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Mental Health Matters:

An Analysis of the European Union Discourse on Mental Health Since 2005

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Abstract

In recent decades, the need to tackle mental health issues and promote mental well-being has been increasingly put in the socio-political spotlight. As a first step towards creating a European strategy on mental health, the European Commission published the *Green Paper, Improving the mental health of the population: Towards a strategy on mental health for the European Union* in 2005. This master's thesis aims to thematically track the development of the EU discourse on the topic of mental health from 2005 until the present time. In particular, the objectives and goals of the European Union concerning the mental health of European citizens are examined through a discourse analysis. Four documents from the European Commission and the Council of the European Union are included in the study. The results show that in the selected documents, mental health is discursively represented as a key priority. It is also envisioned as a *positive mental health* and as a human right. Additionally, the European Commission emphasises the multisectoral involvement required for a comprehensive European mental health strategy. The findings of the paper provide an important entry point to the discussion on the relevance and scope of EU public mental health action.

*Keywords***:** discourse analysis, mental health, positive mental health, human rights, European Commission, European Union

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List of Abbreviations

EC	European Commission
EU	European Union
European Framework	*European Framework for Action on Mental Health and Well-being*
European Pact	*European Pact for Mental Health and Well-being*
Green Paper	*Green Paper, Improving the mental health of the population: Towards a strategy on mental health for the European Union*
MHiAP	Mental Health in All Policies

1 Introduction

The meaning and importance of mental health has long been overlooked and misunderstood in Europe and around the world. In contemporary Europe, it is socially considered to be a taboo subject, which is fuelled by widespread stigmas, prejudices, and discriminations against those with mental health issues. However, in light of the recent Covid-19 pandemic which resulted in a number of lockdowns, heightened anxiety and the loss of a great number of loved ones[1], the necessity to address mental health issues and promote mental well-being has been increasingly put under the socio-political spotlight. Many scholars and experts acknowledge that it is now a suitable time to discuss and develop appropriate mental health policies and practices across Europe, including specific political measures within the framework of European integration.

Mental health is a complex and challenging concept. Its meaning varies depending on cultures, local beliefs, and practices.[2] As a result, policymakers need to plan and implement relevant policies and measures based on the mental health representations of various populations, within different countries. The EU had never attempted to develop a mental health strategy before the publication of the *Green Paper* in 2005 entitled *Improving the mental health of the population: Towards a strategy on mental health for the European Union*.[3] This paper aimed "to launch a debate with the European institutions, governments, health professionals, stakeholders in other sectors, civil society including patient organisations, and the research community about the relevance of mental health for the EU, the need for a strategy at EU level and its possible priorities".[4] Ever since this publication, problems concerning the mental health of EU citizens have been included to a greater degree in the supranational European political discourse. In this context, one may mention for example the *European Framework for Action on Mental Health and Well-being*[5], launched

[1] Kumar, Anant, and K. Rajasekharan Nayar. "Covid 19 and Its Mental Health Consequences." *Journal of Mental Health* 30, no. 1 (2021): 1–2. https://dx.doi.org/10.1080/09638237.2020.1757052.

[2] World Health Organization. *Prevention and Promotion in Mental Health.* World Health Organization, 2002, 28, accessed 12/04/2022, https://apps.who.int/iris/bitstream/handle/10665/42539/9241562161.pdf.

[3] European Commission. *Green Paper: Improving the Mental Health of the Population: Towards a Strategy on Mental Health in the European Union.* OOPEC, 2005, accessed 13/05/2022, https://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf

[4] Ibid., 3.

[5] European Commission. *European Framework for Action on Mental Health and Well-being*, 2016, accessed 13/05/2022, https://ec.europa.eu/research/participants/data/ref/h2020/other/guides_for_applicants/h2020-SC1-BHC-22-2019-framework-for-action_en.pdf.

in 2016 to support the Member States in improving their mental health policies. Thus, mental health is increasingly developing into a supranational socio-political field within the activity of the European Union. Recognising the increased medical and political interest on this topic, I aim to track the development of the European Union discourse on the topic of mental health, from 2005 until the present time. Based on that aim, the following research questions are formulated:

1. What are the main objectives and goals of the European Union concerning the mental health of European citizens?
2. How have these goals and objectives been discursively articulated?

This thesis aims to answer these questions by analysing relevant research material and following a systematic elaboration and analysis, which leads to the structure and disposition of the study.

1.1 Thesis structure

This thesis has been structured into six chapters:

- **Chapter 1** provides an introduction to the topic including the research questions and structure of this thesis (section 1.1), and an overview of the relevance of mental health policies for the EU (section 1.2).
- **Chapter 2** presents the theoretical perspectives and tools of the study by reviewing and elaborating on mental health theories (sections 2.1 and 2.1.1) as well as relevant theoretical positions on human rights (section 2.2).
- **Chapter 3** forms the methodological framework of the study by introducing the discourse analysis method (section 3.1) and its relevance for this thesis (section 3.2), describing the methodological tools in-use (section 3.3), discussing the validity and reliability of discourse analysis (section 3.4), and presenting the main data sources (section 3.5).
- **Chapter 4** outlines the historical background of mental health services in Europe, including institutionalisation and madness from the 1800s until the 1950s (section 4.1), the rise of mental health systems after the 1950s (section 4.2), and mental health in the EU from 2005 to the present day (section 4.3).

- **Chapter 5** presents the findings and research results in a thematic discussion based on the theory and methodology outlined in the previous chapters.
- **Chapter 6** presents the conclusions and the implications for future research.

1.2 Relevance of the EU on mental health policies

Analysing the EU discourse on mental health and related policies requires an understanding of how the EU and its supranational bodies may be relevant in this context. Two interrelated questions are increasingly raised in the general EU discourse: Are mental health policies an important element of the European Union's socio-political role and scope of power? Should mental health policies be initiated and operated mainly at a supranational or national level?[6]

In Article 129 of the "Maastricht treaty"[7], later expanded by article 152 of the "Treaty of Amsterdam"[8], the mandate for action at community level in the field of public health is defined as such:

> 1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.
>
> Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.
>
> The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.
>
> 2. The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.
>
> Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.
>
> 3. The Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

[6] Greer, Scott L., and Holly Jarman. "What Is Eu Public Health and Why? Explaining the Scope and Organization of Public Health in the European Union." *Journal of Health Politics, Policy and Law* 46, no. 1 (2021): 23–47. https://dx.doi.org/10.1215/03616878-8706591.

[7] European Union. *Treaty on European Union (Consolidated Version), Treaty of Maastricht*: Official Journal of the European Communities C 191, 1992.

[8] European Union. *Treaty of Amsterdam Amending the Treaty on European Union, the Treaties Establishing the European Communities and Related Acts*: Official Journal of the European Communities C 340, 1997.

> 4. The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this article through adopting:
>
> (a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;
>
> (b) by way of derogation from Article 37, measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;
>
> (c) incentive measures designed to protect and improve human health, excluding any harmonisation of the laws and regulations of the Member States.
>
> The Council, acting by a qualified majority on a proposal from the Commission, may also adopt recommendations for the purposes set out in this article.
>
> 5. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.[9]

As we can read above, the scope of the EU mandate covers complementing national policies, facilitating cooperation between the Member States, primarily preventing illnesses, and promoting research and information. The section number 5 of the article 152[10] reminds the readers that the Member States have primary responsibility for organising and delivering their own health services and medical care. In regards to mental health policies, the EU certainly has a role in terms of general prevention and information, but its role concerning concrete initiation and implementation of treatment policies and practices pertaining to public mental health is more ambiguous. In the *European Framework for Action on Mental Health and Well-being*[11], the European Commission (EC) acknowledges mental health policies to be "primarily the responsibility of Member States"[12]. Nonetheless, the EC states that a common European framework for actions on mental health, based on the best European knowledge and experience, may be an asset not just for the development of EU policies but also for the Member States. The EC appears to base its relevance in terms of mental health policies on the above-mentioned "Treaty of Amsterdam". Particularly clause number two, which allows the EU to promote cooperation among Member-States in order to develop comprehensive mental health guidelines and policies at the national and supranational levels.

[9] Abbing, Henriette DC. "Public Health in the Treaty of Amsterdam (Treaty on the European Union)." *Eur. J. Health L.* 5 (1998): 171.
[10] European Union, *Treaty of Amsterdam.*
[11] European Commission, *European Framework*, 13.
[12] Ibid.

In this regard, EU action in public health has increased considerably over the years, and the coronavirus crisis has underlined the importance of cross-border coordination in order to, for instance, better respond to pandemics.[13] In summary, the European Union appears to have a somewhat dualistic self-perception of its role and power, while simultaneously emphasising the significance of both national and supranational actors. The exact content of the EU discourse, including this dualistic aspect and the possible restraints that this duality brings, will be carefully analysed in chapter five.

[13] Milotay, Nora. *Eprs Ideas Paper Thinking About Future Eu Policy: Social and Employment Policies in Europe*, 2020, 1–2, accessed 03/05/2022 https://www.europarl.europa.eu/RegData/etudes/BRIE/2020/652057/EPRS_BRI(2020)652057_EN.pdf

2 Theoretical background

Following the introduction to the topic, a relevant theoretical background is required to guide the upcoming study of the European discourse on mental health. This theoretical background includes a concrete set of theoretical tools relevant for conducting a thorough interpretation of the material. Theoretical viewpoints on mental health will be presented first, followed by human rights theories.

