) to strengthen their administrative capacity and promote cross-collaboration among national public administrations. The objective of this initiative is to improve the overall quality of mental health services and is supported through the Technical Support Instrument.

([3]) *The consequences of the COVID-19 pandemic on mental health and implications for clinical practice*.
([4]) Opinion of the European Economic and Social Committee on 'Measures to improve mental health' (OJ C 349, 29.9.2023, p. 100).
([5]) National Recovery and Resilience Plans: https://commission.europa.eu/business-economy-euro/economic-recovery/recovery-and-resilience-facility_en.

3.4. In flagship initiative No 16, the European Commission states its intention to offer Member States technical support to help them roll out mental health reforms across several sectors, in order to improve the availability of cross-sectoral mental health services across the EU. Under the 2024 call of the Technical Support Instrument, five Member State projects have been selected for support to implement mental health reforms. The EESC proposes an approach to the services and a number of solutions, based on the CRPD, with the aim of pinpointing the best practices to be collated and replicated on the basis of a human rights-based approach to mental health.

3.5. The World Health Organization (WHO) stresses the need to reform legislation that is not in line with these principles. It advocates reviewing policies and the organisation of existing mental health and social services, so as to ensure high-quality services and meet the different needs of people with mental health problems.

3.6. The availability and quality of community-based services is of great importance and needs to be addressed as a matter of urgency. This seems too often marked by an ambiguous disconnect between theoretical pronouncements and practice in reality, between principles and organisational models, and between resources available and what is actually possible in terms of treatment and recovery, such as tangible changes in the living conditions and well-being of the individual and their day-to-day lives. Community-based services should be planned on the basis of statistical data that must be available.

3.7. In this context, the aim should be to empower service users, to help them play an active role both in co-designing services and in their own treatment, and to increase awareness and responsibility, while also constantly monitoring quality standards and the respect for human rights in the delivery of the services (WHO QualityRights tool kit ([6]), EQUAS etc.).

3.8. In a person-centred approach based on the individual's real needs, the professionals and services must support people and help them take back control of their lives, to the extent possible and considering their personal circumstances, but without uprooting them from their hometown and their loved ones, and reconnecting them with the real world of relationships, opportunities and choices, to aid a meaningful recovery. Tangible objects such as a house, income, useful items and the body itself do not rematerialise from the treatment itself. On the contrary, they enable the treatment to have meaning, direction and beauty. This is referred to as a 'personal budget' ([7]). It should become the driver of public spending on mental health.

3.9. Community mental health services should be available in sufficient quantity and should be accessible and affordable. They should avoid the risk of being organised as mere specialist clinics with purely outpatient activities, with long waiting lists, open only on weekdays for a few hours, and separated from the rest of the local community. They should be culturally geared towards human rights. Moreover, they must not be built and shaped around profit, or characterised by sterile spaces and furnishings, sometimes run down, and too often empty, cold and impersonal. They should not appear to be geared towards creating an illusion of care, towards a superficial focus on the 'almost normal' or towards distancing themselves from 'patients with serious conditions who are difficult to treat' and who struggle to access treatment and are quickly sent away to private approved facilities.

3.10. On the contrary, they should be open every day and be accessible, welcoming and beautiful places – places to form relations and places of mediation – driving and steering people's treatment and social inclusion journeys in the local community via unique, individual and complex pathways to rebuild meaning, ties and bargaining power, and thus well-being. They should be designed to provide respectful and dignified care, to be 'homes', places that are open 24 hours a day, seven days a week, a starting point for work in a given area, with a defined catchment population (no more than 80 000 people), welcoming the city and its formal and informal groups, encountering them, changing them, and providing a place where people in crisis can find answers and, if necessary, stay for some time, including at night.

([6]) WHO QualityRights Tool Kit.
([7]) https://arts.units.it/handle/11368/3029760.

