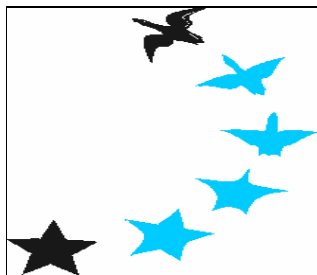


SOCIAL INCLUSION : A CHALLENGE FOR THE EUROPEAN UNION!

HANDBOOK OF THE EUROPEAN PROJECT ON THE SOCIAL INTEGRATION
OF PEOPLE WITH MENTAL HEALTH PROBLEMS



MENTAL HEALTH EUROPE
SANTE MENTALE EUROPE

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Aart Jan VRIJLANDT
MHE's President

INTRODUCTION

Today social exclusion has become one of the biggest problems in Europe. At the same time it is a major challenge for political leaders and it is a painful reality for millions of people. Social exclusion is an offence against human dignity and human fundamental rights, and an important source of tension in our societies. Certain groups are particularly at risk of social exclusion: disabled people, refugees and asylum seekers, ethnic minorities, older people, single parent families, women, unemployed people, and specifically people with mental health problems.

Social exclusion of persons with mental health problems is a universal problem. Improving their situation will depend substantially on the progress made in combating poverty, discrimination and the taboos, which surround mental illness.

Social exclusion /inclusion issues are now getting political attention at the European level. On December 2000 the Heads of States and Governments adopted the European Social Policy Agenda and reached an agreement on common objectives establishing comparable ways to combat poverty and promoting social inclusion. Further this year a five-year Community programme will be adopted in order to help Member States to co-operate in this challenge and highlight positive measures. The European Union can do much to tackle poverty and social exclusion. The employment guidelines, the non discrimination action programme, the social inclusion programme, the modernisation of social protection systems and the Charter of Fundamental Rights are tools to be used to increase the inclusion of everyone, especially those most affected by poverty and social exclusion¹.

This handbook gives politicians, governmental services, NGOs, volunteers, service users, carers and service providers useful tools to become more efficient in their efforts to promote social inclusion of people with mental health problems or a history of psychiatric problems. The handbook provides concrete guiding principles to be used in different areas and examples of good practices where people at risk find support and empowerment to overcome the threat of social exclusion.

Mental Health Europe and its partners of the European project 'Promoting Social Inclusion of People with Mental Health Problems : a Challenge for the European Union !' consider it their responsibility to raise awareness about the social exclusion that people with mental health problems have to face in their everyday life and to promote effective strategies to overcome it. We hope this handbook and the guidelines will provide useful tools in this regard.

¹ See also 'Mainstreaming poverty and social exclusion. Integrating the fight against poverty and social exclusion across all areas of public policy to promote social cohesion' seminar report by the European Anti-Poverty Network, 2000

PROJECT DESCRIPTION

The project “Promoting social inclusion of persons with mental health problems : a challenge for the European Union !” aims to raise awareness about the exclusion of people with mental health problems, and to provide guidelines to policy makers and service providers to foster social inclusion of these people.

The project is partly supported by the European Commission and is part of a larger European Union programme : ‘Preparatory Actions to Combat and Prevent Social Exclusion’.

Mental Health Europe was responsible for the general co-ordination of the project and provided a secretariat to the project. It was conducted in four countries : Austria, Finland, France and the United Kingdom². The European Network of (ex-)Users and Survivors of Psychiatry was associated with the co-ordination of the project and provided useful expertise in terms of user participation and the legislative framework for social inclusion practice.

Social exclusion – social inclusion

“Social inclusion must come down to somewhere to live, something to do, someone to love. It’s as simple – and as complicated – as that. There are all kinds of barriers to people with mental health problems having those three things”.

This statement was made by Charles Fraser, one of the witnesses of an inquiry performed by MIND³ regarding the social exclusion experienced by people who use mental health services – the inquiry report ‘Creating Accepting Communities’. It indicates clearly where the focus of the social inclusion project is, namely in :

- housing
- employment, training and social benefit
- daily living
- media

The sector of media is added to the other three since the media more often portrays negative images and reinforces stigmas and fears.

Each country took responsibility for exploring one sector. Reference groups were set up in each country. Those groups were composed of people who have an expertise in the issue of social exclusion of people with mental health problems together with a majority of users, ex-users or their representatives.

In concrete terms the project was developed in three steps :

- Step 1 : identifying indicators of social exclusion
- Step 2 : identifying practices which combat exclusion and promote inclusion in the society
- Step 3 : preparing guidelines and a handbook to support the social inclusion of people with mental health problems.

² For the list and contact details of the partners, please see annex 2

³ Mind : is the National Association for Mental Health in England and Wales, one of the partners of this project.

⁵ ‘Mental Health in the workplace’, by Phyllis Gabriel and Marjo-Riitta Liimatainen, International Labour Organisation, 2000

Step 1 - indicators of social exclusion

The first task of each reference group was to identify indicators of social exclusion in their respective sector (employment, housing, daily life, media).

Employment

“Everyone has the right to decent and productive work in conditions of freedom, equity, security, and human dignity. For people with mental health problems, achieving this right is particularly challenging” states the recent International Labour Organisation’s report on Mental Health in the workplace⁵ which highlights the importance of decent work in enhancing the economic and social integration of people with mental health problems.

During the project situations of exclusion were reported by the participants :

Often, unemployment leads to poverty, poverty to isolation, social isolation to social exclusion, social exclusion to ongoing mental health problems and to relapse.

There is fear and ignorance from employers and employees about mental health. Many people with a mental health diagnosis who would like to work are unemployed or do work for which they are overqualified. In England , only 13% of people with serious mental illnesses are employed, in Austria the percentage is 20%.

In all the countries, sheltered work was often quoted as repetitive and boring. Sheltered work has to be versatile and recognise individual abilities and needs. Employees must be given credit for their tasks.

In England , the reference group stated that many people with a mental health diagnosis, when they are employed, are doing work for which they are overqualified.

The English and Austrian reference groups stated that workplaces were not a safe environment for employed people who become mentally ill and that there is fear and ignorance about mental health from other employees and their employers. In England , bullying of people with mental health problems at work was reported.

Education and Training

When it comes to accessibility of training courses and education, there was found a tendency to focus on physical and environmental barriers for students with disabilities. Needs of students with mental health problems are seldom taken into account.

The Finnish reference group highlighted that university education does not at all address the issue of disabilities when discussing leadership and employment.

The reference groups stressed that education schemes make it difficult to drop out from time to time to allow for mental ill health care. Finland reported that they have experienced a tightening of the rules pertaining to university studies. The students can receive a study grant for no more than 55 months of study for one degree. Until 1992, the period was 7 years. The student has to complete 2.5 credits per month of study, otherwise the grant may be discontinued. In England disabled students’ allowances are only available to full time students.

Welfare benefit system

The reference group in England stated that if someone is on benefits and decides to start paid work but then after a year or more need to stop working he will have difficulties to receive the same benefits as before if he had not been on benefits before. Welfare benefit systems may be disincentive to work.

The Austrian and English reference groups stated that there was a lack of flexibility of the welfare benefits system. For example, part time work, part time benefit.

Family life - relationships

In Finland, the reference group noted that, for persons suffering from mental health problems, lack of privacy in psychiatric units is a factor increasing social exclusion.

The English reference group stressed that many people in the mental health system have suffered sexual abuse and/or domestic violence, this fact is not taken enough into account by services.

Many users of mental health services feel lonely and isolated because of their families attitude towards them reflects that of society as a whole.

Children whose parents are users of mental health services can be victimised. They can be ridiculed by fellow pupils ('your Mum's a nutter'), and also teachers may be reluctant to talk to these parents.

Leisure activities

The reference group in France reported that a medical certificate is required to register with gyms or sports clubs. If you have been a patient in a psychiatric hospital, the certificate must state that such sport is appropriate for you. In practice in the majority of cases gyms and club managers choose to refuse access.

The English reference group stated that users can be excluded from taking part in leisure activities mainly because of cost, they do not have enough money to stay at hotels, go on holiday or to the theatre.

Citizenship

In all the countries where the study took place, people with mental health problems are discriminated against when it comes to insurance coverage. For example they are not allowed to contract life insurance, they have difficulties to contract loans and they encounter problems when they want to get car insurance and travel insurance. They may be denied necessary Visas for entry to other countries.