2.1 Mental health theories

Mental health is a broad term that was largely discussed in the 20th century by scholars in various disciplines such as anthropology, sociology and psychology.[14] One important example was Maria Jahoda, a social psychologist who tried to define the meaning of mental health.[15] Jahoda's work was significant because she broadened the perspective that being mentally healthy did not only include the absence of mental illness or diseases but also the ability of an individual to engage in their social environment.[16] The definition of mental health according to her was based on the six following concepts:

1. Positive view of the self
2. Capability for growth and development
3. Autonomy and independence
4. Accurate perception of reality
5. Positive friendships and relationships
6. Environmental mastery – able to meet the varying demands of day-to-day situations[17]

This holistic definition of mental health, involving different factors and requiring more than the absence of mental illness to be mentally healthy, has had a considerable impact on current perspectives on mental health and on academia in general. It also illustrates the complexity of mental health by having multiple criteria. Several scholars who have reviewed definitions of mental health[18] have contested Jahoda's viewpoint, arguing that this definition lacked a

[14] Scheid, Teresa L, and Eric R Wright. *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems.* Cambridge: Cambridge University Press, 2017, XV.
[15] Jahoda, Marie. *Current Concepts of Positive Mental Health.* New York: Basic Books, 1958, 23.
[16] Thompson, Chalmer E., and Helen A. Neville. "Racism, Mental Health, and Mental Health Practice". *The Counseling Psychologist* 27, no. 2 (1999): 170. doi:10.1177/0011000099272001.
[17] "Defining Mental Health: A Short Introduction." 2019, accessed 15/04/2022, https://www.classcentral.com/course/defining-mental-health-12346.
[18] See for example: Ramseur, Howard P. "Psychologically Healthy Black Adults." In *Black Psychology, 3rd Ed.*, 353-78. Berkeley, CA, US: Cobb & Henry Publishers, 1991.

conceptual framework, resulting in ambiguity between one criterion and another.[19] Moreover, it is rarely possible to meet all of these criteria simultaneously, and if only one criterion were missing, the person could still be happy.[20]

Furthermore, we cannot describe being mentally healthy without comparing it to what is deemed important according to societal and cultural norms. Richard Lazarus, an American psychologist, addressed this issue and cautioned his readers about it: what is considered as healthy is not any different from what is regarded as "virtuous" by society[21], "in spite of our tendency to run for cover under pseudo-scientific and medical terms".[22]The meaning of mental health is therefore ambiguous and can be approached from two perspectives: positive and negative mental health, notions that will be presented in the sub-chapter below. Jahoda's interpretation of mental health is understood in a positive sense. It is evident to her that a state of normality is not a synonym for mental health, it is too "unspecific and bare of psychological content"[23]. Jahoda's approach is consequently compatible with Gilmour's definition of mental health: a state of well-being that means "both flourishing and being free of mental illness".[24]

2.1.1 Positive and negative mental health

Positive and negative mental health are the two principal perspectives on mental health.[25] Negative mental health is approaching mental health from the angle of mental disorders, symptoms, and problems. According to this definition, a person without any mental disorder has good mental health which, while simplistic, was the focus of epidemiological studies during the past half-century: determining who was mentally ill and who was healthy.

Positive mental health, the theory mentioned by Jahoda and Gilmour, considers mental health as a resource. It is a holistic approach to health in which the importance of general well-being is emphasised. Good mental health and well-being enable us to "experience life as meaningful, helping us to be, among other things, creative and productive members of the

[19] Thompson, Chalmer E., and Helen A. Neville. "Racism, Mental Health, and Mental Health Practice." *The Counseling Psychologist* 27, no. 2 (1999): 170. https://dx.doi.org/10.1177/0011000099272001.
[20] Gross, R. *Psychology: The Science of Mind and Behaviour 7th Edition.* Hodder Education, 2015, 737–38.
[21] Lazarus, RS. "The Healthy Personality—a Review of Conceptualizations and Research." *Society, stress and disease: Childhood and adolescence* 2 (1975): 7.
[22] Ibid.
[23] Jahoda, Marie. *Current Concepts of Positive Mental Health.* New York: Basic Books, 1958, 22.
[24] Gilmour, Heather. *Positive mental health and Mental Illness.* Statistics Canada (2014), 4.
[25] Lavikainen, Juha, Eero Lahtinen, and Ville Lehtinen. "Public Health Approach on Mental Health in Europe." (2000): 55.

society."[26] George E. Vaillant, a psychoanalyst and research psychiatrist at Harvard Medical School, suggests safeguards for mental health research. He mentions four obstacles to defining *positive mental health*:

- Cross-cultural differences: One's perspective on mental health may be influenced by cultural diversity, diverse values, ethnicities, or backgrounds.
- Positive representation of "average": Having average mental health does not equate to being healthy. Community surveys always combine healthy individuals with the prevalent psychopathology rate.[27]
- Lack of clarity: It is essential to specify whether one is discussing a trait or a state. A trait is a long-term characteristic, whereas a state is temporary. In Vaillant's example, for instance, a world-class athlete with a temporarily sprained ankle (state) is probably healthier than a type 1 diabetic with momentarily normal blood sugar (trait). In this regard, longitudinal studies are of paramount importance.
- Socio-cultural context: Mental health must be considered in context. Certain diseases are harmful in Europe but not in other regions. For instance, in Paris, sickle cell trait is unhealthy, but not in central Africa, where malaria is common.[28] In certain communities, punctuality and competitiveness are considered healthy, but not in others.[29]

The intricacy of *positive mental health idea* has been attempted to be illustrated through a number of models and theories. Some of them are mentioned in the George E. Vaillant's paper:

> Mental health as above normal, epitomised by a DSM-IV's Global Assessment of Functioning (GAF) score of over 80; mental health as the presence of multiple human strengths rather than the absence of weaknesses; mental health conceptualised as maturity; mental health as the dominance of positive emotions; mental health as high socio-emotional intelligence; mental health as subjective well-being; mental health as resilience.[30]

There is truth to each of these characteristics, but the broad concept of mental health varies depending on cultures and contexts.

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[26] Lavikainen, Juha, Eero Lahtinen, and Ville Lehtinen. "Public Health Approach on Mental Health in Europe." (2000): 36.
[27] Vaillant, George E. "Positive Mental Health: Is There a Cross-Cultural Definition?". *World Psychiatry* 11, no. 2 (2012): 93. https://dx.doi.org/10.1016/j.wpsyc.2012.05.006.
[28] Ibid.
[29] Vaillant, "Positive Mental Health,", 93.
[30] Ibid.

2.2 Human rights theories

As a second theory, complementing the above-mentioned positive understanding of mental health, I include theoretical perspectives connecting mental health with human rights. Human rights are frequently mentioned in the EU discourse on mental health, and I will proceed to analyse their correlation in the analysis chapter (section 5.3).

Human rights are an ancient concept that is rooted in the eighteenth-century Enlightenment. The numerous revolutions of the time granted civil and political rights to all people. A British philosopher, John Locke, asserted that all individuals are born with "inalienable"[31] natural rights, making them all equal. He believed that the purpose of government was to protect the inalienable natural rights of the people, in exchange for obedience to the law. He considered that if the state failed to care for its citizens, the people had the right to revolt, to revolutionise.[32] According to him, the government is consequently responsible for human rights. More recently, Thomas Pogge stated that human rights principles are addressed at people in positions of power in a society.[33] He held governments and states accountable for human rights violations.[34] Following Pogge and Locke's arguments, the EU as a powerful institution is responsible for upholding human rights principles, including those pertaining to (mental) health.

Human rights did not become an international right until after World War II, when the United Nations was founded.[35] Prior to that, those who were involved in international affairs were regarded as sovereign, which meant that they were not subject to a higher political authority in their own territories. This is more commonly known as the principle of non-intervention.[36] As a result, extending human rights beyond national borders was never an option. However, the concept of sovereignty has evolved over time. The European Union and the rest of the world now have a common understanding of human rights. The protection and fulfilment of human rights are intrinsically related to good health, which includes good mental health.

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[31] Locke, John. "Two Treatises of Government, 1689." *The anthropology of citizenship: A reader* (2013): 43–46.

[32] O'Toole, John Winfred. "The Right of Revolution: An Analysis of John Locke and Thomas Hobbes' Social Contract Theories." Boston College, 2011, 49.

[33] Pogge, Thomas. "How Should Human Rights Be Conceived?". *Jahrbuch für Recht und Ethik* 3 (1995): 103-20.

[34] Ibid.

[35] Donnelly, Jack, and Daniel J. Whelan. "International Human Rights." (2020): 3. https://dx.doi.org/10.4324/9780429266072.

[36] Ibid.

Health, in particular, "has both national and international dimensions"[37] because it deals with problems that affect the whole world, such as infectious diseases, health research, or international regulatory initiatives.[38] "The right to the highest attainable standard of health"[39] has been internationally recognised and is inseparable or "indivisible" from any other human rights. Slavery, violence against women and children, and other forms of torture are all examples of human rights violations that can lead to mental illness. Human rights can be affected by how health policies and programmes are made. Examples include the right to privacy and the freedom from racial or ethnic prejudice. As a consequence, human rights can help those who are vulnerable and in need of mental health care.

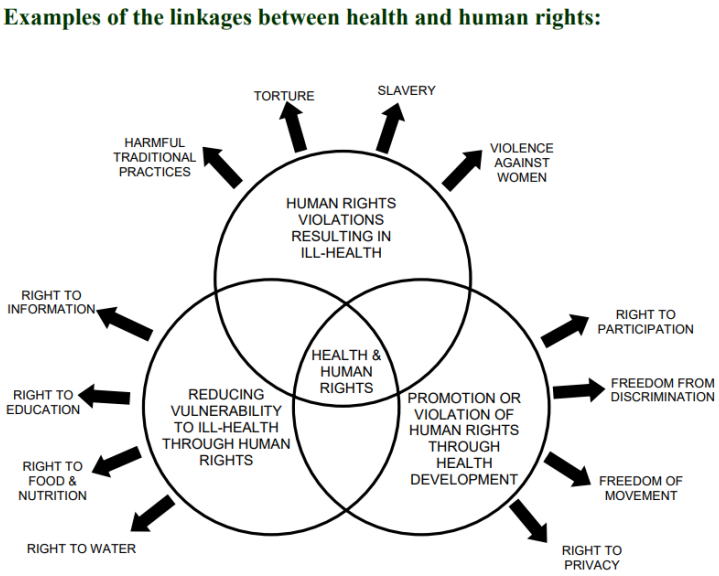

Figure 1 World Health Organization. "Examples of the Linkages between Health and Human Rights.", accessed 12/04/2022, www.who.int.

