EXECUTIVE SUMMARY

This report entitled “Mapping and Understanding Exclusion - Institutional, coercive and community-based services and practices across Europe” is a new and expanded edition of Mental Health Europe’s 2012 Mapping Exclusion report. The report was put together by the University of Kent and Mental Health Europe (MHE), with the help of MHE members and partner organisations, and with support from the Open Society Mental Health Initiative and the European Union’s Rights Equality and Citizenship Programme. The report aims to capture updated and more comprehensive information on European countries’ mental health laws, the use of involuntary or forced placements and treatments, the practice of seclusion and restraint, as well as emerging issues in the mental health field in Europe. In mapping mental health systems across Europe, the report also sheds light on the situation of human rights for people who use mental health services and people with psychosocial disabilities. This time around there is a special focus on the stories of people who have experienced institutionalisation and coercion in mental health services which we hope will contribute to a more profound understanding of the exclusion these individuals face in society.

The report shows that while the situation described in 2012 has changed somewhat, there is still a substantial number of people with mental health problems living in institutions across Europe and in need of community-based services. Although reforms have taken place, the report shows that there are several barriers such as the poor cooperation between social and health authorities, lack of human rights compliant community-based services, trans-institutionalisation and austerity. Furthermore, in recent years deinstitutionalisation has been painted as a largely Central and Eastern European issue, however institutions exist in many Western countries as well, including France, Belgium, Ireland, the Netherlands, Portugal, and Germany, where tens of thousands of people with mental health problems are still living and where little is being done about this situation. In Central and Eastern Europe, the implementation of EU-funded deinstitutionalisation programmes has been slow, and there are limited data about the actual outcomes of these programmes for people with mental health problems.

The personal testimonies which were graciously provided by people with lived experience of coercive measures and collected for this report show that involuntary placement and treatment can have long-term and devastating effects on people’s lives. Lack of information before and during admission, poor physical conditions, forced medication with severe side effects, the absence of legal aid, physical and emotional harm, social and physical isolation, and stigma all featured in personal testimonies of ex-users and survivors.

In the previous Mapping Exclusion report in 2012, several countries were planning or implementing progressive and promising legal capacity reforms. However, by 2017 our report found that only some countries have actually changed their relevant laws and practical implementation of supported decision-making remains wanting almost everywhere. Overall the evidence collected in this report shows that the human rights issues facing people with mental health problems and psychosocial disabilities both within and outside of mental health services should still be of great concern.
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RECOMMENDATIONS

Based on the report, we have put together the following recommendations:

1. Those States who have not done so, adopt holistic deinstitutionalisation strategies in partnership with representative organisations of persons with mental health problems and psychosocial disabilities and other relevant stakeholders which are in line with human rights standards, bringing in all relevant ministries and sectors, including health, social care and employment, and are supported by adequate investment to ensure the sustainability of the transition to recovery-oriented, human rights compliant community-based mental health services and supports.

2. In order to reduce coercion in mental health services, European States should:
   - Adopt policies which aim to immediately reduce coercion in mental health services and ultimately eliminate such practices altogether in line with human rights standards. Policies and practice should also focus on: providing information to people and their families about their rights and their health; improving the communication between community and hospital teams; utilise “zero visions”, de-escalation procedures and other techniques; establishing outpatient mobile units; and providing human rights training for users and staff with a particular focus on the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) and informed consent
   - Support the empowerment of (ex)users of mental health services and persons with psychosocial disabilities and their representative organisations and ensure that they know their rights and can participate in all decisions concerning their lives, in line with Article 4.3 of the UN CRPD;
   - Move towards systems of supported, rather than substitute, decision-making in line with Article 12 of the UN CRPD, including through the amendment of capacity and mental health legislation as well as the creation of support services and scaling up of promising practices;
   - Properly document and report all incidence of the use of involuntary placement and treatment, restraint and seclusion and reasons for their use and publicly release this data.

3. In line with Article 31 of the UN CRPD, States should document institutional placements and make the statistics publicly available. Such statistics should be disaggregated to contain data on number of placements, type of institution, duration, reasons for placement as well as demographic characteristics such as age and gender.

4. In line with Article 8 of the UN CRPD, States should invest in population level anti-stigma programmes which are evidence-based. Advocacy campaigns and awareness-raising both at the national and the local levels should always be an integral part of mental health reforms, deinstitutionalisation strategies and implementation.

5. States should introduce personal budget schemes to support deinstitutionalisation and independent and community living. Those States that already have such schemes should ensure that these are available to people with psychosocial disabilities on an equal basis with other persons with disabilities.

6. States need to better monitor deinstitutionalisation programmes and gather data to ensure that people with mental health problems are benefitting from reforms and that the alternatives created through these programmes actually support independent and community living, in line with Article 19 of the UN CRPD.

7. The European Union (EU) should ensure the continuation of vital support for the transition from institutional to community-based services in the Post-2020 Multiannual Financial Framework while also ensuring the strengthening, extension and efficient monitoring of the conditions in the regulations governing the use of funds and that funding processes are simplified and reformed to ensure that all funds are used to make the greatest impact possible and in a manner that complies with human rights standards.

8. Efforts at EU level should be complemented by the exchange of information and experiences between countries in the mental health field including follow-up to the Joint Action on Mental Health and Well-being and the EU Compass on mental health and well-being.

9. The EU should provide funding for research on alternatives to coercion, for the scaling up of promising practices on supported decision-making as well as for the empowerment of users of services and persons with psychosocial disabilities.