Until recently, in the England there was indirect discrimination in access to pension schemes. There were no pension schemes which allowed for a fluctuating income. They were therefore impractical for anyone not in permanent employment which includes many users of mental health services.

Access to health care

When a user in a public psychiatric hospital or day clinic complains of physical symptoms, psychiatric disorders are used to explain the problem and patients may go untreated. Likewise, if people are being treated at a general hospital which then receives their psychiatric file, this may lead to actions which may have serious health consequences. Even outside the hospital, general practitioners, specialists (e.g. dentists) hesitate treating persons under psychiatric medication.

There is sometimes a refusal to act in a transparent manner and to provide access to medical records. Furthermore, in some psychiatric hospitals, "free and informed consent" to care received, either during or after a crisis, is not often sought or given. Too many patients are systematically forced to take medication with destructive consequences, even when hospitalised on a voluntary basis.

Austria, France and England reported an unequal access to psychiatric care depending on the region or district you live in. The type of treatment may vary also. The reference group in the UK, also reported that ECT was more common in treatment of older people and that compared to white people, people from black and ethnic minority groups were more likely to be offered drug treatments and ECT, rather than alternative treatments.

Transport

Restriction of access either to planes or buses on ground of psychiatric problems have been reported by the French and the English reference groups.

The dependence on private cars increases in today society due to 'out of town' shopping and leisure sites. In many areas, especially deprived areas, public transport is inadequate so if you do not possess a car, as do many users, then isolation may become a problem.

Housing

In Finland as well as in the three other countries, users and ex-users of mental health services can find it very difficult to get housing because of stigmatisation and discrimination by the surrounding community. It is a long and hard process to change prejudices and distorted attitudes.

The UK reference group stated that users of mental health services are often housed in undesirable, 'sink', estates. In many areas there is a 'one offer only' policy of public sector housing. If that offer is not accepted then the alternative is homelessness. Many people accept the flat but never spend any time there and it never becomes home. They get depressed and isolated and the situation is ripe for the revolving doors syndrome.

In the four countries represented in the project, the problem seen to be the housing-hospital-housing circle for psychiatric patients was highlighted. Many psychiatric patients cannot afford to pay hospital fee plus the housing rent during their hospital stay. During a long hospital stay people may lose their job or their housing benefit.

Media

In Austria, the media representation of users and ex-users of mental health services is often poor. In UK it was stated that the representation of users and ex-users from black and ethnic minorities is nearly always worse.

The results of this consultation were very interesting for the group as it gave a clear idea of where and when people with mental health problems feel excluded from the society. Furthermore, the reference groups compared the indicators and it was possible to identify differences between countries. Differences can be culture-bound but may also result from the absence of adequate legislation.

Sheltered employment can be experienced as exclusive or inclusive depending on the type of contract which people get. Mainstream workers and sheltered workers should benefit from the same rights.

It was reported that in France, people with a diagnosis of mental illness may not be allowed to join a political party. This is not the case in Austria or in England.

The way people are forced to have treatment varies from one country to another.

Guardianship is still very common in France. In England other ways have been developed to preserve personal interests.

The French reference group reported that persons placed under guardianship lose their right to vote. In Austria the right to vote is maintained. Until recently in England psychiatric patients lost their right to vote as a hospital address was invalid for voting purposes. The situation has changed and now the law on voting allow people in hospital and homeless people to be able to vote. In Finland, legislative measures have been taken to clarify the position of persons under guardianship. A revised act on guardianship entered into force on 1 February 1999. According to the act, there are three levels of protecting a person's interests. The most restrictive level affects people's legal capacity and places severe restrictions on their eligibility for loans and other similar economic considerations. However this act does not disqualify a person from joining a political party or restrict a person's right to vote or get married.

The French reference group reported that in many cases psychiatric services may refuse to act in a transparent manner as well as to provide access to medical records. It seems that in England the situation is a bit better than it was. The medical profession, in all fields, is constantly under question now so there is more openness and less closing of ranks. Doctors are more thoughtful about what they put in patient records. In Austria, patients have a right to see their files. They also may make a "psychiatric testament" which is included in their file.

Step 2 - practices promoting social inclusion

In their respective countries, reference groups had to look for examples of practices promoting the social inclusion of people with mental health problems. They were asked to select practices which they considered as innovative, effective and respectful.

- Innovative : a project that develops an original, creative answer (or partial answer) to a standard problem (in the framework of this project, the social exclusion of people with mental health problems from areas of our current society : employment, training, education, housing, daily living, media).
- Effective : a project which works, which produces results, in this case which reduces exclusion and negative discrimination.
- Respectful : a project which guarantees the respect of the people who use it, in this case people with mental health problems, users and ex-users.

Each reference group selected approximately 3 examples of what they consider to be good practice⁶.

Further each project was assessed by each reference group and it appears that some projects which were innovative in one country may not be so in others.

Regarding the difficult issue of the effectiveness of projects, it was realised that few projects perform in depth evaluation. The term “evaluation” covers a wide range of practices going from systematic observation, client evaluation to large randomised control trials. As underlined in another project managed by Mental Health Europe on children mental health⁷ : “There are many different criteria (to define effectiveness) and it depends on the position and the perspective of those who are making the assessment – policy makers, funders, researchers, practitioners, consumers and community leaders may have different agendas and different definitions of success”. In this project we decided to base our selection on the opinion of the users regarding certain types of services as they are, in the end, the main “clients or consumers” of the measures designed to increase the inclusion in the society.

In the framework of this project one of the criteria which would guarantee the respect of persons with mental health problems is the involvement of people with mental health problems in various levels, if not all, of decision-making and implementation of projects. In this respect an Austrian project entitled “Anti-stigma campaign” did not include users or ex-users in the planning of the project. Feelings towards this project were very ambivalent both within the Austrian reference group and in the group of partners of the social inclusion and it was decided on this basis not to consider it for selection.

Step 3 – guidelines

On the basis of the material collected, strategies adopted by each project to include people with mental health problems were highlighted and guidelines for policy makers and service providers were prepared. The guidelines are detailed in the next chapter.

Examples provided by the partners illustrate some of the issues raised by the guidelines.

⁶ Examples are described in section 5

⁷ ‘Mental Health Promotion of Children up to 6 Years – Directory of Projects in the European Union’, Mental Health Europe, 1999

GUIDELINES

Mental Health Europe and the partners of the European project 'Promoting Social Inclusion of People with Mental Health Problems : a Challenge for the European Union !' have prepared guidelines after consulting groups of (ex-)users of mental health services and representatives of organisations working in the field of the rehabilitation of people with mental health problems in Austria, Finland, France and the United Kingdom.

These guidelines are for policy makers, service providers and the general population to use to combat the social exclusion that users and ex-users are facing daily.

I. GENERAL GUIDELINES

I.1. To policy makers

- People with mental health are among the most excluded in today's society. **Non-discrimination legislation** should cover all areas of society and all excluded people as stipulated in Art. 13 of the Treaty on the European Union. Efforts should be made to increase awareness of the legislation and to enforce it.
- **Advocacy** : opinions of people with mental health problems should be considered of equal value with any other voice especially when it comes to sectors that concern their lives. Appropriate financial support should be made available to self-help and advocacy users groups.
- Every attempt should be made to challenge **indirect discrimination**.
- Users of mental health services should have access to their own files and attempt should be made to agree on legislation which improves and controls **data-protection**. Users of mental health services should be involved in the formulation of this legislation. The legislative process should react rapidly to new technological developments. Failure to comply with legislation should be treated as a serious offence.

I.2. To service providers

- There is a lack of understanding of what mental health, mental illness and the needs of people with mental health problems are. **Awareness raising** should be organised for all sections of society, including decision makers, service providers of different sectors (health, media, education, employers, Trade Unions, etc.) and the general population. Independent and fully financed positions for user-led information services are required to answer this need.
- Mental Health needs should be addressed with **respect to gender, cultural, spiritual and religious backgrounds**.
- Professionals should look for the **empowerment** of people with mental health problems (make them aware of their rights, explain how social services work, how welfare benefit works, etc). Users and ex-users should, by legal right, be informed of their rights and benefits by trained staff, either professionals or (ex-)users.
- Besides the above, independent and fully financed **counselling services** should be set up to allow users to access all information and decision making.

I.3. To general public

- **Families** and friends, supporting someone with a mental health problem should themselves have access to the support they need.
- **Awareness raising** on mental health issues is crucial in order to reduce stigmatisation. As experts by experience, users and ex-users are essential to any awareness raising activities.