Mental health policies should be understood as connected to the right to health and therefore to human rights. There is no such thing as long-lasting, holistic mental health if human rights are not well-established. International organisations, states, and the European Union are all responsible for implementing these rights. Health as a human right is a challenging policy issue because good (mental) health is only partially dependent on healthcare, a policy area that we can legislate on. In addition, it depends on "nutrition, lifestyle, education, women's

[37] Hunt, Paul, and Gunilla Backman. "Health Systems and the Right to the Highest Attainable Standard of Health". *Health and Human Rights* 10, no. 1 (2008): 86. https://dx.doi.org/10.2307/20460089.
[38] Ibid.
[39] International Health Conference. "Constitution of the World Health Organization. 1946." *Bull World Health Organ* 80, no. 12 (2002): 983–84.

empowerment, and the extent of inequality and unfreedom in a society".[40] Consequently, human rights in health include extensive requirements that go beyond health care legislation.[41] Multiple policy areas need to be taken into consideration, and even more so for specific measures regarding mental health than general public health. Coordination between multiple sectors and departments is crucial; the need for coordination "extends to policy-making and the actual delivery of services."[42]

If health is seen as a right, then multisectoral policy commitments must ensue, which is what the EU is attempting to achieve. Following what Amartya Sen said, European policies will be treated as interconnected with the issues of mental health and the Right to the Highest Attainable Standard of Health.

[40] Sen, Amartya. "Why and How Is Health a Human Right?". *The Lancet* 372, no. 9655 (2008): 2010. https://dx.doi.org/10.1016/s0140-6736(08)61784-5.

[41] Ibid.

[42] Hunt, Paul, and Gunilla Backman. "Health Systems and the Right to the Highest Attainable Standard of Health." *Health and Human Rights* 10, no. 1 (2008): 86. https://dx.doi.org/10.2307/20460089.

3 Methodology

After the theoretical perspectives and tools of the study have been discussed, an appropriate methodology must be developed before conducting the primary analysis. This chapter will introduce the thesis's methodological approach—discourse analysis—and its relevance. Subsequently, the methodological tools will be presented, followed by a reflection on the validity and reliability of the chosen methodology. Finally, the principal sources will be enumerated.

3.1 Discourse analysis

This study employs discourse analysis as its methodological foundation. The earliest perspectives on discourse analysis centred on the study of language, including phonology and morphology.[43] Over time, discourse came to include practices involving speaking and writing.[44] In the "new" discourse analysis[45], the discourse is critically examined in relation to society and social change, with a focus on both its production and its reception by the audience.[46] It is composed of two main dimensions: textual and contextual. The textual aspect examines the language and the structure of the discourse, whereas the contextual dimension scrutinises the cultural, social, and political contexts. As a result, discourse analysis encompasses more than linguistics, it is also closely tied to our social identities and our social relationships.[47] It reflects the speaker's internalised or socialised preconceptions and prior knowledge. Whenever a person expresses themselves through speech or writing, they are discursively demonstrating who they are, their relative social position, and their relationship with others. Through discourse, people "enact their identity".[48] By doing so, they build "a system of representation"[49] — the relationship between concepts and language — that promotes a particular ideology to varying degrees. According to Foucault, discourse

[43] Coulthard, Malcolm. *An Introduction to Discourse Analysis.* London: Routledge, 2014, 1–4. https://dx.doi.org/10.4324/9781315835884.
[44] Woodilla, Jill. "Discourse and Organization." London: SAGE Publications Ltd, 1998, 2.
[45] Lupton, Deborah. "Discourse Analysis: A New Methodology for Understanding the Ideologies of Health and Illness." *Australian Journal of Public Health* 16, no. 2 (2010): 145–50. https://doi.org/10.1111/j.1753-6405.1992.tb00043.x.
[46] Ibid.
[47] Jones, Rodney H. *Discourse Analysis: A Resource Book for Students.* Routledge English Language Introductions. Abingdon: Routledge, 2012, 4.
[48] Ibid., 3.
[49] Hall, Stuart. *Representation: Cultural Representations and Signifying Practices.* SAGE Publications, 1997, 17.

can also transmit and produce power.[50] With a methodology based on discourse analysis, I will analyse the institutional power exerted by the European Commission discourse on mental health policies.

The examined mental health discourse is understood throughout this thesis as a positive emphasis of the EU in its policies, on building and developing a coherent, long-lasting, and human rights-based collective mental well-being of Europeans.

3.2 Discourse analysis relevance

Deborah Lupton, an Australian sociologist, argues that discourse analysis is suitable to be applied to public health matters. It is an interdisciplinary methodology used in different discourses relating to public health, such as: official texts (for instance, government health policy documents); government-sponsored health promotion; medical and public health journals; and textbooks.[51] Quantitative and content analysis are broadly applied in public health, but their conclusions are restricted to the textual dimension. The contextual factor is missing, and consequently, there cannot be any assumptions or underlying meanings of a message or on the perceived discourse by the audience.

Mental health in particular "needs to be seen in context"[52]. Capturing the discourse of the European Union through a discourse analysis will assist in deciphering the complexity and comprehension of mental health while also taking context into account. Discourse analysis is therefore a good supplement to, or replacement of, quantitative methodologies seen in public health.[53] For this reason, a discourse analysis was applied to analyse the EU mental health policy.

3.3 Methodological tools

Discourse analysis offers a variety of analytical concepts and tools. As explained by Marianne W. Jørgensen and Louise J. Phillips, analysis, theory, and method are intertwined. The researcher has the freedom and the responsibility to combine these elements in order to

[50] Foucault, Michel. *The History of Sexuality: The Will to Knowledge.* Vol. 95, London: Penguin, 1998, 100–101.
[51] Lupton, Deborah. "Discourse Analysis: A New Methodology for Understanding the Ideologies of Health and Illness." *Australian Journal of Public Health* 16, no. 2 (2010): 145-50. https://doi.org/10.1111/j.1753-6405.1992.tb00043.x.
[52] Vaillant, "Positive Mental Health,", 93.
[53] Ibid.

create a coherent framework.[54] I selected the following methodological tools to analyse the EU discourse on mental health in this study:

Finding power in discourse: Power relations are negotiated and performed through discourse[55], and this is particularly true in European discourse. Powerful social and political actors such as the EU Commission "convey knowledge, affect opinions or change attitudes"[56], hence, it is pertinent to examine the discursive representations of power in EU mental health policy texts.

Chains of equivalence and *nodal points*[57]: *Nodal points* are central themes in the discourse. They are "privileged signifiers that fix the meaning of a chain of signifiers"[58] and are formed through *chains of equivalence* that constitute the connections of signs.[59] Thomas Diez, professor of Political Science and International Relations at the University of Tuebingen, argues that a discursive *nodal point* approach is applicable to discourses on European governance.[60] This thesis will analyse the relevant *nodal points* articulated in the EU discourse and examine their implications for EU mental health objectives.

Foregrounding and backgrounding: These terms denote an emphasis or de-emphasis on certain concepts or issues thanks to textual prominence.[61]

Modality: This tool reveals the degree of certitude and authority emanating from a statement in a discourse. [62]

Transitivity: This concept analyses the connection, or lack thereof, between events to subjects and objects. Transitivity is an "essential tool in the analysis of representation".[63] It

[54] Jørgensen, Marianne W, and Louise J Phillips. *Discourse Analysis as Theory and Method.* Sage, 2002, 4.
[55] Paltridge, Brian. *Discourse Analysis: An Introduction.* Bloomsbury Discourse Series. London: Bloomsbury, 2012, 188.
[56] Van Dijk, Teun A. "Aims of Critical Discourse Analysis." *Japanese discourse* 1, no. 1 (1995): 17–28.
[57] *Chains of equivalence* and *nodal points* are terms developed by Ernesto Laclau and Chantal Mouffe in their work Hegemony and Socialist Strategy published in 1985.
[58] Laclau, Ernesto, and Chantal Mouffe. *Hegemony and Socialist Strategy: Towards a Radical Democratic Politics.* Vol. 8: Verso Books, 2014, 112.
[59] Engvall, Linn. "Women's Empowerment-a Discourse Analysis of the Women's Empowerment Concept in Un Women." Lund University, 2018, 7.
[60] Diez, Thomas. "Europe as a Discursive Battleground." *Cooperation and Conflict* 36, no. 1 (2001): 16–19. https://dx.doi.org/10.1177/00108360121962245.
[61] Huckin, Thomas N. "Critical Discourse Analysis." *Functional approaches to written text: Classroom applications* (1997): 87–92.
[62] Ibid., 93.
[63] Fowler, R. *Language in the News: Discourse and Ideology in the Press.* Routledge, 1991, 70.

reveals the author's ideologies or world views[64] as well as a "cline of dynamism"[65], which indicates a degree of power in the discourse.[66]

Contextualisation: This tool examines the context in which the discourse is being produced and used, since "discourse can be seen as the process of activating a text by relating it to a context in use."[67]

These tools will be used to address the aforementioned research questions (section 1). However, a methodological framework and methodological tools are insufficient to carry out a thorough and rigorous thesis. The next section will outline the steps taken to ensure that the thesis is reliable and valid in light of the researcher's potential bias in qualitative research.

3.4 Validity and reliability

This thesis applies a discourse analysis methodology. As with the majority of studies, its design is subject to limitations. Due to the impossibility of analysing all documents pertinent to the research objective, other relevant EU documents may have been overlooked in favour of a limited number of mental health papers (to ensure feasibility). I sought to include only the most significant documents, but this choice may have diminished the representativeness of the study. In addition, discourse analysis is a qualitative research method, which means that I did not take a passive role during the process of analysis, but rather took an active role by choosing the selection of analysed documents and interpreting them. As a result, the forthcoming analysis is based on my interpretation, inevitably influenced by my background and opinions. I endeavoured to be as objective as possible by drawing on the work and recommendations of several researchers, including Potter and Wetherell[68] and Jørgensen and Phillips.[69]

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[64] Fairclough, Norman. *Media Discourse.* London: Edward Arnold, 1995, 25.
[65] Lee, Chang-soo. "A Corpus-Based Approach to Transitivity Analysis at Grammatical and Conceptual Levels: A Case Study of South Korean Newspaper Discourse." *International Journal of Corpus Linguistics* 21 (2016): 467.
[66] Ibid.
[67] Mogashoa, Tebogo. "Understanding Critical Discourse Analysis in Qualitative Research." *International Journal of Humanities Social Sciences and Education* 1, no. 7 (2014): 109
[68] Potter, Jonathan, and Margaret Wetherell. *Discourse and Social Psychology: Beyond Attitudes and Behaviour.* Discourse and Social Psychology: Beyond Attitudes and Behaviour. Thousand Oaks, CA, US: Sage Publications, Inc, 1987.
[69] Jørgensen, Marianne W, and Louise J Phillips. *Discourse Analysis as Theory and Method.* Sage, 2002.