3.11. Given the crisis, there is a risk that residential structures could proliferate, requiring a huge amount of financial resources. Moreover, the existing models appear oversized in terms of numbers, with 40+ users, and are far removed from the day-to-day life of cities and neighbourhoods, anonymous, devoid of objects, and still governed as asylums, with closed doors and authoritarian rules. They are often operationally separated from the local services in the areas in which they are located, sometimes with completely separate teams and inadequate job profiles. They come across as completely inward-looking. They are, for the most part, places from which it is not possible to escape to more independent forms of living or co-living where people can find support when needed and for as long as necessary and become integrated into the community, as many positive experiences have shown us is possible, and with very sustainable costs.

3.12. The excessive emphasis that has recently been put on residential facilities is worrying. It is almost as if psychiatrists, administrators and politicians have a continual need for places and defined spaces in which to exercise – more than care – control and the power to lock people away indefinitely. The global community of doctors specialised in psychiatry has taken a clear position on this matter, set out in a specific document ([8]).

3.13. According to research by the European Social Network ([9]), 65 % of local communities affiliated with them claim that resources for deinstitutionalisation and the construction of community services are not sufficient. It is argued that the process is long and expensive and there is a difference between how different local communities decide to invest resources. It should also be underlined that there is often a diversity between cities and rural areas.

3.14. Based on the choice of the person, co-living arrangements, including general services like social housing units for a small number of individuals (between 1 and 5), and group homes (for 3-5 people) – which have already been tried and tested – should be increasingly set up in residential homes within towns or city neighbourhoods, where everyday life is possible, where people are free to go out and participate in community life, where in the normality of day-to-day life people can build up a history, trust, the ability to choose and the ability to own objects, while reclaiming time and space, and gaining opportunities. Living a normal life like any other citizen. This will also help promote peer support, not only as a way to enable cohabitation, but also to facilitate the sharing of experiences, encouraging and promoting meaningful and quality participation in the community and society as a whole, and allowing people to participate, as far as possible, with their own financial resources.

3.15. These empowerment experiences include the possibility of 'foster families' – where people with mental illnesses are taken in by host families – which features on UNESCO's list of intangible cultural heritage.

3.16. Specific needs of children and adolescents in mental health policies, including the unique challenges and pressures they face, should be addressed (specialised services and support systems in educational institutions may be suggested).

3.17. Tailored approaches for different cultural and vulnerable groups such as older people, refugees, the LGBTQ+ community and people with disabilities should be promoted, responding to the specific needs of different societal groups.

3.18. Ongoing research into effective mental health interventions should be encouraged, and new therapeutic techniques developed, to ensure the services are based on the latest scientific evidence. Even more so, the training of professionals for the transition must be provided at every level and be consistent with the defined objectives.

3.19. In addition, the EESC is concerned about the shortage of mental health professionals. This gap could be bridged by means of a step-by-step system that would involve different professionals at different times, depending on the condition of the person concerned, making more effective and efficient use of the existing professionals. The professionals themselves must receive ongoing psychological and physical support to avert the risk of burn-out.

([8]) https://www.wpanet.org/_files/ugd/842ec8_e2e8fbfb2d7a4a168f0df4726c528543.pdf.
([9]) https://socialserviceworkforce.org/wp-content/uploads/2024/03/Enhancing-Community-Care_0.pdf.

3.20. The role of technology in improving mental health services, especially in remote or underserved areas should be more elaborated (digital services should not replace services provided by people, but might facilitate access to those services in certain circumstances).

3.21. A comprehensive approach needs to be taken to mental health, as part of an individual's normal life experience, ensuring prevention, preservation, promotion and the highest attainable standards of mental health, and ensuring that individuals live, to their fullest potential, the life they want to live. Above all, mental health literacy for the whole society is needed. In this direction, it is essential to adopt strategies directed to self-representation support.

3.22. It is essential to produce co-designed guidelines that determine clear standards based on human rights and the indicators of every single topic mentioned above. A systematic review process to continually assess and adapt mental health services based on outcomes and changing societal needs should be provided for.

3.23. Statistics and disaggregated data, including the resources invested, are fundamental to highlight the homogeneity of spending in the different territories, and the coherence with respect to the objective of deinstitutionalisation and the construction of community-based services. It is therefore necessary to acquire a useful framework for Member States and local communities so that the cost-effectiveness and possibly also the need for further resources can be assessed.

Brussels, 18 September 2024.

The President
of the European Economic and Social Committee
Oliver RÖPKE