II. SPECIFIC GUIDELINES

II.1. To policy makers

II.1.1. Employment

- Unemployment is high among of people with mental health problems.
- When there is a quota regulation in the law, this law should be enforceable. Employers should be compensated and there should be a harmonisation of quota legislation at European level.
- Users representatives should be involved in all stages of decision-making when it comes to employment policies and regulations that concern people with mental health problems.
- Employment agreements used in sheltered work-centres should follow the mainstream labour legislation.
- Reasonable adjustments in the workplace should be compulsory.

II.1.2. Education/training

- Teachers and students' curricula should include training on positive mental health promotion and mental illness issues.
- Equal opportunities policies should apply to both students and staff.
- Users organisations should be involved in providing teaching and training agents

II.1.3. Welfare Benefits system

- There is a correlation between mental health difficulties and poverty and this should be recognised.
- The benefit system should motivate people to lead a mentally healthy life.
- The benefit system should be constructive in helping people who want to work and / or study part-time.
- The benefit should allow people to go to work without immediately losing the rights connected with the benefit system.
- Full information on the benefit system should be available in a way that people can easily understand.
- Everyone should have the right to a decent basic income relevant to the standard of living of each country.

II.1.4. Family life

- Every effort should be made to keep families together.
- Mental health problems alone can never be a reason to remove a child from their parent. When this type of decision is taken, it should be re-evaluated on a regular basis.

II.1.5. Human Rights/citizenship:

- People with mental health problems are full citizens and are entitled to enjoy all fundamental rights.
- Mental health problems are not a sufficient reason to refuse access to financial or insurance services.
- Guardianship decisions should take into account individual situations and opinions. These decisions should be re-evaluated regularly and systematically with the people concerned in order to avoid abuse of power by guardians. Procedure to void guardianship decisions and appeal procedures should be accessible and simplified.

II.1.6. Housing

- Everyone should be entitled to adequate and decent housing.
- Stigmatisation affects users' access to mainstream housing. Awareness and information campaigns should be organised in order to counteract discrimination by the community.

II.2. For service providers

II.2.1. Information

- Trade Unions, employers and employees need to be informed of the facts of mental health and mental illness without any prejudice.
- Basic information on mental health should be in the curriculum of every health and social worker. Users and ex-users of mental health services, having expertise by experience, should be involved in these training sessions.

II.2.2. Data-protection

- In the field of work (voluntary or not) the regulations should protect personal data of employees.
- Service users should have access to their own records.
- Confidentiality : access to medical records should be limited only to the patients concerned and may not be accessed without the permission of the patients themselves

II.2.3. Employment

- Employment at any price might have negative effects on a user's mental health and may cause relapse. Users should therefore enter employment rehabilitation schemes at the optimum time. These should be flexible and offer a wide range of different opportunities suitable for the person concerned.
- The opportunity to (re-)enter the workforce again should be part of any rehabilitation program.
- Regular paid work should always be considered as the final goal, however voluntary work can be a first step to get back into the workforce.
- Voluntary work is a way to contribute to society. It has a value in itself and should be considered equal to paid work.
- Voluntary work means voluntary but not uncommitted.
- Employees should get reasonable and fair wages for the work they are doing.
- Sheltered work should be attractive and diversified.

II.2.4. Education/training

- There is a need to teach the teachers about indicators of mental distress.
- The needs of service-users should be taken into account in every educational programme.
- When taking into consideration the accessibility of an education or a training programme focus should be on the needs of students with mental health problems, on an equal basis to those with physical disabilities,
- Mainstream facilities are to be preferred to special institutions.
- Education has to be an irreplaceable part of care and rehabilitation plans.
- Education and training rehabilitation schemes should allow for flexibility and accommodate changes in the students' mental health.
- The financing of education and training rehabilitation schemes should not rely on payments linked with outcomes in a specified time or the successful completion of a course. Payment should rather depend on people getting a suitable job.

II.2.5. Family life

- Mental health institutions should consider sexuality as a part of the patients' life.
- Unjustified sterilisation for psychiatric medical reasons should be challenged.
- The situation of families with mental health problems having and rearing children remains a taboo, more discussion and debate is necessary.

II.2.6. Leisure activities

- Access to leisure activities should be granted on a normal basis without any hindrance.
- People who run leisure activities should be trained on mental health issues.
- Access to leisure activities helps to overcome loneliness. A wide range of leisure activities should be financially accessible for excluded people, among them people with mental health problems.

II.2.7. Healthcare

- The right to choose your own doctor should be respected.
- The level of physical health care in psychiatric hospitals should meet the same standards as in general hospitals.
- Access to certain types of treatments seems to depend on the age and the race of the patient. All type of treatment should be made available to all people regardless of their age, gender, race, disability, sexuality, etc.
- Doctors and medical staff should have to inform the users about conditions and consequences of any treatment and measures of rehabilitation.
- Hospitals should be a safe place for staff and patients alike.
- Knowledge of mental health/illness issues should be improved in general health care services.

II.2.8. Transport

- Unjustified denied of driving licence on psychiatric ground should be constantly challenged.

II.2.9. Housing

- Having to pay simultaneously a hospital fee and rent on one's home is often too costly. In these cases, to avoid debt and eviction, there should be financial support to meet either the hospital fee or the housing costs.
- More specific attention should be paid to groups suffering from double discrimination such as women, asylum seekers, ethnic minorities, young people with mental health problems threatened by exclusion.
- Different types of accommodation meet different types of needs. There should be sufficient variety and quantity of accommodation to suit each user's needs. The final aim is the access to independent and accommodation of an acceptable standard.
- Private accommodation should stay private and be independent of other therapeutic goals and aims.
- Supported housing should respect the privacy of the person. Support services should be agreed with the person.
- Supervised housing should be a safe place in which to reside.
- Information flow between supported accommodation and mental health care providers should be very smooth but only with the consent of the patient. The activities from all organisations working in the field of mental health and housing should be co-ordinated.
- Social support should be available to overcome loneliness and isolation. Professionals should encourage self-help practices and self-management of accommodation.

II.2.10. Media

- Media should give a voice to users as experts of their own experience.
- Stigmatisation should be banned from media. Training and monitoring should be organised.
- Media should have more positive mental health promotion programmes.
- All mental health service providers should have a financed user-supported public relations service.

EXAMPLES OF NATIONAL PROJECTS

AGAINST NONSENSE IN MADNESS

ASUMISEN TUKITOIMINTA

CLUB DU PONT NEUF

CYBER CAFE PROJECT

DIRECT PAYMENT

FOYER LEONE RICHELIEU

HAUS DES LEBENS

JUMELAGE CULTURE HOPITAL

L'AUTRE REGARD

MEDIA-FEEDBACK AGAINST DISCRIMINATION

MONINGELMAISET MIEHET-PROJEKTI

PATHFINDER USER EMPLOYMENT PROGRAMME

SCHOOL FOR SOCIAL ENTREPRENEURS

TURVA-ASUMISEN KEHITTÄMIS-PROJEKTI

AGAINST NONSENSE IN MADNESS

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In the population there are wide spread prejudices against people suffering from mental health disorders. It is primordial to address young people as they are the mainsprings of tomorrow's opinions.

In Spring 2000 a schools project was launched in the framework of the Austrian Anti Stigma campaign. The project aims to :

- give basic information about severe mental illness
- inform on views and experiences of users
- demonstrate the effects of prejudices and exclusion

Classes of children between 16 and 18 years of age have the opportunity to invite one member of the project (5 people are involved) who will present information on the issue of mental illness. Presentations are 4 hours long spread over 2 days. After the presentation, debates are organised. Halfway through the meetings a user joins in and pupils have the opportunity to talk to him and ask questions.

The total amount of activities organised in the schools demonstrate that students are interested in this issue and that they are greatly impressed by the authenticity of users' testimonies. From the first evaluation of the project, 98% of the students who have

participated in the project would recommend it to other pupils. The project significantly reduced the negative attitude and raised the understanding for the users' situation as well as the need for community mental health services. The events in which users spoke with the pupils were more appreciated and produced a larger change towards a significantly more positive attitude than those without users.

The budget of the project is 10172 EURO which is provided by the Lower Austria Health and Social Fund and the Austrian Institute of Health.

Most valuable aspects :

- to give students the opportunity to have a direct discussion with users
- to integrate the topics of mental health and of the effects of stigmatisation within the school cursus
- the evaluation of the project is foreseen in its implementation
- partnership between schools, users and families
- project designed at national level and implemented taking into account regional specificity
- choice of target group for the project.