Validity refers to the accuracy of a method to measure what it is intended to measure[70] and reliability refers to the consistency, stability, and repeatability of the research study.[71] In any academic research, it is important to consider validity and reliability in order to produce credible and trustworthy findings.[72] My analysis is therefore fruitful as recommended by Potter and Wetherell: there is very little research made based on a discursive approach to mental health policies. It is also solid; my interpretations are based on several official documents, and I also use various peer-reviewed articles and books. Additionally, it is comprehensive; every research question is answered thoroughly. Lastly, it is transparent. In accordance with the guidance of Marianne W. Jørgensen and Louise J. Phillips[73], I have provided all the documents on which I based my research so that the readers can determine for themselves whether my interpretations are accurate and consistent. Considering the need for transparency, the primary sources are listed in the section below.

3.5 Main sources

The primary sources of this thesis are official documents directly issued by the European Union or one of its many sub-branches. I wanted to illustrate the EU discourse represented in the analysed documents as opposed to the European discourse on mental health policies. Due to this, I decided not to include the analysis of the World Health Organization's "The European Mental Health Action Plan 2013-2020"[74]. The EU is not involved in writing the aforementioned action plan. The European Commission did not participate in the creation of this paper; instead, the EC bases its work on non-communicable diseases and mental health on the international policy frameworks of the World Health Organization.[75] The WHO therefore appears as an inspiration rather than a policy for the EU institutions.

[70]Heale, Roberta, and Alison Twycross. "Validity and Reliability in Quantitative Studies." *Evidence-based nursing* 18, no. 3 (2015): 66–67.
[71] Brink, H. I. L. "Validity and Reliability in Qualitative Research." *Curationis* 16, no. 2 (1993): 35. https://dx.doi.org/10.4102/curationis.v16i2.1396.
[72] Ibid., 37.
[73] Jørgensen, Marianne W, and Louise J Phillips. *Discourse Analysis as Theory and Method.* Sage, 2002.
[74] World Health Organization. "The European Mental Health Action Plan 2013–2020." *Copenhagen: World Health Organization* 17 (2015).
[75]"Mental Health." accessed 26/04/2022, https://ec.europa.eu/health/non-communicable-diseases/mental-health_en.

The main analysed documents, representing the EU discourse, are, in chronological publication order, the following:

- The *Green Paper: Improving the Mental Health of the Population: Towards a Strategy on Mental Health in the European Union*, published by the European Commission in 2005.
- The *European Pact for Mental Health and Well-being*, published by the European Commission in 2008.
- *Council conclusions on 'the European Pact for Mental Health and Well-being: results and future action'* published by the Council of the European Union in 2011.
- The *European Framework for Action on Mental Health and Well-being* published by the European Commission in 2016.

The *Green Paper* is at the root of EU policies on mental health (see section 4.3). Following papers focused primarily on concrete actions, making their analysis less fruitful.

As of the time of writing, the European Commission has not published any action plans for mental health across the EU.

4 Historical background of mental health services in Europe

This chapter will offer a historical background of mental health systems in the countries that came to form the current European Union (simplified into "Europe" hereinafter) from the nineteenth century to the present day. Without focusing on a particular country's history, a summary of the overall trend in mental healthcare history across Europe will be provided to better comprehend the current state of health services. Views on mental illnesses have changed greatly through time, and prior to the early nineteenth century, the treatments offered to the mentally sick were frequently non-medical in nature and tied to the Church and local authorities.[76] It is therefore appropriate to start examining the development of mental health services starting from the early nineteenth century which we can divide into three main periods: institutionalisation from 1800 until 1950, the rise of mental health systems after the 1950s and mental health in Europe since 2005, the year of publication of the *Green Paper.*[77]

4.1 Institutionalisation and madness from the 1800s until the 1950s

In the eighteenth century, only the most extreme violent and harmful people with mental health issues, also known as "insane," were locked up and separated from the rest of the population. However, by the mid-nineteenth century, this was the official response to all forms of mental illness.[78] The confinement of the "insane" in purpose-built institutions more commonly known as asylums symbolised the modern Western world.[79] Psychiatry was closely associated with asylums[80] and mental health was unsurprisingly considered to be a “negative mental health”, as mentioned in the theory section. This means that mental health

[76] Shorter, Edward. "The Historical Development of Mental Health Services in Europe." *Mental health policy and practice across Europe* 15 (2006): 15–16.
[77] European Commission, *Green Paper*.
[78] Scull, Andrew T. "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs." *European Journal of Sociology / Archives Européennes de Sociologie / Europäisches Archiv für Soziologie* 16, no. 2 (1975) : 218–22. http://www.jstor.org/stable/23998602.
[79] Wright, D. "Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century." *Social History of Medicine* 10, no. 1 (1997): 137–55. https://doi.org/10.1093/shm/10.1.137. https://dx.doi.org/10.1093/shm/10.1.137.
[80] Donnely, Michael. "Roy Porter, Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency." *History of the Human Sciences* 4, no. 2 (1991): 283. https://dx.doi.org/10.1177/095269519100400205.

was previously only defined in terms of the presence or absence of mental illnesses. The focus at the time was on "madness" and not on a general view of mental health.[81] The concept of *positive mental health* is relatively recent and was not envisioned before the twentieth century. Mental health hospitals exemplified a quality mental health-care option at the time: closed, secluded institutions where individuals' needs were rigorously regimented and controlled.[82]

Mental hospitals were widespread until the mid-1900s and people with mental health issues would either have stayed with their family or friends or been sent to an asylum.[83] There were very few other alternatives since community-based care and organisations did not exist yet. This practice may appear outdated, but in the absence of effective psychiatric medication, the institutionalisation reflex was appropriate. As late as in the 1840s in Denmark, the mentally ill were locked up in wooden cages in the villages or chained in stalls.[84] Therefore, early mental hospitals were a step forward compared to these horrible substitute methods employed in the community. The asylums were clean and functional hospitals, which were welcomed by patients and their families.

Despite mental hospitals being the primary locus of care, a few other methods should be noted: home care, general hospitals admitting patients into psychiatry divisions, spa therapy for the upper class[85], private urban psychiatric clinics for short-term patients and some rare "community organisations for post-discharge care"[86] that were usually arranged by private charities and organisations. These mental health services were relatively rare, and asylums remained the most common mental health service in the nineteenth century and the first half of the twentieth century. Indeed, according to American sociologist George W. Dowdall, mental hospitals are "maximalist" institutions[87] that are resistant to change and have exceptionally lengthy lifespans, which may explain how they have withstood the passing of time for nearly two centuries.

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[81] Donnely, "History of Madness," 285.
[82] Scheid, Teresa L, and Eric R Wright. *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems.* Cambridge: Cambridge University Press, 2017, 408.
[83] Ibid.
[84] Shorter, Edward. "The Historical Development of Mental Health Services in Europe." *Mental health policy and practice across Europe* 15 (2006): 16–17.
[85] Shorter, Edward. "'Private Clinics in Central Europe' 1850–1933." *Social History of Medicine* 3, no. 2 (1990): 159–95. https://dx.doi.org/10.1093/shm/3.2.159.
[86] Shorter, "Historical Development,", 18.
[87] Dowdall, George W. *The Eclipse of the State Mental Hospital: Policy, Stigma, and Organization.* SUNY Press, 1996, 23.

4.2 The rise of mental health systems after the 1950s

The past century was characterised by the institutionalisation of mental health patients, but the middle of the twentieth century witnessed a transition for mental health services. Social insurance plans and the welfare state began including mental health treatments in the 1950s[88]. In addition, sociologist Erving Goffman argued persuasively against current psychiatric practices. He questioned the efficiency of asylums and private psychotherapy. In his view, asylums became "dumping grounds for people whom society could find no better way of helping"[89] and hospitals stigmatised, alienated, and demoralised patients.[90] Erving Goffman was one of the leading figures associated with the anti-psychiatry movement.[91] This movement's traditional beliefs held that madness was a form of protest against unfair social conditions, that psychiatry was social control disguised as "treatment," and that antipsychotic medications enforced conformity.[92] Furthermore, journalists, sociologists, Hollywood filmmakers, and even many psychiatrists tarnished the reputation of traditional mental hospitals.[93] As a result, the 1960s and 1970s were characterised by the anti-psychiatric movement[94], which led to the expansion of community-based care —the treatment of mental disorders outside of the mental hospital[95]— and the beginning of the deinstitutionalisation process. Deinstitutionalisation is defined by sociologist Leona Bachrach, who specialised in mental health services as "…the replacement of long-stay psychiatric hospitals with smaller, less isolated community-based service alternatives for the care of mentally individuals".[96] The United Kingdom was one of the first countries to introduce legislation to that effect; a deinstitutionalisation reform with the publication of the Mental Health Act of 1959, which emphasises community settings instead of mental health

[88] Shorter, "Historical Development,", 20
[89] Nolan, Peter. *A History of Mental Health Nursing.* Stanley Thornes, 2000, 15.
[90] Goffman, Erving. *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates.* Asylums: Essays on the Social Situations of Mental Patients and Other Inmates. Oxford, England: Doubleday (Anchor), 1961.
[91] Staub, Michael E. *Madness Is Civilization: When the Diagnosis Was Social, 1948 -1980.* University of Chicago Press, 2011, 3.
[92] Ibid.
[93] Scull, Andrew. *Madness: A Very Short Introduction.* OUP Oxford, 2011, 112.
[94] Majerus, Benoît. "Revisiting Psychiatry in Twentieth-Century Europe1." *European Review of History: Revue europeenne d'histoire* 15, no. 1 (2008): 61. https://dx.doi.org/10.1080/13507480701852720.
[95] Gijswijt-Hofstra, M., and R. Porter. *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands.* Brill, 2020, 20–22.
[96] Bachrach, Leona L. "Deinstitutionalisation: Promises, Problems And." *Mental health service evaluation* (1996): 4.

institutions.[97] Community-based care became a viable option due to the development of psychotropic drugs.[98] These drugs allowed community mental health centres to maintain patients in the community. With the shift from institutionalisation to community-based care, individuals with mental health problems could be customers rather than patients. Moreover, day care and outpatient services developed within mental health and general hospitals. For example, in Norway, in 1961, public plans were made to expand outpatient clinics.[99]

Another key element in the middle of the twentieth century, besides deinstitutionalisation, was the Member States taking a growing role in defining, managing, and operating a mental health system.[100] States started to encompass regulation of medical work and even define technical standards for medical work. [101]After the 1970s, there was a continuous growth of the community-based care settings as well, meaning that mental health teams were also based outside of hospitals and could replace unaffiliated psychiatrists and family doctors.[102] As a consequence, in the 1980s and 1990s, Europe witnessed the closure of many psychiatric hospitals – from 107 965 beds in the 1980s in Western Germany, for instance, to 60 000 in the 1990s[103] – and shorter stays at hospitals. This shift, also called "psychiatric reform" was complex. Becker and Vázquez-Barquero summarise the multiple implications of such a change in their article "The European Perspective of Psychiatric Reform":

> Psychiatric reform is not just about abolishing the old-fashioned psychiatric institutions but also concerns a number of issues such as: legislation, attitudes of society towards psychiatry, the choice of the scale of the catchment area for alternative facilities, the realisation of new facilities, the roles of other care suppliers such as the GP, the welfare sector, the general healthcare services, the balance and financing of the care, the fate of the patients coming from the old-fashioned institutions, the way to cope with the ever-increasing demand for psychiatric help and finally the actual quality of psychiatric help.[104]

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[97] Jones, Julia. "Mental Health Care Reforms in Britain and Italy since 1950: A Cross-National Comparative Study." *Health & Place* 6, no. 3 (2000): 174.

