



Conference of European Churches  
Conférence des Églises Européennes  
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**EURODIACONIA**

European Federation for Diaconia  
Europäischer Verband für Diakonie  
Fédération Européenne de la Diaconie

To the  
European Commission  
Directorate-general for Health and Consumer Protection  
Unit C/2 “Health Information”  
L- 2920 Luxembourg

## **Mental Health from the perspective of European Churches and Diaconal Organisations**

### **Contribution of European Churches and Diaconal Organisations to the Green Paper “Improving the mental health of the population: Towards a strategy on mental health for the European Union.”**

#### **1. How relevant is the mental health of the population for the EU’s strategic policy objectives, as detailed in section 1?**

**1.1** Eurodiaconia and the Church & Society Commission of the Conference of European Churches welcome the EU Commission’s initiative in providing a coordinating contribution to *the establishment of a common and comprehensive strategy on mental health* in the European Union. We understand this to be aimed at promoting the mental health of the citizens in the European Union, while respecting the competence of the Member States and the subsidiarity principle.

**1.2** We respond to this paper with reference to our own background, as organisations already involved in promoting mental health for the people in Europe. We consider the churches and diaconal organisations as important participants and partners in the proposed strategy and dialogue on mental health. *Churches and diaconal organisations implement strategies to prevent mental ill health, and provide services at the local and national level to children, youth, families, old people and excluded groups.* They offer social support and human networks, pastoral care, counselling for risk groups, and health and rehabilitation services. They also provide opportunities for spiritual guidance, volunteer work, interpersonal activities, and empowerment and anti-discrimination practices. Every day churches and

diaconal organisations are in contact with millions of people on spiritual and mental health issues. We, therefore, believe that these parties should be considered as important stakeholders in the discussion and process of promoting mental health.

**1.3** We ask for your *special attention concerning spiritual and religious factors in mental health*. We do not find these factors quoted as determinants in the Green Paper on Mental Health nor in the WHO-list of factors in annex 7. A number of research studies have shown that participation in religious practices and communities is a relevant factor in the promotion of mental health and its impact should not be left unassessed at EU level. Religious and/or spiritual care is a necessary part of health and other services. The same comments apply equally to the role and relevance of religious education.

## **2. Would the development of a comprehensive EU-strategy on mental health add value to the existing and envisaged actions and does section 5 propose adequate priorities?**

**2.1** We are aware of the perception of mental health in the Green Paper as a ‘resource’ for citizens and society, but we are convinced that mental health should not in the first place be approached in such a reduced, instrumentalised way. *(Mental) Health is a fundamental part of the wellbeing of every human being and thus much more than a factor of productivity in terms of GDP*. We consider ‘improving the mental health of the population’ to be an important policy goal as such and as an end in itself. We believe that the fundamental rights and the unique value of every single human being should be at the centre of the Commission’s approach. Thus, the EU’s mental health policy should not only be based on Art. 152 of the EC Treaty, but also on Art.13 of the EC Treaty (anti-discrimination) and on the Charter of Fundamental Rights. This means that the Commission’s policy should focus on the mental health of each individual person, in his or her context and in good balance with the surrounding nature and community, and not on the abstract objective of the mental health of the population as a whole.

**2.2** In a comprehensive approach, both treatment and care for individuals and addressing of the challenges associated with stigma and human rights are needed as stated in the Green Paper. We want to underline this and think that the most important policy goal should be to *change arrangements and networks in society*. This should be done with the aim of ensuring that people with mental health problems and disabilities are not stigmatised or excluded. We are particularly worried that certain behaviours are being unnecessarily medicalised, and treated with drugs, when other strategies ought to be employed. Such strategies often require more time, but allow a much greater degree of acceptance and empowerment as fellow citizens with full rights and dignity.

**2.3** Regarding the categories being used in the Green Paper, a *much more precise differentiation* of the terms ‘mental ill health’, ‘chronic mental ill health’ and ‘mental disability’ is needed in order that appropriate (preventative) strategies can be developed. To give an example, mental health problems as a result of social factors like poverty, work stress and economic pressure do not necessarily lead to mental ill health but nevertheless need to be addressed; this can often be done through better social and welfare arrangements, in bringing a new balance between life and work, and improvement in working conditions.

Mental health and intellectual disabilities should not be confused. Intellectual disabilities should be beyond the scope of the green paper on mental health. Intellectually disabled

persons are a vulnerable group of people, but they are not mentally ill – nor in special danger of becoming so. On the contrary, different national experiences of de-institutionalisation prove that much commitment and energy is needed to change arrangements and attitudes both among those coming from institutionalised care and among those in the surrounding community if stigmatisation and exclusion are to be avoided. An example is the specific measures required for this group in the sphere of work, particularly in relation to health and safety regulations.

**2.4** We miss in the Green Paper on Mental Health any perception of *gender-related factors*. The WHO and manifold research studies clearly indicate gender-specific aspects of mental illness, while diagnosis and therapies still do not sufficiently take into account gender specific patterns of illness. The neglect of the gender aspect is leading to a lack of diagnosis of women's mental health problems and the implementation of inappropriate therapies. The same is true for special forms of mental ill health among men (e.g. regarding the very high suicide rate among men above the age of 60).

**2.5** The strategy should differentiate the viewpoints of mental health and should *focus rather on potentiality than on deficit*. It is also important that not one professional subject division dominates the strategy but there should be room for different social, psychiatric and spiritual viewpoints. Instead of competition, for instance, between social psychiatry and hospital psychiatry the strategy should promote co-operation and coherence.