ASUMISEN TUKITOIMINTA

(‘Supported accommodation’)

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The Slot Machine Association provided plans for supported accommodation. The Family Association Promoting Mental Health in Finland and the Y-Foundation joined the planning of the project. The task of the Y-Foundation was from the very beginning to provide housing. The Finnish Association for Mental Health (FAMH) is responsible for organising the residential care facilities. The patient association Helmi Association joined the project later.

The project aims at offering auxiliary services for young ex-users of psychiatric services and the youth trying to start their independent living through while living different crisis situations.

The aim was to train volunteers, relatives of mental health patients as well as the ex-users of mental health services to be support persons. The basic training is arranged by local mental health associations and further training is provided by the FAMH. Each support person will have his own support person and they will meet approximately once a week. The support person can assist the young person or the ex-user in coping with everyday chores of independent living, e.g. by teaching how to cook, how to find their way in administration offices or how to find hobbies. There are also training courses and rehabilitation courses organised for both supported and support persons.

The young person, the community social worker and the support person sign together an agreement on auxiliary service which estimates the need and the approximate duration of the support. At the same time the co-operation between these partners improves.

The activities do not replace the public services or treatment but complement them. There is a close co-operation with the municipalities. The project also organises training for house

managers, municipalities and other organisations producing auxiliary services housing and support measures.

The evaluation of the project is on-going. It is based on the number of localities involved in the project, the number and duration of the support relationships, and the number and type of training sessions. Young people and ex-users have also commented on their experiences. In the future it could be possible to edit a booklet on experiences of the clients which could give useful information about the quality and impact of the activities.

The budget of the Finnish Association for Mental Health for the year 2000 is 280 000 EURO. The main part of it is covered by the Slot Machine Association. In addition the municipalities pay 400 Euro per year for each supported person. A part of the costs is covered by the training fees.

The Finnish Association employs one co-ordinator at national level and four regional workers. Approximately 220 people work as volunteers in the project

Most valuable aspects :

- there is an agreement on the kind and duration of services that the person would like to receive – support is tailored to individuals
- the activities of the support person are a type of preventive measure
- support persons receive thorough training and supervision securing the quality
- there is a co-operation between municipalities and the organisations
- the project provides training to housing authorities
- the project fits in well with the social network.

CLUB DU PONT NEUF

('Pont Neuf Club')

**Christian TRUMEL
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Founded in 1989 in a disused workshop of craftsmen in a building that had more or less been abandoned, the club developed under very precarious circumstances (difficulties to keep squatters away, to become the reference of a few inhabitants and then to be able over time to receive people 7 days a week).

The Club aims at enabling patients who leave psychiatric hospitals to find a network of contacts, participate in activities, be able to exhibit pictures or sculptures, to be published or to find support in the case of a relapse or arbitrary confinement.

It is a place with agitation and sometimes conflicts, it is a reference place which has a memorising function (there are numerous photo albums, videos, newspapers, magazines). A place which tries not to ban deliriums but to protect them, a place where mutual understanding is the ultimate goal.

The Club is not only for users and ex-users but also for retired or lonely people who have experience difficulties in building relationships. A mental health professional briefly stops by every day. For the rest, only the affiliated members and the volunteers take on the administrative tasks and the supervision of the activities.

There is a collaboration link and exchange of expertise with numerous associations.

The project is subsidised by a psychiatric hospital but this subsistence is not enough and the rest of the running costs is covered by the sale of drinks and by contributions. The budget of the Club being very limited, many initiatives cannot be carried out.

Most valuable aspects:

- A structure offering responsibilities ;
- The proliferation and mobility of the ideas ;
- The club offers systematic and continuous support. It has the capacity of welcoming patients who are very unwell, of protecting them and accompanying them to the emergency locations ;
- The project aims at different groups of excluded people and not only at those with mental health problems;
- Open 7 days a week;
- The projects is self-managed by the participants ;
- The fact that the budget for functioning is limited guarantees the autonomy of the project ;
- The venue for the activities is very accessible and central.

CYBER CAFE PROJECT

Disability Alliance Merton (DAM)

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Following its Inquiry into Social Exclusion Mind wants to create sustainable, transferable models which promote the social inclusion of people with mental health problems. Disability Alliance Merton had identified a need to enable people with mental health problems to learn skills and have access to information through use of computers and the internet with a view to helping them secure employment. This is now one of the pilot projects through which Mind is exploring models of inclusive practice. The pilot project will run for 1 year from August 2000 – 2001, its budget is approximately 116 600 EURO which is covered by Mind, the Department of Health, Disability Alliance Merton, and The Sainsbury Centre for Mental Health

The Mind Inquiry showed that social exclusion is a compound process and that exclusion in one area means exclusion in another. Therefore one of the main aims of the project is to create a model of partnership across health, mental health, social services, the voluntary sector, education and training and employment.

The partners include social services, the health authority, local voluntary groups and a local college. Links will also be made with local employers.

The objectives of the pilot project are :

- to enable understanding of and access to the internet
- to promote leisure
- to promote employment through providing users with a site to share skills information and prospective employers with a site to advertise local job vacancies

- provision of information on benefits
- to provide training for staff and users
- to generate user involvement
- to enable access to social and other networks through sharing information about activities, help and advice
- to enable access to further education
- to promote inclusive practice for black and minority ethnic service users
- to contribute to inclusive neighbourhoods for people with mental health problems through demonstrating the contribution which people with mental health problems can make

Users of mental health services are involved in the planning, implementation, delivery and evaluation of the project.

The pilot project is to be evaluated by the Sainsbury Centre for Mental Health and Mind in August 2001

Most valuable aspect :

- The project is addressing the compound process of social exclusion by creating a model of partnership across health, mental health, social services, the voluntary sector, education and training and employment
- People are trained in a tool which is future oriented
- Thanks to the project new social network can be created

DIRECT PAYMENT

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A Direct Payment is a statutory welfare benefit which can be paid to anyone with a disability so that they can buy the care services they need rather than use those provided by statutory services. There has been a very low take up by users of mental health services. In theory this benefit can be very empowering, enabling people to have the help of their choice at the times they choose. They could, for example, choose to have help with work in the house, help with travelling and to pay for counselling of psychotherapy. One of the reasons the take up is so low is that service users have to become employers of the people who care for them.

Direct Payments was introduced and developed in Essex in May 1997. There was a deliberate policy to include all disabilities. A joint Working Group was set up, which included users of mental health services, advocates and staff. This Group developed policy and practice guidelines, and then facilitated countywide introductory workshops for all interested parties. It was also decided to set up a Mental Health Steering Group, which would provide a focus for information on Direct Payments (D.P.), co-ordinate efforts on supporting users/carers, staff and voluntary organisations, in the mental health services, and could continue to offer education and training in respect of D.P. The membership of the Group is made up of users of mental health services, voluntary organisations representatives, and advocacy service representatives.

Multi-agency mental health service staff are provided with introductory workshops, alongside voluntary organisations and users of these organisations. Through this process an awareness of D.P. and its use is generated. Within the statutory service (mental health teams), it is now considered an integrated part of the Assessment and Care Planning process.

Once the needs and/or difficulties have been identified Care Co-ordinators have the responsibility of exploring with Users/Carers how these needs may be met.

At the point at which D.P. has begun to be considered, users will be offered the opportunity to meet with "Independent Living Advocates" who will provide independent advice and support.

Once the type of service has been decided Care Managers will then present the "Care Plan" to the local "Purchasing Panel", for a decision to be made in respect to finances. A D.P. can be combined as part of a joint Care Package.

As part of the Care Planning process, a discussion would have occurred surrounding the administration of the D.P. component. If the users would find it complicated to administer, then another voluntary organisation (Co-op2000) will provide this service on the users behalf. Co-op2000 is a voluntary organisation that will deal with any difficulties that people might have with being an employer.

Once the service starts users can continue to be supported by the Independent Living Advocates. The Care Co-ordinator continues to have the responsibility of ensuring that the assessed needs are met and are reviewed on a regular basis.

There have been evaluations at different levels within the Social Services Department. The County Review made recommendations for change. However, it concluded that D.P. is a positive contribution to service provision, providing choice, independence, self-control and a sense of self-esteem. The D.P. system has made a major change for some individuals, who for the first time are in control of their lives and routines.

The Mental Health Steering Group noted the small numbers of users using this service and investigated the possible reasons behind this.