[98] Gronfein, William. "Psychotropic Drugs and the Origins of Deinstitutionalization." *Social Problems* 32, no. 5 (1985): 449. https://dx.doi.org/10.2307/800774.

[99] Ludvigsen, Kari, and Åsmund Arup Seip. "The Establishing of Norwegian Child Psychiatry: Ideas, Pioneers and Institutions." *History of Psychiatry* 20, no. 1 (2009): 16.

[100] Henckes, Nicolas. "Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis." *History of Psychiatry* 22, no. 2 (2011): 28.

[101] Ibid., 28–29.

[102] Shorter, Edward. "The Historical Development of Mental Health Services in Europe." *Mental health policy and practice across Europe* 15 (2006): 21–22.

[103] Ramon, S. *Mental Health in Europe: Ends, Beginnings and Rediscoveries.* Macmillan Education UK, 1996, 25–26.

[104] Becker, I., and J. L. Vázquez-Barquero. "The European Perspective of Psychiatric Reform." [In eng]. *Acta Psychiatr Scand Suppl*, no. 410 (2001): 8–14.

An implication of utmost importance for patients and policymakers was the question of human rights for people with mental health problems. Since 1979, the European Court of Human Rights (ECHR hereafter), has affirmed that some ECHR rights are relevant to mental health. For instance, Article 3 regards the prohibition of torture and inhuman and degrading treatment, Article 5 regards the right to liberty and security and Article 8 regards the right to respect for private and family life, home and correspondence. These three articles can therefore be related to protecting individuals from unwarranted and excessive detention and treatment.[105] Alongside these questions comes the right to administer medication to patients without their consent. In this context, the relevance of psychotropic drugs was questioned and alternatives were sought. All of these patterns appear to be slower in Eastern Europe, its history of totalitarianism has influenced "many areas of social and economic life, which also has to be taken into account in mental health policy".[106]

Since the 1970s, the focus of mental health services in Europe has been on managing and coordinating community-based care services and improving the application of human rights principles to mental health. Developing an inclusive, efficient, and cost-effective mental health system is crucial for every Member State at present.

4.3 Mental health in the EU since 2005

In January 2005, the fifty-two Member States of the WHO (World Health Organization) European Region gathered in Helsinki for the WHO European Ministerial Conference on Mental Health to address European mental health issues. They endorsed the WHO Declaration[107] and the Action Plan[108] for mental health. They also invited the European Commission to contribute to the implementation of a framework for the development of a comprehensive action plan concerning mental health and well-being. In response, the Health and Consumer Protectorate Director-General of the European Commission issued the *Green Paper* in October 2005 with the objective of sharing and debating with a wide variety of

[105] Stavert, Jill. "Mental Health, Community Care and Human Rights in Europe: Still an Incomplete Picture?". *International Journal of Mental Health and Capacity Law* 1 (09/08 2014): 182. https://doi.org/10.19164/ijmhcl.v1i16.214.

[106] Dlouhy, Martin. "Mental Health Policy in Eastern Europe: A Comparative Analysis of Seven Mental Health Systems." *BMC Health Services Research* 14, no. 1 (2014): 42. https://doi.org/10.1186/1472-6963-14-42.

[107] World Health Organization. *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions*. Helsinki, 2005, accessed 13/05/2022, https://www.euro.who.int/__data/assets/pdf_file/0008/88595/E85445.pdf

[108] World Health Organization. *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions*: World Health Organization, 2005.

interested actors to define a European strategy on mental health and set the main priorities.[109] This open consultation, which ended in May 2006, was a success. Responses were received from supranational, national, sub-national and multi-level stakeholders[110], including the WHO Regional Office for Europe, numerous state governments, the British Medical Association, and others. The 2005 *Green Paper*[111], one of the main sources of this dissertation, is therefore at the root of current EU action on mental health.

Following the positive reception of the *Green Paper*, the European Commission presented and launched in 2008 the *European Pact for Mental Health and Well-being*[112] at the EU high-level Conference Together for Mental Health and Well-being in Brussels.[113] The *European Pact* was considered by some quarters as a "major setback" since an EU-wide public strategy for mental health could have been expected after the *Green Paper* consultation.[114] Instead, the European Commission decided to focus on cooperation and coordination on key topics alongside the Member States and other stakeholders. The leap was not as big as anticipated, but it is significant that the *European Pact* demonstrated the realisation that "multi-sector dialogue and co-operation between stakeholders in both the public and private sectors"[115] is required and that the European Commission should play a major role in informing and encouraging actions.

The *European Pact* was followed by a three-year EU Joint Action on Mental Health and Well-being launched in 2013. The main issues that were tackled in this joint action were: mental health in the workplace; mental health and schools; depression, suicide, and eHealth; community-based approaches; and mental health in all policies (MHiAP)[116]. This strategy was defined as the promotion of mental health and well-being within different non-health public policy areas.[117] This joint action resulted in the 2016 Framework for Action on Mental

[109] Di Fiandra, Teresa. "European Strategies for Mental Health." *Annali dell'Istituto superiore di sanità* 45, no. 1 (2009): 54–58.
[110] Kelly, Brendan D. "The Emerging Mental Health Strategy of the European Union: A Multi-Level Work-in-Progress." *Health Policy* 85, no. 1 (2008): 65. https://dx.doi.org/10.1016/j.healthpol.2007.06.005.
[111] European Commission, *Green Paper*.
[112] European Commission. *European Pact for Mental Health and Well-Being*. Brussels, 2008, accessed 13/05/2022, https://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf.
[113] Di Fiandra, Teresa. "European Strategies for Mental Health." *Annali dell'Istituto superiore di sanità* 45, no. 1 (2009): 54–58.
[114] McDaid, David. "Mental Health Reform: Europe at the Cross-Roads." *Health Economics, Policy and Law* 3, no. 3 (2008): 219. https://doi.org/10.1017/S1744133108004520.
[115] McDaid, "Mental Health Reform," 220.
[116] Scholz, Nicole. "Spotlight on Mental Health in Europe.", accessed 13/05/2022, https://epthinktank.eu/2016/10/10/spotlight-on-mental-health-in-europe/.
[117] European Commission. *Joint Action on Mental Health and Well-Being: Mental Health in All Policies*, 2017, 4.

Health and Well-being[118], which provides Member-States with policy recommendations regarding mental health, the prevention and treatment of mental disorders, and multisectoral cooperation.[119] To support the implementation of these policies, the European Commission used the EU compass for action on mental health and well-being (2015-2018), a web tool designed to collect, exchange, and analyse information on policy and stakeholder activities regarding mental health.[120]

Mental health is also addressed through EU-financed projects such as CAMHEE (Child and adolescent mental health in the enlarged European Union) and Pathways (Participation in healthy workplaces and inclusive strategies in the work sector)[121] and more recently by the EU4Health programme, which was created in response to the coronavirus crisis and is the largest health programme to date in monetary terms (5.3 billion euros, 2021-2027).[122] However, the EU4Health initiative addresses broad health objectives such as improving and promoting health in the Union, combating cross-border health threats, improving medical products, and strengthening health systems, their resilience, and resource efficiency.[123] Mental health is merely one aspect of it.

Since the publication of the *European Framework*[124] in 2016, no European mental health strategy has been published. Mental health is included in the EC topic "Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases" and is therefore not considered as a distinct issue. Some members of the European Parliament have joined together to promote mental health. Examples include the Coalition for Mental Health and Well-being established in 2012 by Mental Health Europe and the MEP Alliance for Mental Health established in 2009.[125] In the European Parliament's resolution of July 20, 2020, on the EU's public health strategy post-COVID-19, the European Parliament called for an "EU Action Plan 2021–2027 on mental health, with equal attention being paid to the

[118] European Commission, *European Framework.*
[119] OECD, and European Union. *Health at a Glance: Europe 2018.* (2018): 32.
[120] "Eu-Compass for Action on Mental Health and Well-Being." accessed 26/02/2022, https://ec.europa.eu/health/non-communicable-diseases/mental-health/eu-compass-action-mental-health-and-well-being_en.
[121] Scholz, "Spotlight."
[122] "Eu4health 2021-2027 – a Vision for a Healthier European Union." accessed 26/04/2022, https://ec.europa.eu/health/funding/eu4health-2021-2027-vision-healthier-european-union_en.
[123] "Eu4health 2021-2027 – a Vision for a Healthier European Union." accessed 26/04/2022, https://ec.europa.eu/health/funding/eu4health-2021-2027-vision-healthier-european-union_en.
[124] European Commission, *European Framework.*
[125] "What Is the EU Doing to Support Good Mental Health?", accessed 26/04/2022, https://epthinktank.eu/2021/10/06/what-is-the-eu-doing-to-support-good-mental-health/.

biomedical and psychosocial factors of ill mental health".[126] Mental health is consequently a relevant topic for the European Union. In the following chapter of this thesis, I will examine how the EU discourse represents mental health and what its objectives and goals are for the mental health of European citizens.