### **3. Are the initiatives proposed in section 6 and 7 appropriate to support the coordination between Member States, to promote the integration of mental health into the health and non-health policies and stakeholder action, and better liaison of research and policy on mental health aspects?**

**3.1** *Prevention of mental ill health* is ethically a very sensitive area, especially regarding *pre-natal diagnosis*. Churches and diaconal institutions have always expressed their conviction that prenatal diagnosis should not lead to selection procedures. Moreover, we should be aware of the "tyranny of normality". That is to say, there is a danger that our societies begin, with our new knowledge, to make some level of health, and particularly the absence of certain so-called genetic "defects", into a kind of societal norm. By comparison with this norm, anyone with a "defect", or any foetus diagnosed to carry a "defect" is regarded as "abnormal", and in some sense less than a full member of human society. In contrast, our understanding of all human persons is his or her unique worth and dignity as children of God, without regard for ability or disability, genetic or otherwise. The dignity of human beings does not depend on health or being free of handicaps.

We strongly support EU's intention for a better *prevention of mental health problems in the social field*, especially regarding working conditions. This should also imply a strengthening of policies to overcome the challenges of unemployment (especially long-term unemployment), as unemployment and its linked effects of social exclusion are important psychosocial perturbations, which can lead to mental ill health.

**3.2** We would also like to draw the EU's attention to the importance of a *better compatibility of work and family life* for a healthy environment. The actual demographic changes in Europe reflect important qualitative changes of living conditions in European societies. European societies need to find solutions in a network society with more availability of time for care for

others with a new quality of relations between generations, between family life and work and in the integration of migrants. This new quality of relations will need a profound reconsideration of principles and values in European societies and in European politics. The close cooperation with civil society could ensure a more appropriate policy to face demographic changes, taking into account the experiences of these organisations working in very close relationship with people. (Cf. Contribution of European churches, diaconal, migrant and youth organisations to the EU Green Paper on demographic changes: “Strengthen a mutual sense of responsibility in European societies.” <http://www.cec-kek.org/pdf/DemographyGreenPaper.pdf>).

**3.3** We welcome the fact that the Green paper is mentioning the *importance of a conducive school environment and ethos*. There cannot be a full community without participation of vulnerable people. Community building and participation are an essential part of the Christian understanding of social life. Thus, the teaching of Christian religion is based on the fundamental respect for every person and the building up of a fellowship among all people in the search for the common good. In this way religious education contributes to a better social environment for all.

**3.4** The *abuse*-paragraph only sums up alcohol and drugs and should be expanded with issues like the impact of medicine-dependency, gambling, Internet- or TV-dependencies, with a special regard to the risks for young people. We also want to stress the importance of sexual abuse as a factor for mental ill health and the need for better preventive measures in this area.

In section 6 and the annexed WHO-list of determinants we miss a reflection on the *role and influence of the mass media* and suggest that serious attention be devoted to research into this area. The influence of mass media in raising public awareness and in building networks of information is crucial.

**3.5** We ask the European Commission and the Member States to pay special attention to the *mental health situation of migrants*. In many cases, particularly refugees have had to go through traumatising experiences, which forced them to leave their countries, such as detention, torture or sexual abuse in conflict situations. In some Member States programmes are in place to address the specific trauma situations of migrants and the need for intercultural training of personnel, which could be models for further activities in this area.

**3.6** The status of and relationship between the two proposed means in section 7 - ‘*dialogue with Member States*’ and ‘*European platform with relevant actors*’ - needs clarification:

How will the European Union and its member states cooperate with the WHO and the Council of Europe on these issues? The Green Paper proposes some kind of Open Methods of Co-operation activities. Such actions should be clear, consistent and operational and have full political backing from the Member States. We recommend taking lessons from other OMC fields to improve the outcome of the strategy.

What is the *specific role of the proposed platform* in relation to other existing European platforms? How will the results of the proposed EU-Platform on Mental Health be integrated into the proposed “action plan”? *Are churches and diaconal organisations among the included stakeholders?* Given the importance of their work in this area, we were very much surprised to see that they have not been mentioned explicitly.

European churches and diaconal organisations are ready to contribute to a policy, which cares about every single person with their distinctive gifts and needs. We are ready to contribute to strengthening a mutual sense of responsibility in European societies, also regarding mental health.

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*The Conference of European Churches (CEC) is a fellowship of some 125 Orthodox, Protestant, Anglican and Old Catholic Churches from all countries of Europe, plus 40 associated organisations. CEC was founded in 1959. Its Church & Society Commission has the task of helping the churches study “church and society” questions from a theological and social-ethical perspective, especially those with a European dimension, and of representing the member churches of CEC in their relations with political institutions working in Europe.*  
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*Eurodiaconia is a federation of 36 members - churches, non-statutory welfare organisations and NGOs in Europe - operating at national and international level. Our members are rooted in Christian faith within the traditions of the Reformation as well as in the Anglican and Orthodox traditions. We network diaconal and social work of institutions and church communities and co-operate with civil society partners.*

*Our Mission: We link our members to serve for solidarity and justice. Our strategic aims are to ensure quality of life for all in a social Europe, to link institutions of diaconia, social initiatives and churches in Europe, to be and to enhance a network of competence.*

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