Their findings suggested that the main gateway to D.P. is through the professional staff and often D.P. is either not being considered or if it is considered then it is not robustly pursued.

Feedback indicates staff in the teams sees D.P. as being too bureaucratic, and they find it difficult at times to evaluate how it will benefit the users. Additionally all teams in Essex have dedicated Support Workers in the team. Often it is easier for staff to access the Support Worker.

The Steering Group decided services should take a more proactive approach to these issues. It was also decided that all mental health staff, and voluntary organisations

should be offered two to three day training sessions on D.P., the Act, practice issues and benefits to users/carers. The course would include if possible contributions from users who had benefited from the D.P. service.

Most valuable aspects :

- This project develops the self-determination and empowers people with mental health problems
- The project develops a multi-level co-operation in the implementation of the Direct Payment

FOYER LEONE RICHEL

(‘Leone Richet Home’)

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The project started in 1975 to enable young adults qualified as “psychotics” to live outside of hospitals and “get a hold of their lives”, to allow them to build up their self-esteem while overcoming their anxieties, to help them build up confidence through the activities and the requirements of daily life as well as to help them integrate into society and come to terms with social life.

During the first ten years, the home was confronted with the nearly total incomprehension of psychiatric services and a lack of financial means. The violent acts from young people were also much more frequent than today.

The home consists of:

- A community home for ten people in the countryside
- A community home for four people in the city
- Fifteen other users have their own apartments in the city
- The administration and functioning of a cafeteria open to the public.
- The participation in activities (theatre, music, radio, painting, yoga) organised in different places offering social activities in the city.

In the community homes, the users are responsible for buying groceries, the meals, cleaning their rooms with the support of the staff.

The young users are included in the administration of the project in several aspects. First, they manage the cafeteria of the home also open to the public. Secondly, through the

Board, they advise and give their comments to the management. Finally, by the means of committees (welcoming committee, twinning committee, holiday committee, leisure committee), they are able to initiate themselves activities for the institution.

The home employs 28 staff members. 60% of the project is financed by social support, 40 % by health insurance. The users also participate according to their financial means.

Besides the evaluation of the administration and the objectives of the project through external contributors, the home set up an evaluation system of the individual projects of the users in terms of integration as well as of the feeling of well being for the person.

There is also an evaluation of the group projects in the form of fortnightly meetings. Each committee has to give an account of its activities.

Most valuable aspects :

- the empowerment of young people with mental health problems within the care system. This empowerment is reinforced by the fact that the young people have to pay a contribution;
- the respect of the relationships and the dignity of the individual;
- the feeling of security created by the spirit of trust and brotherhood between the people ;
- a place for expression;
- the personnel receive a specific training to participate in this particular project.

HAUS DES LEBENS

(‘House of Life’)

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In 1994 it became increasingly clear that impulses towards self-help which were addressed by speakers invited by the House were not taken up by the members. It became necessary to structure the meetings and to develop the self-help themes through « healing workshops » and life competencies.

Since April 2000, information exchange meetings are organised for people suffering from depression, anxiety and other mental health problems.

The “House of Life” gives the opportunity to people suffering mental health problems to find out how their illness appeared, to observe their impairment, and to find a way to leave their illness behind them.

The activities organised by the project consist in training and debates in which speakers are invited to take part, as well as in physical and artistic activities.

The project aims at :

- overcoming mental disorders
- preventing risk of further impairment
- advising, informing and supporting people in self-help.

The work is based on discussions, the use of each other’s competencies, empowerment, and the encouragement to change in order to develop a positive attitude towards life.

The group does not work on its own, contacts are maintained with different doctors, therapists and their institutions. Furthermore there are 4 paid staff members and 7 people working for the project as volunteers.

The budget of the project is 41.200 EURO which comes from various subsidies, donations, membership fees and the sale of objects created by the members.

From the evaluations, the work of the “House of Life” allowed members to :

- reduce inpatient admissions
- solve the difficulties of living on one’s own
- concentrate on effective types of support

Most valuable aspects :

- utilisation of self-help as a therapeutic tool
- empowerment
- place for re-socialisation
- place for training
- place where one can develop their own resources
- independence from psychiatrists and therapists with maintenance of a collaboration
- variety of proposed activities
- involvement of users and ex-users in the management of the project

JUMELAGE CULTURE HOPITAL

(‘Twinning Culture – Hospital’)

IRFASUD

Association Destination Avenir

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The project « Twinning Culture – Hospital » aims at developing cultural activities for people with very different life experiences. The objective of the project is not to keep people with mental health problems busy but to accelerate their healing process by giving them the possibility to discover ways of expression and exchange.

The project carries out a twinning between the artists of a theatre group and the users of mental health services whose major problems are social isolation and loneliness. These people are either rehabilitated or in the process of rehabilitation.

The twinning with the theatre group has allowed to discover possibilities of expression and exchange through theatrical activities, under the supervision of the actors and in collaboration with the care staff and volunteers. People with mental health problems are included in the planning and the administration of the project as well as in the final product, a theatre play performed in different places.

About twenty actors met over a period of four months once a week, in places to rehearse (halls - theatre) supervised by a professional actress. Their preparation consisted in :

- Writing and reading exercises as well as choosing texts
- Exercises for the body, the voice and for breathing.
- Joint participation in the production and the décor

On top of the theatrical activities, this cultural project has also developed a workshop for plastic arts.

The experience was evaluated and has proven to be very enriching from a relational point of view. The group grew together, insofar as everyone was able to express themselves, to open up, and to get out of their shells within a matter of weeks. The participants were able to integrate into a group enabling them to enjoy themselves in a leisure activity and to rediscover the pleasure of meeting regularly.

The psychiatric hospital of Thuir, the DRAC (the regional office of the French Ministry of Culture) and the regional council collaborated in the realisation and the financing of the project. La DRAC committed itself to perpetuating the theatre workshop.

Most valuable aspects :

- to help people with mental health problems to overcome their marginalisation.
- Break down the unilateral relationship carer/cared and the hierarchy.
- to put people with very different life experiences but motivated by theatre into one group. The users thereby lose their labels and have a more appropriate identity.
- to invest in the pleasure of theatrical art.
- to have fun while expressing something with the own body

L'AUTRE REGARD

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The association « L'Autre Regard » was created in 1985 after the organisation by the city of Rennes of « two weeks of information on mental health » organised by the city of Rennes. The association brings together (ex-)users, families and professionals from the sanitary and social sectors. The association addresses adults suffering or having suffered psychological difficulties, a painful feeling of loneliness, ill being or depression as well as people in precarious situations.

From the beginning, the users had a majority on the Board and in the office, as well as in the planning, the administration and the organisation of activities.

The aims of the association are :

- To provide a population suffering from mental illness, ill being or loneliness with mean to avoid social exclusion.
- To raise awareness among society of the problems of the target group and take part in the destigmatisation of people with mental health problems.

The association is a non-medical place located in the city. An almost ordinary place where these people can feel that they act in a micro-society open to the society as a whole.

There is someone on duty at the association five times a week. The association offers essentially expressive and cultural activities, spread over the whole week. Besides the 25 proposed activities, there are workshops for young people (age range 18-25) and others intended for people living in underprivileged neighbourhoods with the aim of preventing psychological suffering.

The association works in collaboration with local associations, several federations, among which FNAP PSY, as well as with state services: a specialised hospital, the Regional Office of sanitary and social affairs, etc. This collaboration consists in supporting the activities of other associations or institutions and in financial support.

The association is financed by four institutions :

- The Centre Hospitalier Guillaume Régnier
- The regional Council of Ille et Vilaine.
- The city of Rennes.
- The Caisse Primaire d'Assurance Maladie (health insurance company).

In its last report, the body responsible for evaluating the activities of the association « l'Autre Regard » mentions that this semi-protected place promotes:

- socialisation and the promotion of the individual,
- the reconstruction of the identity of fragile people having or not been in psychiatric care

Most valuable aspects :

- non-medical place where people can take over responsibilities and feel active;
- place where people can learn to socialise ;
- stable and long-term environment
- good co-operation between users, their families and professionals ;
- (ex-)users participating in the administration of the project.

MEDIA-FEEDBACK AGAINST DISCRIMINATION

pro mente kärnten
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The image of the mentally ill that is being conveyed in the media has great impact on the self-image of users as well as on stigmatisation and exclusion.

The media pass on positive or negative stories, and supply people with information. It is therefore important that people with psychiatric experience are more strongly involved in media work than they used to.