[126] "European Parliament Resolution of 10 July 2020 on the Eu's Public Health Strategy Post-Covid-19 (2020/2691(Rsp))." accessed 26/04/2022, https://www.europarl.europa.eu/doceo/document/TA-9-2020-0205_EN.html.

5 Analysis

Following the methodological and theoretical frameworks outlined in chapters two and three, this chapter will thematically present the key findings and data analysis. The purpose of the analysis is to highlight the European Union's objectives and goals regarding European citizens' mental health, as well as examine their discursive representations. The analysis will focus first on the discursive depictions of mental health as a recent priority, followed by the representations of positive and holistic visions of mental health, the discursive articulations of health as a right, and finally, the manifestations of multiple actors leading to multiple stakeholders within mental health policies.

5.1 Mental health as a recent priority

Mental health has been depicted in the official EU discourse as a long-standing socio-political priority. On the European Commission's official website, it is mentioned that "the European Commission **has long been dedicated** to improving the mental health".[127] Additionally, in the *European Framework for Action on Mental Health and Well-being,* it is noted that "the need to include mental health among the first priorities of the public health agenda has been increasingly recognized in Europe **over the past decades**".[128] The EC places an emphasis on the duration since they started to set mental health as a priority. This could be explained by the fact that the EU wanted to articulate, on a supranational level, mental health under a "positive image" and as a "long-lasting process"; concepts that were elaborated previously in the theoretical background of this thesis. The EU is discursively trying to give a certain sense of stability and continuity while expressing its own agenda and work regarding mental health issues. This long-lasting and steady perspective indicates a holistic view of mental health and a discourse on mental health that is similar to the understanding of a general state of public well–being, as previously described by the analyst Heather Gilmour.[129] Another interpretation of the discourse, articulated in the analysed documents, and depicting mental health as a long-lasting, holistic priority, could be that the EU doesn't want the readers to be aware of the lack of past measures and agencies regarding European mental health and well-being. In other words, the fact that mental health has been

[127] "Mental Health." accessed 26/04/2022, https://ec.europa.eu/health/non-communicable-diseases/mental-health_en.
[128] European Commission, *European Framework*, 4.
[129] Gilmour, "Positive Mental Health," 4.

neglected for a long time, and has been almost invisible on the EU's political agenda until recently[130], is discursively downplayed. There were no EU policies solely dedicated to mental health before the *Green Paper* that was published in 2005. In 2006, there was no organisational unit devoted to mental health either in the EC's services or at the European Centre for Disease Control[131].

This is still the case in today's European Union, where mental health policies belong to the sub-section named "Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases" of the section "Non-communicable Diseases" within the European Commission. Particular emphasis on mental health diseases is absent from the official list of topics highlighted on the webpage of the "European Centre for Disease Control"[132]. Thus, the EU started quite recently to implement mental health policies within the European Commission's official strategies. However, in the analysed documents, published from the year 2005 onwards, mental health has clearly been noted as a socio-political priority. Since the *Green Paper*[133], this emphasis has been discursively visible, as shown by the presence of the *nodal point* of *necessity*. As stated previously, *nodal points* have been commonly used within discourse analysis methodologies. Thomas Diez illustrates this point clearly, arguing that a discursive *nodal point* approach is an asset in discourse analysis, particularly in studies of European governance.[134] The discursive signs shaping a *chain of equivalence* focusing around the word *necessity* in the *Green Paper* are: priorities, need, important, major, required, and prominent. Since 2005, the *nodal point* of *necessity* has confirmed the importance and priority of mental health in the EU discourse. It is seen as a need for all Europeans.

Another manifestation of the EU's commitment to prioritising mental health measures is the foregrounding that we can observe in the *European Pact*:

> **We agree that:**
>
> - There is a **need** for a decisive political step to make mental health and well-being a key priority.

[130] Braddick, F., A. Gabilondo, D. McDaid, G. Lang, C. O'Sullivan, and K. Wahlbeck. "European Pact for Mental Health and Well-being." *Die Psychiatrie* 07, no. 02 (2010): 75. https://dx.doi.org/10.1055/s-0038-1669590.

[131] Wahlbeck, Kristian, and Vappu Taipale. "Europe's Mental Health Strategy." *BMJ* 333, no. 7561 (2006): 211. https://dx.doi.org/10.1136/bmj.333.7561.210.

[132] "All Topics: A to Z." 2022, accessed 10/05/2022, https://www.ecdc.europa.eu/en/all-topics.

[133] European Commission, *Green Paper*.

[134] Diez, Thomas. "Europe as a Discursive Battleground." *Cooperation and Conflict* 36, no. 1 (2001): 16–19. https://dx.doi.org/10.1177/00108360121962245.

- Action for mental health and well-being at the EU level **needs** to be developed by involving the relevant policymakers and stakeholders, including those from the health, education, social and justice sectors, social partners, as well as civil society organisations.
- People who have experienced mental health problems have valuable expertise and **need** to play an active role in planning and implementing actions.
- The mental health and well-being of citizens and groups, including all age groups, different genders, ethnic origins and socioeconomic groups, **needs** to be promoted based on targeted interventions that take into account and are sensitive to the diversity of the European population.
- There is a **need** to improve the knowledge base on mental health: by collecting data on the state of mental health in the population and by commissioning research into the epidemiology, causes, determinants and implications of mental health and ill-health, and the possibilities for interventions and best practices in and outside the health and social sectors.[135]

The frequent use of the word "need" manifests the strong will of the European Union to make mental health a key priority. This need discursively appears as urgent and necessary due to the foregrounding created by the repetition of the aforementioned word "need". In addition of this point, the title of the above-quoted column is "we agree that", which is a presupposition. The need to prioritise mental health therefore appears as if it was taken for granted; as if there was no other alternative. According to a discourse analysis, the analysed material manifests the discursive development and increased willingness to place mental health on the supranational political agenda. We can feel that the EU projects (conscientiously or not) a feeling of guilt about the lack of actions toward public mental health in the past. The EU is eager to present its past actions in the analysed documents and in particular in the *Council Conclusions on 'the European Pact for Mental Health and Well-Being: Results and Future Action'*.[136] The first conclusion explains the relevance of the EU in mental health policies, and the seven following conclusions of the Council of the European Union start with "recalls". These seven points present seven past actions (conferences, strategies, and policies) organised or launched by the EU to tackle mental health problems and promote general well-being. The analysis shows that a European discursive priority on mental health is accompanied by factual political activities to a limited degree. The policies on mental health as well as funding for mental health services have been generally small in the past decades[137] and as mentioned previously, mental health still does not have its own organisational unit within the European Commission. The intricacy of mental health issues,

[135] European Commission, *European Pact*, 3.

[136] Council of the European Union. *Council Conclusions on 'the European Pact for Mental Health and Well-Being: Results and Future Action'*. Luxembourg 2011, accessed 13/05/2022, https://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/122389.pdf

[137] Knapp, Martin, David McDaid, and Elias Mossialos. *Mental Health Policy and Practice across Europe.* McGraw-Hill Education (UK), 2006, 3.

as discussed in previous sections by the scholar George E. Vaillant, may be one factor. A lack of concrete decision-making and funding from the European Union or insufficient interest and policies from the Member States might also be a contributing factor. According to the EU discourse, it is not the EU that has delayed and is now delaying tangible measures and policies. At the supranational level, much is occurring, but it is assumed that these decisions and strategies are not reflected at the Member States' level.

In summary, mental health policies have been high priority goals and objectives in the EU discourse ever since they were first exposed in the *Green Paper*, yet the actions that supposedly should come next are still very limited. One possible explanation is the complexity of mental health; its definition itself is multi-faceted, and the visions of mental health understood in the European discourse will be examined below.

5.2 Holistic and positive visions of mental health

The following topics will be discussed in this section: Firstly, the vocabulary used in association with mental health in the EU discourse will be scrutinised, and secondly, the content and objectives of the analysed discourse will be studied.

5.2.1 Vocabulary in use

"Mental health" is mentioned, unsurprisingly, a staggering number of times in the chosen EU documents. In the *Green Paper* dating back to the year of 2005, the terms "mental health" and "mental ill-health" are defined and used. Mental health is described in that document, as "a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[138] The terms "mental health" and "well-being" are both mentioned extensively, one interacting with the other. The EC's understandings and definitions correspond to the idea of a *positive mental health* elaborated academically by Marie Jahoda[139] and Heather Gilmour[140]. The social psychologist, Marie Jahoda, argued that mental health constitutes a complex enumeration of several factors, opposing the common definition of being mentally healthy as the absence of mental illness. In the definition given by the EC, mental health is also defined with the help of an enumeration of factors. I believe

[138] European Commission, *Green Paper*, 4.
[139] Jahoda, "Current Concepts," chap. 3.
[140] Gilmour, "Positive Mental Health."

that the EU, thanks to this articulation of foregrounding, emphasises the complexity of mental health and seems to hold the same understanding of mental health as elaborated by Marie Jahoda. The EU additionally conveys a discursive agreement with a vision of *positive mental health.* The use of adverbs such as "productively" and "fruitfully" indicates a positive outlook Additionally, it implies that mental health encompasses more than a feeling of average well-being or the absence of illnesses. The European Commission discursively manifests that being mentally healthy is a state of general well-being. This vision seems to be compatible with the concept of *positive mental health* described by Heather Gilmour. According to her, complete mental health means "both flourishing and being free of mental illness". [141] The EU's definition of mental health follows an understanding of mental health as *holistic* and *positive*, similarly to the theoretical definitions of Marie Jahoda and Heather Gilmour.