At the users' meetings on 17th of April and 6th of June 2000 a working group was installed to deal with the topic of the European project on "Promoting social inclusion of people with mental health problems : a Challenge for the European Union" co-ordinated by Mental Health Europe. The proposals and recommendations of the users represented at the meetings were then summarised in a project.

The project has four objectives :

- to provide feedback on media reports
- to promote users' opinions
- to provide press services
- to draft a list of contact persons to ensure that communication between the project on one hand and the media on the other, will be permanent and effective

The Media Feedback Against Discrimination project deals with mental health information on TV and radio broadcasts as well as in the press. It supports and mobilises groups and individuals who will be reacting towards negative or positive reports.

The feedback on media reports will be made via letters to the editors, phone calls, petitions addressed to the appropriate.

Besides this feedback action it will be necessary to organise training programmes for people with psychiatric experience to teach them to deal effectively with the media. People who make or represent public opinion will be sensitised to the issue of mental health/ill-health via Internet site, regular and systematic information on events, invitation to participate in workshops, etc.

The project, for the time being, is organised by pro mente kärnten. However sponsors and subsidies will have to be found in order to develop it nationally.

An evaluation will be carried out in 2001.

Most valuable aspects :

- the project deals with a very important topic, the relationship between media and stigmatisation
- People with mental health problems are involved in the planning, the management, the delivery, and the evaluation as equal partners
- People with mental health problems appear actively in the media. They contribute towards improving public opinion by standing up to prejudice, social exclusion and discrimination and by taking a stand on their own self-image (e.g. by their history of recovery)
- Training of users by other users who have already acquired media experience, together with media experts
- The project encourages individuals and groups to react to negative media messages

MONIONGELMAISET MIEHET-PROJEKTI

(‘Men with multiple problems’)

Rauman kriisikeskus Ankkurpaikk’

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In 1996, the social services in Rauma, a town on the west coast of Finland, estimated that there were about 70 people in the town who could be classified as homeless. Only a few of them had any realistic chance of getting a flat on the open market. Behind this exclusion there were factors caused by both mental problems and substance abuse.

A project was set up by the Crisis Centre of Rauma in order to support service users, homeless people, people socially excluded, and multi-problems men at risk in their growth processes towards independent housing, and in this way decrease social exclusion.

The target group was contacted through various ways :

- by organising men’s camps
- through co-operation with social services, the A-Clinic, Street Mission and the Varvinmäki Service Centre
- men with multiple problems at risk of social exclusion were found among people seeking help from the Crisis Centre

The project is based on the principle of community care. There are 9 apartment with support available in the Osmonen house. Until now 27 men have received support and 8 men have left Osmonen house and live now independently, two of them receive still some support. The staff working for the project

encourage the clients to live without alcohol and drugs and motivate them to have a life as regular as possible. Living in a community supports men. The rules and the control give them a feeling of safety and participates in their rehabilitation into society.

There are 10 support persons and one employee. Support persons are very important in the project. They talk with the men, listen, discuss, accompany them in their administrative procedures, share some leisure activities, etc.

The budget to run this project is approximately 148150 EURO which is covered by the Slot Machine Association RAY.

Most valuable aspects :

- this project considers men with multiple difficulties
- the support relationship is enhanced
- the project is set up within a community care philosophy
- the project is based on networking with other organisations dealing with the same target group
- the work of the paid employee is smoothly combined with the work of voluntary workers

PATHFINDER USER EMPLOYMENT PROGRAMME

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The project Pathfinder aims to help people who have experienced mental health problems to work successfully as paid staff within the South West London and St. Georges Mental Health NHS Trust. The project is addressed to people with mental health problems who wish to obtain paid work in clinical and non-clinical posts within the Trust, those who want work experience to prepare for any paid employment, and managers in the Trust who wish to recruit people who have experienced mental health problems

The value of employment in mental health is well documented and there are 3 main reasons why UK mental health services might employ people who have themselves experienced mental health problems:

1. Leading role - we cannot expect others to employ our clients if we are ourselves not prepared to employ people with mental health problems
2. Experts by experience - our business is in helping people who experience mental health difficulties. These people have a wealth of experience and expertise which clinicians who have not experienced mental health difficulties do not have. By employing people who successfully manage their mental health problems we increase the expertise available to our clients.
3. It helps remove the 'them and us' barriers. It provides a powerful role model for users of a service and helps staff members gain a deeper understanding of psychiatric disabilities

Most people who have experienced mental health problems are well able to work within the Trust without special help. However a specific programme has been set up (*Supported Employment Programme*) to

provide a variety of practical and emotional support for those who do need some extra help. All help is tailored to the individual's needs and confidentiality is central consideration.

The key points of the project are :

- Work Experience : it offers work experience for a limited period of time to help someone re-build confidence, develop work skills, explore the type of work that might suit them best and gain a credible current reference.
- Recruitment : Help for candidates in completing job application forms and with interview skills. Support in post either initially or on a longer term basis. Support is given to managers to enable them to recruit people who have experienced mental health difficulties.
- Ongoing support : Once in post an employee and their manager are given the support that they need – practical and emotional support.

An in-depth evaluation is in process however findings from the 1999 progress report have proved that there is a direct financial gain to public funds. When people are working there are savings in welfare benefits paid out and an increase in taxation. These exceed the cost of the project. There are also savings through decreased use of psychiatric services.

There are also personal and social benefits. Everyone employed through the project said that having a real job had positively changed their life in some way

Two assessments were carried out. User employees and other staff were compared on their attitudes to policies on mental health care. User employees were significantly more positive than non-users in their attitudes, being (for instance) more open to having friends with a

mental illness. These two groups of staff were also rated (blind) by in-patients on various qualities which they regarded as important in care staff. There were no significant differences in the ratings of user employees compared to those of non-users.

The budget of the project is approximately 161,600 EURO which are covered by various sources of statutory funding : Mental Illness Specific Grant, Mental Health Challenge and National Health Service Executive Equal Opportunities Funding

Four people are employed for the Pathfinder project and users are involved at all levels of the project.

Most valuable aspects :

- Valuing mental health service users as experts by experience.
- Making a major step toward a user-directed mental health system which provides a powerful role model to users and providers
- The support provided is personalised and is provided even when the person has found a job
- The project has gone through a good critical analysis and will be further evaluated
- The project works at different levels of relationships : employee/employers and employee/employee

SCHOOL FOR SOCIAL ENTREPRENEURS

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The purpose of the School is to identify and to encourage entrepreneurial talent amongst people who want to work for public benefit. It is not specifically a mental health project. However, social inclusion at its best must take place when service users participate in mainstream activities.

The School for Social Entrepreneurs allowed a service user to attend the courses. The School recognised her talent and suitability for the course and made the reasonable adjustments necessary to enable her to participate and qualify.

The user discussed her mental health difficulties at her interview which she attended with her carer. The School agreed to pay for her carer's travel costs throughout the course. Once she was accepted on to the course other

issues connected with her mental health difficulties were addressed as they became apparent. For example :

- She was able to move around in classes and leave the room as she needed to
- she was able to sleep in the school building during the day when she needed to
- she was provided with hotel space for the 8 residential weeks of the course.

Most valuable aspects :

- this is a good example of mainstreaming education
- the service user gets a good qualification in relation to her inherent qualities
- financial support is available for the person and her carer

TURVA-ASUMISEN KEHITTÄMIS-PROJEKTI
(‘Development project for sheltered housing’)

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In 1997, the Finnish Central Association for Mental Health was granted funding for improving sheltered housing for persons undergoing mental health rehabilitation who suffer from the ‘revolving door syndrome’. The sheltered housing development project is being carried out in four towns: Jyväskylä, Mikkeli, Rovaniemi and Vantaa.

The objectives of the project are to develop a service package to prevent repeated periods of psychiatric hospital treatment. It consists of three sections:

- The opportunity for interval sheltered housing to persons undergoing mental health rehabilitation who feel that they cannot live independently at home.
- Rehabilitation counselling for both sheltered housing users and other persons undergoing mental health rehabilitation who need extra support.
- Communal activities offered by local associations for mental health and day centres and facilities for the rehabilitation counsellors.

At the beginning of the project, a great deal of time was spent creating co-operation between the various actors in the different towns (associations for mental health, healthcare districts, social and health services, other service providers and facilities working with persons undergoing mental health rehabilitation), in order to encourage them to participate in the project and direct their clients to the services it provided.

Now there is close co-operation between various service providers in the participating towns, since the idea of rehabilitation counselling is specifically to co-operate with other treatment and service providers.

Users and ex-users are involved at many levels, not only as clients of this service, but as well as voluntary workers, as support persons, as part of a social network through communal activities. Some users are also

members of the monitoring groups of the project.

The budget of the project is approximately 303,000 EURO per year, which covers the running of the project as well as nine paid employees. Many members of the local associations for mental health and the day centres are involved as benevolent workers. The project received subsidies from the Slot Machine Association RAY’s and the participating towns.

An interim report was published in the summer 1999, which highlights some essential results:

- The ideas of the objectives and activities of the sheltered housing project differ among the actors of the project and the representatives of the towns involved.
- The number of clients in each town differs notably.
- The target group includes a substantial number of clients who are not users of repeated psychiatric hospital treatment.
- The level of sheltered housing is low for the time being.

An external evaluation has been commissioned from the Rehabilitation Foundation.

Most valuable aspects:

- Sheltered housing and the large-scale use of peer support as a resource for the project.
- The project facilitates co-ordination of concerned services while keeping a good approach of the individual.
- Users are involved in the monitoring of the project.
- Users of this service can determine themselves the need and the time for support.

LEGAL & POLICY FRAMEWORK

Introduction

The social inclusion of people with mental health problems depends not only on a change in the attitude of individuals, but it is the whole of society which has to stop discriminating and start to think and act in an inclusive manner.

Legislation and policies are important frames within which communities can act. The legislation described below can be divided in two categories : those texts which provide for individual rights and those which combat discrimination. Many policies to improve social inclusion are based on the second category which is more enforceable than the first one.

National legislation and policies are more and more influenced by European Union and other International decisions. In this chapter we have tried to draw the framework whereby social inclusion of people with mental health problems can be promoted. Inclusion cannot be realised if people do not have equality of civil and human rights.

International scene

1. United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities

Although the Rules are not compulsory. They imply a strong moral and political commitment on behalf of States to take action for the equalisation of opportunities for persons with disabilities. The Rules indicate important principles for responsibility, action and co-operation. Areas of decisive importance for the quality of life and for the achievement of full participation and equality are pointed out. The Rules offer an instrument for policy-making and action to persons with disabilities and their organisations. They provide a basis for technical and economic co-operation among States, the United Nations and other international organisations.

The purpose of the Rules is to ensure that girls, boys, women and men with disabilities, as members of the society, may exercise the same rights and obligations as other citizens. In all societies of the world there are still obstacles preventing persons with disabilities from exercising their rights and freedoms and making it difficult for them to participate fully in the activities of their communities. It is the responsibility of States to take appropriate action to remove such obstacles. Persons with disabilities and their organisations should play an active role as partners in this process.

People with mental health problems should also benefit from the Standard Rules. In 1997, Mental Health Europe co-ordinated two projects on the UN Standard Rules⁸. One of the question raised by the projects were : "Are the Standard Rules relevant for people with psycho-social disability ?" and after four seminars held in four different countries the answer was 'yes, they are relevant though they were not written with psycho-social disability in mind'. Another conclusion of the above projects, was that in theory national legislation incorporated many of the principles of the rules but that there was a large gap between the theory and the reality, especially for people with mental health problems.

⁸ The projects were : "Training and employment for persons with psycho-social disabilities" and "Equal opportunities for persons with psycho-social disabilities – Myth or Reality ?". The projects focused on 7 out of the 22 Standard Rules. They were held in four countries : Denmark, Italy, Netherlands and Portugal.

2. Declaration of Human Rights

Two Declarations can be considered as starting-points for any legislation on human rights. The first one is universal and the second is European.

A. Universal Declaration of Human Rights

The Universal Declaration of Human Rights was adopted on 10 December 1948 with the aim to create a common standard of achievement for all peoples and all nations. Every individual, organisation and institution, keeping the Declaration constantly in mind, should respect for these rights and freedoms, and by national and international progressive measures, secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

B. Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms

The Convention was prepared by the governments and heads of member States of the Council of Europe. Each member state has to ratify individually the Convention. By July 1998, all 40 member States of the Council of Europe had ratified the European Convention and accepted the right of their citizens to make individual petitions to Strasbourg and agreed to submit themselves to the compulsory jurisdiction of the European Court of Human Rights.

The Convention which recognises the Universal Declaration of Human Rights proclaimed by the General Assembly of the United Nations in 1948 is aimed at achieving unity between its members by the maintenance and the realisation of the human rights and fundamental freedoms.

With the Convention, the signatories reaffirm their profound belief in those fundamental freedoms which are the foundation of justice and peace in the world and are best maintained on the one hand by an effective political democracy and on the other by a common understanding and observance of the human rights upon which they depend. The Member States which signed the Convention are also resolved, as the governments of European countries which are like-minded and have a common heritage of political traditions, ideals, freedom and the rule of law, to take the first steps for the collective enforcement of certain of the rights stated in the Universal Declaration.

European Union scene

Actually there are key challenges that the European Union has to face that concern directly the social exclusion of people with mental health problems :

- Social exclusion and poverty
- Exclusion from labour market
- Role and affordability of social protection
- Long term unemployment
- Public Health
- Protection of Human Rights

All these issues should also be considered in the perspective of the enlargement process.

1. European Social Policy Agenda

Before the European Union summit of Amsterdam, the fight against social exclusion was considered only as a subsidiarity or national matter. In 1999, the adoption of a specific article on the fight against social exclusion in the Amsterdam Treaty (Article 137) has set the foundations for building a European social inclusion policy while competencies remain national.

A significant step was taken by the Lisbon European Council (Lisbon European Council, 23-24 March 2000) where it was stated that the number of poor and excluded in the EU is unacceptable, that the knowledge-based society can be seen as an opportunity and a threat, and that more and better jobs are the best safeguard against social exclusion.

The European Heads of States and Governments decided then to develop a common strategy on social inclusion with the aim of reaching a significant reduction in poverty in the next 10 years (from 18% to 15% in 2005 and to 10% in 2010).

Within this context the Commission drafted a **European Social Policy Agenda** which concerns social dialogue, employment, social protection and the combating against social exclusion and poverty. The agenda will last 5 years.

In order to achieve this agenda, the Heads of States and Governments adopted the method of open co-ordination. This method is supported by two types of initiatives which will allow to tackle social exclusion and poverty both at national and European level : **National Action Plans** and a **Community Action Programme**.

On 7 December 2000 at the Nice Summit the Heads of States and Government adopted appropriate objectives on fight against exclusion and poverty. These are set around four main axes :

1. To promote participation to employment and universal access to resources, rights, goods and services ;
2. To prevent risks of exclusion ;
3. To undertake action for the most vulnerable persons ;
4. To mobilise all the relevant actors.

All these objectives are very relevant to people with mental health problems.

A. National Action Plans

National government will have to take into account all the objectives while identifying priorities among the objectives (most relevant objectives for their national current situation), and draft bi-annual National Action Plans (NAPs). The first NAPs should be presented to the European Commission by June 2001. The NAPs will be assessed by the European Commission during the summer and a first report will be prepared to be adopted by the Members States at the Laeken Summit (Belgium) in December.

The NAPs to combat poverty and social exclusion should receive the support of three European programmes : EQUAL, Structural Funds and a new Action Programme to combat social exclusion.

B. Community Action Programme

The European Commission drafted a proposal for a Action Programme to combat social exclusion (COM(2000)368). The Action Programme comes as a support to national initiatives and to promote co-operation at European level :

- to achieve greater understanding of the problems of social exclusion,
- to promote exchange of good practices, and
- to seek to develop common approaches and compatibility in regard to indicators.

The programme will also support the introduction of inclusive policies and actions in member states on employment, education, training, health and housing policies, and in the structural funds. The multidimensional nature of social exclusion is one of the key aspects of the new programme.

The proposal provides also for participation of representatives of NGOs and voluntary organisations involved in the fight against social exclusion in the design, implementation and follow up of the Community Action Programme.

The programme will last 5 years, starting in 2001.

2. Social protection

People with mental health problems require social protection systems in order to provide them with a safeguard against financial vulnerabilities and to provide them with the financial means to combat social exclusion, discrimination and promote independent living.

The social protection systems in member states are confronted with similar challenges – adapting to the changing world of work, new family structures and demographic changes.