The European Union appears to want to include "well-being" and positive connotation to the word "mental health" in its discourse, but does not deny that mental health may have a detrimental impact on individuals, associating it with the term "mental ill-health" in such cases. Mental ill-health is connected to the so-called *negative mental health theory* mentioned in the theory chapter (section 2.2). It is a mental health defined solely under the angle of mental disorders, symptoms and problems. *Positive mental health* is a recent approach, hence why in the first chronological analysed document, the *Green Paper*, there is very little mention of "well-being". It is only alluded to in the definition of mental health and nowhere else throughout the whole document. This approach is however strengthened in the next years given that all the analysed documents published from 2008[142] mention abundantly "well-being" to be in connection to mental health. To be accurate, it is discursively referred to as "mental health and well-being" the two concepts are frequently articulated as interrelated. On the Mental health page of the European Commission's webpage[143], it is explicitly stated that "mental health and well-being are interlinked issues". The EU is looking for an approach that is not only referring to public health matters, but also to a role of prevention and nurturing, as seen by the increasing focus on general well-being and *positive mental health*. In the latest document under study in this thesis[144], "positive

[141] Gilmour, "Positive Mental Health." 4.
[142] European Commission, *European Pact*.; Council of the European Union, *Council Conclusions*.; European Commission, *European Framework*.
[143] "Mental Health." accessed 26/04/2022, https://ec.europa.eu/health/non-communicable-diseases/mental-health_en.
[144] European Commission, *European Framework*.

mental health and well-being"[145] is mentioned clearly. The vocabulary used effectively sums up the long-lasting and holistic visions of mental health as agreed upon by the aforementioned positive mental health theories, demonstrating how the European Union articulates its own goals and objectives.

5.2.2 Content and objectives

If the vocabulary used denotes a holistic and positive representation of mental health, the analysis of the content and objectives of EU mental health policies qualifies their preferred mental health interpretation. In the *Green Paper*, set to implement the basis of EU mental health policy, the areas of focus were promising:

1) Promote the mental health of all;

2) Address mental ill health through preventive action;

3) Improve the quality of life of people with mental ill-health or disability through social inclusion and the protection of their rights and dignity;

4) Develop a mental health information, research and knowledge system for the EU.[146]

Promoting, preventing, improving and informing are all actions in line with a positive definition of mental health in which mental health policies should contribute to well-being and not only focus on people with illnesses. However, as mentioned in section 4.3, a strategy was not implemented following this *Green Paper*. Instead, the EC focused on building consensus among the Member States, and published the *European Pact* in 2008.[147] In the aforesaid pact, five priorities are established: prevention of depression and suicide; mental health in youth and education; mental health in workplace settings; mental health of older people and combating stigma and social exclusion. The announcement of depression, suicide, and stigma as the primary topics appears to imply a shift in their mental health approach. Few references are made to long-lasting and holistic mental health, and well-being appears to be entirely absent from the major issues. For Kristian Wahlbeck, a research professor and psychiatrist "It seems that the EC mental health agenda has gradually moved from the public health arena into the arena of mental disorders".[148]

[145] European Commission, *European Framework, 4*.
[146] European Commission, *Green Paper*, 8.
[147] McDaid, "Mental Health Reform," 219.
[148] Wahlbeck, K. "European Mental Health Policy Should Target Everybody." *The European Journal of Public Health* 21, no. 5 (2011): 552. https://dx.doi.org/10.1093/eurpub/ckr122.

5.3 Health as a right

Health is a human right and as demonstrated in the theoretical chapter of this thesis, mental health policies should be understood as connected to the right to health and therefore to human rights. Following this line of reasoning, the European discourse refers to human rights in every document analysed in this study. “Mental health is a human right” is stated as a strong affirmation in the *European Pact*[149] and in the *European Framework.*[150] In his influential study “Aims of Critical Discourse Analysis”, Teun A. van Dijk posits that powerful speakers influence mental model structures.[151] When the EU states that mental health is a human right at the beginning of two EU mental health policy documents, it shows a power relation that is performed through the European discourse. The European Union as an international and influential political entity, discursively articulates a message that is presented as fact, “mental health is a human right”. According to van Dijk’s theory, this articulation could influence, reaffirm, or change, the opinions and beliefs of the recipients. This statement, in my opinion, causes recipients to assume that the EU respects mental health as a human right and is willing to adopt concrete measures to defend human rights ideals. However, although the EU discursively connects mental health and human rights, several important features of human rights appear to be missing in its mental health discourse.

In the four documents analysed herein, human rights are mentioned, but always in a brief or vague manner. Applying human rights principles to mental health policy is a real challenge to which the European Union does not appear fully committed, judging by the content and language used within the analysed documents. In the scrutinised EU discourse, providing community care and informing the population to avoid stigma and misrepresentations of people with mental health illnesses are topics which are represented. Nevertheless, there is scarce mention of circumstances justifying compulsory care and treatments, or of safeguarding the human rights of individuals receiving care in psychiatric facilities. In the *Green Paper*, it is written that the Council of Europe will initiate work on a “European reference tool for ethics and human rights in mental health”[152] in 2006. It is also stated that the project entitled "Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States" demonstrated the need for

[149] European Commission, *European Pact*, 2.
[150] European Commission, *European Framework*, 4.
[151] Van Dijk, Teun A. "Aims of Critical Discourse Analysis." *Japanese discourse* 1, no. 1 (1995): 21–24.
[152] European Commission, *Green Paper*, 11.

homogenisation of the EU legal framework regarding compulsory admissions. After the *Green Paper*[153], representing the true starting point of the EU mental health policy, one could expect some new elements in the forthcoming policy documents concerning compulsory care, treatments, and safeguarding of the human rights of individuals receiving care in psychiatric facilities.

Almost two decades after the publication of the *Green Paper* in 2005, very few references are made in the subsequent documents, most of them referring to international organisation texts. In the *European Pact*, the only mention is of the "United Nations Convention on the Rights of Persons with Disabilities"[154]. In the *European Framework*, it is said that legislation should be developed and updated according to the "WHO Mental Health Plans and the Convention on the Rights of People with Disabilities".[155] Thus, the EU refers to worldwide organisations every time the topic of human rights is mentioned, which brings our attention to two elements. The first element is that the European Union bases and supports its decisions and policies on the advice of specialised NGOs, as specified in the cited article of the Treaty of Amsterdam (section 1.2).[156] This way of working is officially stated in an international and recognised treaty. It is therefore articulated coherently and clearly. However, from the perspective of discourse analysis, it appears as if the EU cedes its institutional power on the matter to the WHO and the UN. Mentioning an entity that appears to be more knowledgeable than the EU on the topic of human rights confirms the fact that the EU is not itself actively producing any particular and independent policy. The second element, backgrounding, reveals one facet of the EU discourse's rhetorical strategy. Backgrounding is illustrated by the omission of human rights measures in the analysed documents. Human rights are exclusively mentioned in relation to international organisations. The usefulness of the omission strategy is highlighted *i*n the sixth chapter of *Functional Approaches to Written Text: Classroom Application.*[157] An omission is the ultimate backgrounding strategy for pulling the recipient's attention away from something specific.[158] It is difficult to raise concerns about a missing component. The EU discourse emphasises its desire for readers to be unaware of European human rights measures in connection to mental health.

[153] European Commission, *Green Paper*.
[154] European Commission, *European Pact*, 6.
[155] European Commission, *European Framework*, 19.
[156] European Union, *Treaty of Amsterdam.*
[157] Huckin, "Critical Discourse," 87–92.
[158] Ibid., 91.

The Council of Europe has recently been put under the spotlight for their harm to human rights in the mental health sector. In 2014, the Council of Europe and its Committee of Bioethics (DH-BIO) began working on legislation regulating Compulsory Admission and Involuntary Treatment of Mentally Ill Patients in a document called the "Draft Additional Protocol concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment" shortened into "Draft Additional Protocol to the Oviedo Convention". This initiative has been strongly criticised by organisations representing people with disabilities, the UN Committee on the Rights of Persons with Disabilities, the UN special rapporteurs on health and disability, and the Council of Europe's own Parliamentary Assembly, and by the Commissioner for Human Rights.[159] The controversy stems from the fact that this draft protocol undermines the rights of people with disabilities and it is not aligned with a human rights approach as defined in the UN Convention on the Rights of Persons with Disabilities (2008).[160] This draft allows involuntary admissions for therapeutic purpose and a risk of harm and electroconvulsive therapy for instance. Helena Dalli, the Commissioner for equality on behalf of the European Commission, stated that:

> The EU is not a party to the Oviedo Convention. As a party to the UN Convention on the Rights of Persons with Disabilities (UNCRPD), and in line with its competences, the EU is engaged in ensuring and promoting the human rights and fundamental freedoms of all persons with disabilities, including those with intellectual and psychosocial disabilities and mental health problems, without discrimination of any kind.[161]

The EU distances itself from the Council of Europe and strengthens once again its connection to the UN, an international organisation. The analysed discourse demonstrates a vision of mental health policies connected to human rights as described in the theory chapter of this thesis (cf. chapter 2): mental health cannot be separated from the right to health and other necessary human rights.

In summary, while the EU discourse manifests support for a human rights-based approach to mental health, it does not appear to be taking the appropriate steps to reform its human rights policies. This could be explained by the task's complexity, which stems from the multiple factors that affect mental health. The following section will examine the EU

[159] "Council of Europe: A Threat to Rights of People with Disabilities." 2018, accessed 16/04/2022, https://www.hrw.org/news/2018/11/21/council-europe-threat-rights-people-disabilities.
[160] "#WithdrawOviedo." 2022, accessed 16/04/2022, https://www.withdrawoviedo.info/join.
[161] "Parliamentary Questions", 2022, accessed 16/04/2022, https://www.europarl.europa.eu/doceo/document/E-9-2022-000023-ASW_EN.html.

discourse on the involvement of numerous factors—detailed below—in mental health and, as a result, the necessity for a multi-stakeholder approach.

5.4 Multiple factors resulting in multiple stakeholders

The right to health is affected by multiple policy areas, as mentioned by the economist and philosopher Amartya Sen in the theoretical chapter of this thesis (section 2.3). He claims that "political, social, economic, scientific, and cultural actions"[162] may be taken to support the goal of universal good health. The reason for those manifold stakeholders is that mental health relies on a multiplicity of factors that are not only related to health care. In this section, the EU discourse in relation to multiple factors and actors will be analysed.

The totality of documents under study places an emphasis on a variety of factors specific to mental health. The following *chain of equivalence* was identified in these (excluding the *European Pact*[163]): multiplicity of factors[164], multifactorial[165], several further aspects.[166] This finding denotes the presence of the *nodal point* of *multiplicity* that exacerbates the holistic vision of mental health. As previously stated, mental health is seen by the EU as a positive and fulfilling mental health that goes beyond the absence of mental illness. This definition embodies an ultimate state of well-being in different areas of life meaning that mental health is influenced by numerous factors that therefore lead to the need for multiple actors. In the *European Pact for Mental Health and Well-being*, a *chain of equivalence* was not found but an enumeration foregrounding the multiple actors was present:

> Action for mental health and well-being at EU-level needs to be developed by involving the relevant policy makers and stakeholders, including those from the health, education, social and justice sectors, social partners, as well as civil society organisations.[167]

The long enumeration mentioning six relevant actors increases the number of actors needed to develop action for mental health at the EU level. This amplification could be interpreted as a need for time due to the complex coordination that the EU mental health policy requires. The multiplicity of actors required for mental health policy was mentioned as early as in the *Green Paper*: "Such an approach **should** involve many actors, including health and non-health policy sectors and stakeholders whose decisions impact on the mental health of the

[162] Sen, "Why and How Is Health a Human Right?," 2010.
[163] European Commission, *European Pact*.
[164] European Commission, *Green Paper*, 4.
[165] Council of the European Union, *Council Conclusions*, 3.
[166] European Commission, *European Framework*, 13.
[167] European Commission, *European Pact*, 3.

population. Patient organisations and civil society **should** play a prominent role in building solutions."[168] The modality "should" used twice evokes the notion of desirability. The modal "should" is flexible enough that it can take on the meaning of moral obligation as well as a piece of advice depending on the context[169]. This is relevant because in my opinion even though the EU is stating what is desirable — the *Green Paper* is after all a document made to gather suggestions for the future of the EU mental health policy — the fact that the EU is a powerful speaker influences mental model structures.[170] This representation is therefore discursively influencing its recipients into acknowledging the need for several actors to be involved in mental health policies. We can read another discursive representation emphasising the need for many actors on the European Commission's official website:

> Mental health **is influenced by** many factors, including genetic predisposition, socio-economic background, adverse childhood experiences, chronic medical conditions or abuse of alcohol or drugs. Mental health and well-being are interlinked issues that **are affected by** policies and actions in a range of sectors, including education, health, employment, social inclusion and efforts to tackle poverty.[171]

The study of transitivity is relevant considering that this extract contains the link between both factors and actors within mental health policies. The use of passive voice allows the reader to have in mind the most important concept of "mental health" and to be able to link it with the various factors. If it were an active voice, then the reader would not be able to think of the correlation until the end of the sentence which would be confusing. However, according to a discourse analysis, another reason for the use of the passive voice can be recognised. In the early work of the East Anglian School, it was established that it was no coincidence if the authors of formal documents tended to use nominalisation and passivisation; the passive voice assisted to perpetuate uneven power relationships.[172] In this light, one may claim that mental health is in a vulnerable position and is affected by a variety of factors. Mental health is regarded as weak since it is influenced by several powerful policies and other factors. The EU discourse emphasises its responsibility as a powerful actor to prioritise the mental health of its citizens. Nonetheless, this responsibility is not simple, as several sectors are included.

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[168] European Commission, *Green Paper*, 5.
[169] Coates, Jennifer. *The Semantics of the Modal Auxiliaries.* Routledge, 1983, 247.
[170] Van Dijk, Teun A. "Aims of Critical Discourse Analysis." *Japanese discourse* 1, no. 1 (1995): 21–24.
[171] "Mental Health." accessed 26/04/2022, https://ec.europa.eu/health/non-communicable-diseases/mental-health_en.
[172] Billig, Michael. "The Language of Critical Discourse Analysis: The Case of Nominalization." *Discourse & Society* 19, no. 6 (2008): 786.

This difficulty can be evaluated through the concept of contextualization. David McDaid points out that the analysis of funding within mental health has been focused on actions taken in the healthcare system, which overlooks the contribution of other sectors.[173] This is highly problematic due to the mental health sector being inextricably related to other domains, in reason of the extensive reach of a *positive mental health* as envisioned by Jahoda in the theoretical chapter of this thesis (section 2.1). Diverse mental health strategies at both the supranational and Member States levels must target their actions at a multitude of sectors, not only the health sector. In light of this objective, the European Commission included a Mental Health in All Policies (MHiAP) strategy in the *European Framework*. MHiAP is a derived notion from Health in all Policies (HIAP). Health in All Policies has been defined as such:

> An approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.[174]

This approach promotes the discursively emphasised intersectoral aspect of mental health in European discourse. One could expect this new "way of working"[175] to be central in the mental health European discourse given the connection to the EU discourse. However, in the *European Framework*, only two implemented EU-level activities related to MHiAP are stated. It is said that mental health is a priority for EU health policy and that there is an "informal interservice group" [176] to promote collaboration between policy areas. The first activity is only marginally relevant, as the fact that mental health is a priority does not tell us of any concrete MHiAP measures implemented in the Member States. The second activity is even qualified by the EC itself as "informal". The readers might wonder why the EU has opted – even temporarily, for an "informal" solution. Assumptions can be made with the aid of contextualization. Member states have criticised the EU's participation in sectors outside of the health sector for creating new EU competencies.[177] Health systems are large

[173] McDaid, "Mental Health Reform," 225.
[174] "Helsinki Statement on Health in All Policies." accessed 05/05/2022, https://apps.who.int/iris/bitstream/handle/10665/112636/9789241506908_eng.pdf.
[175] Godziewski, Charlotte. "Is 'Health in All Policies' Everybody's Responsibility? Discourses of Multistakeholderism and the Lifestyle Drift Phenomenon." *Critical Policy Studies* 15, no. 2 (2021): 232. https://dx.doi.org/10.1080/19460171.2020.1795699.
[176] European Commission, *European Framework*, 16.
[177] Greer, Scott L. "Uninvited Europeanization: Neofunctionalism and the EU in Health Policy." *Journal of European Public Policy* 13, no. 1 (2006): 138-140. https://dx.doi.org/10.1080/13501760500380783.

organisations that require monetary, material, and human resources[178] and all of these factors may be subject to EU legislation.[179] Therefore, the spread of MHiAP may pose a threat to the Member States. The representative from the Scottish Executive Health Department even claimed: "We're sitting on the tracks, watching the EU coming at us, and thinking about doing something"[180] confirming the feeling of threat felt by some Member States. Consequently, the multisectoral stakes of mental health policies provide a challenge for the European Union.

As discursively represented, it is admitted that many actors and sectors have to be involved in a comprehensive and efficient mental health policy, at a supranational and national level. In *Mental health policy and practice across Europe*, Martin Knapp, David McDaid, and Elias Mossialos clearly illustrate this strenuous challenge. Mental health policies will require the involvement of several actors, including individuals, organisations and government sectors, in addition to service users and their families, mental health professionals, mental health non-governmental organisations (NGOs) and the health ministry.[181] It will also require the participation of various government sectors, including social welfare, housing, education, employment, and social security.[182] This might lead to conflicts such as an "Uninvited Europeanization"[183], the need for appropriate expertise to cooperate across the various actors and levels, as well as the difficult task of breaking down mental health funding between sectors.[184]

[178] Greer, "Uninvited Europeanization," 135.
[179]Ibid.
[180] Scottish Executive Health Department official. 2002.
[181] Knapp, McDaid and Mossialos, *Mental Health Policy*, 317.
[182] Ibid.
[183] Greer, "Uninvited Europeanization," 138-140.
[184] McDaid, "Mental Health Reform: Europe at the Cross-Roads," 225.

6 Conclusion

In the present thesis, I examined the EU discourse since 2005 on mental health, using a relevant discourse analysis methodology. The analytical emphasis was on the statements and strategies defined primarily by the European Commission. The study was also guided by relevant theoretical perspectives and tools pertaining to mental health and human rights in the European Union. The thesis aimed to answer the following questions:

1. What are the main objectives and goals of the European Union concerning the mental health of European citizens?
2. How have these goals and objectives been discursively articulated?

The main analytical findings from the conducted study are as follows:

Firstly, mental health has been discursively represented as a socio-political priority in the EU discourse, particularly since the publication of the *Green Paper* in 2005. The *nodal point* of *necessity* articulated in the analysed EU documents demonstrates this emphasis. In addition, this priority has been identified in the foregrounding techniques used in the discourse.

Secondly, mental health in the European Union discourse is regarded as a human right and understood as a *positive mental health* interconnected with the notion of general well-being. This understanding of mental health and well-being embodies a holistic approach and consistently places a focus on several aspects of well-being as opposed to focusing exclusively on mental illnesses. This suggests that the EU has an objective of implementing preventive strategies and nurturing *positive mental health*.

Thirdly, the EU discourse emphasises the necessity of a multisectoral strategy at both the supranational and national levels for the success of mental health initiatives. The European Commission aspires to a "Mental Health in All Policies" (MHiAP) approach to promote collaboration between policy areas. Nevertheless, multisectoral strategy involves a variety of actors and sectors that may threaten Member States' responsibility for organising and delivering their own health services and medical care. In other words, there is a risk of tensions between the supranational and national levels.

Lastly, analysing EU mental health documents through a discourse analysis reveals a duality of positions regarding the power and legitimacy of the European Union mental health

strategy. A self-awareness of the EU's limited role in human (mental) health, as outlined in Article 152 of the "Treaty of Amsterdam,"[185] is apparent in the discourse under study. However, since disruptions in healthcare systems across Europe contribute to the decline in mental health, it is acknowledged by the European Commission that urgent action is needed, both at supranational and national levels.

Despite mental health policies being represented as high-priority goals and objectives in the EU discourse, the ensuing measures are still quite modest. The European Parliament has explicitly mentioned the necessity of a comprehensive European mental health strategy[186], but there has been a lack of further concretisation from the European Commission since the publication of the *Green Paper*. According to the studied discourse, this lack of response may be related to insufficient Member States interests and policies or to the complexity of mental health policies. Given the multisectoral involvements and various discourses across the countries of the European Union, establishing a unified European mental health policy is indeed a strenuous task. Presumably, the lack of clarity regarding the EU's supranational scope, role, and power in public health action is also a factor in the absence of conclusive measures to publish a Pan-European mental health strategy.

In future research, the analysis might be extended to the future development of the EU discourse regarding mental health to observe if mental health will continue to be articulated as a priority and presented *positively.* A regressive approach to mental health, reorienting the focus back to mental illnesses, could indicate a willingness to retreat from the articulation and creation of a common European mental health strategy while simultaneously emphasising the importance of Member States.

[185] European Union, *Treaty of Amsterdam.*
[186] "Parliamentary Questions." 2022, accessed 16/04/2022, https://www.europarl.europa.eu/doceo/document/E-9-2022-000023-ASW_EN.html.

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