The European Union had started a reflection process in the early 1990s to help member states to cope with these challenges. This reflection process led to a Commission Communication entitled **'Modernising and improving social protection in the Union'**. This Communication which aims to reconcile government attempts to cut spending on health and social security systems with measures to foster social inclusion, has provoked strong reactions from the Council and the Members of the European Parliament. Recently the European Parliament adopted a report on "Modernising Social Protection". This report includes explicit reference to the need to maintain a high safety net in the social security system for those unable to be integrated into the labour market. It also makes a reference to disabled people in relation to inclusion of binding legal acts to combat discrimination in line with Art.13 of the Treaty of the European Union and on recommendations with regard access to care and compilation of information and statistical indicators on disabled people in the European Union and in Central and Eastern Europe.

3. Non Discrimination

A. Directive on equal treatment in employment and occupation

On 27 November 2000, the Council for Employment and Social Affairs adopted the **Framework Directive on equal treatment in employment and occupation**.

Based on the non-discrimination clause, Article 13 of the Amsterdam Treaty, this new Directive presents for the first time concrete non-discrimination legislation for disabled people in the European Union and new initiatives to combat discrimination in Europe. It mentions disability in relation to the prohibition of both direct and indirect discrimination and includes clear language as to reasonable accommodation/adaptation measures requiring employers to adapt the working environment for disabled people, and thus people with psychosocial disabilities as well.

Especially relevant to the disability movement is Article 5, which includes a reference to reasonable accommodation which states that employers shall take appropriate measures to enable a person with a disability to have access to, participate in, or advance in employment, or to provide training for this person. However, if these measures imply a disproportionate burden, e.g. high financial or other costs, employers will be exempted from the obligation.

Harassment is also seen as a form of discrimination, violating the dignity of a person.

Differential treatment in relation to religious or other ethical beliefs as well as in relation to age is allowed in some cases where it can be justified by a legitimate objective.

The Directive will apply to private and public companies as well as public authorities.

The Member States are given the decision on how the existence of direct and indirect discrimination will be established according to national law or practice. The Member States are also responsible for ensuring that appropriate judicial and/or administrative procedures are accessible to victims of discrimination. The Directive also requires that Member States abolish all laws, regulations or administrative provisions contrary to the principle of equal treatment.

They are required to implement the terms of the Directive within the next three years, with the possibility of requesting a supplementary three years to implement the provisions in relation to disability and age.

The role of NGOs in the consultation and implementation of the Directive is also recognised.

B. Non Discrimination Action Programme

The Non Discrimination Action Programme will promote measure to combat direct and indirect discrimination based on racial or ethnic origin, religion or belief, disability, age or sexual orientation.

The Programme will last 6 years (2001-2006) and will have a budget of 98,4 MEUROS. Both the Council and the European Parliament have recognised the need to guarantee up to 90 % core funding for European NGOs.

The Programme has three objectives :

- to improve the understanding of issues related to discrimination through improved knowledge and through evaluation of the effectiveness of policies and practices
- to develop capacity to prevent and address discrimination, in particular by strengthening organisation's means of action and through supporting exchange of information and good practice, while taking into account the specific characteristics of the different forms of discrimination
- to promote and disseminate the values and practices underlying the fight against discrimination.

4. Charter of Fundamental Rights in Europe

The ***European Union Charter of Fundamental Rights*** is an initiative taken by the European Union to state the importance of civil, social, economic, political and cultural rights of its citizens.

The Charter was signed by the Council on 7 December 2000 at the summit of Nice. By this act, the European institutions mark their commitment to respect the Charter in all actions and policies of the Union. The final status of the Charter and its relationship to the Treaties remain unresolved. Would it be a simple declaration or would it be a legally binding set of rights, enshrined in the Treaties ?

The Charter includes several articles that concern people with mental health problems : art. 8 on data protection, art. 21a on non discrimination, art. 26 on integration, art 29 - Right of access to placement services art. 34 on social security and social assistance, art. 35 on health care. The Charter can be considered as a meaningful progression to a more social European Union. However it is a shame that important rights such as the right to minimum income and the right for housing are not included.

NGOs have campaigned on issues such as the enforceability of rights and how to make sure that Charter is not a retreat from rights acquired through the United Nations, the International Labour Organisation, or the Council of Europe. Fundamental rights are indispensable in strengthening the social dimension of the EU. For the NGOs the full set of civil, political, economic, social, cultural and trade union rights must remain indivisible and should be incorporated in the Treaty in a binding manner even if their legal enforceability may vary.

5. European Employment Strategy

In December 1999, at the Luxembourg summit, a specific decision was taken at European Union level to take action to improve the employment situation of member states. The Employment Strategy was launched. The Strategy is based on 4 pillars :

- Employability
- Entrepreneurship
- Adaptability
- Equal Opportunities

Each pillar corresponds to a range of range of objectives that Member States have to take into consideration in their national employment strategies. Since then, each year, the European Commission prepares an employment package to be adopted by the Council of Ministers. The package contains employment guidelines and a set of recommendations that member states have to implement at national level, in National Action Plans. This is what is called the open method of co-ordination.

From the beginning of the Employment Strategy process, the European Disability Forum (EDF) has been very active in raising awareness on the poor employment rate of people with disabilities, and among them people with mental health problems. In its recent response on the proposal for a Council's directive on guidelines for Member States' Employment Policies for the years 2001⁹, EDF writes "In spite of the absence of reliable statistics regarding the employment of disabled people, there is a general consensus that the unemployment rate of disabled people in the EU is significantly higher than for non disabled people. Furthermore a majority of disabled people are excluded from the labour market and are therefore invisible in labour statistics. In the 2001 guidelines, the Commission, following the decisions of the Lisbon European Council, has invited Member States to set national targets in order to reach the objective of an overall employment rate of 70% (60% for women) by 2010. Considering the very low employment rates of disabled people and taking into account the fact that they represent about 10% of the population, increasing their employment rates would constitute an important contribution in reaching the general objective set in Lisbon.

When employed, disabled workers are at particular risk of dismissal and often do not perform jobs that truly reflect their skills or potential. They also face longer unemployment periods than their non disabled peers. Moreover disabled women experience often a double form of discrimination in the labour market. "

The movement of disabled people is a heterogeneous group. The needs of a person with a psychosocial handicap, will be different than those of a person with a hearing impairment or a wheelchair-user. However all disabled people are concerned by all objectives and pillars of the European Employment Strategy. Unfortunately until now most of the Member States only to devote their attention to actions in the first pillar: employability.

6. European Public Health Strategy

The proposal for a programme of **Community action in the field of public health** (2001-2006) contains proposals which will enable the Community to respond more effectively to its obligations by setting out clear objectives and policy instruments.

The proposal for a health strategy does set out the legal context, the key objectives and in a concise review of health trends and challenges within the EU, it identifies also the major challenges for health systems.

There will be three major strands of action :

- The first strands 'improving health information and knowledge' will aim to put in place a comprehensive data system on the major determinants of health in the EU, together with mechanisms to evaluate this data.
- The second strand 'responding rapidly to health threats' will aim to ensure that the Community is in a position to counter threats to health which cannot be tackled by member states in isolation.
- The third strand 'addressing health determinants' will be to put in place strategies to identify the most effective policy for combating disease and promoting health.

The new strategy also outlines legislative initiatives being considered under the Community's direct competence in relation to public health.

The programme is proposed for participation by the EEA countries and the associated countries of Central and Eastern Europe as well as Cyprus, Malta and Turkey.

The public health programme is a key initiative which will provide added value while reflecting the Treaty provision that Community action in the field of public health shall fully respect the

⁹ Response on the proposal for a Council's directive on guidelines for Member States' Employment Policies for the years 2001, October 2000, European Disability Forum

responsibilities of the Member States for the organisation and delivery of health services and medical care.

It is intended to set up a new mechanism, the European Health Forum, to give the public health community at large an opportunity to play a role in the development of health policy. Proposals in other key areas of Community activity (internal market, social affairs, research and development, agriculture, trade and development policy, environment, etc.) should actively promote health protection. The new strategy therefore includes a number of specific measures to give effect to this requirement.

For mental health interests the operational context will appear in the main within the strands one and three with their focus on health monitoring in terms of morbidity as well as mortality, the strategies on life style related health determinants, and the strategies and measures of socio-economic health determinants.

Mental health as a component of the health strategy figures significantly in the detail of supporting evidence of serious public health problems. It will therefore impose a challenge to the mental health constituency of governmental and non governmental interests to secure the necessary responses to the proposals for action.

ANNEX 1

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ANNEX 2

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