THE MISSING LINK

COORDINATED GOVERNMENT ACTION ON MENTAL HEALTH

AMNESTY INTERNATIONAL

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Amnesty International Ireland,
Ballast House,
First Floor,
18 - 21
Westmoreland Street,
Dublin 2
www.amnesty.ie

Graphic design and art direction by
swollen.ie
Photography by studioseventyseven

CONTENTS

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH

4 **FOREWORD**

5 **EXECUTIVE SUMMARY**

6 **INTRODUCTION**
12 Introduction to the report
13 The costs to individuals and society of mental health problems

17 **HUMAN RIGHTS AND INTERNATIONAL GOOD PRACTICE**
18 The human rights basis for interdepartmental action on mental health
23 International guidance on an interdepartmental approach to mental health
25 International examples of good practice

33 **THE IRISH CONTEXT**
34 The Irish context for interdepartmental action
34 The Office for Disability and Mental Health
35 The National Office for Suicide Prevention
35 The Independent Monitoring Group
36 A Vision for Change
40 The National Economic and Social Forum's social inclusion report
42 The National Disability Strategy
45 The gaps left in the National Disability Strategy in relation to mental health
46 The Mental Health Commission Quality Framework
47 A sample of policy recommendations from people with mental health problems
48 Gaps in interdepartmental action
53 Irish examples of interdepartmental practice

61 **CONCLUSION AND RECOMMENDATIONS**
62 Recommendations for the whole of Government
64 Priority actions for individual departments
66 Conclusion

69 **ENDNOTES**

FOREWORD

We are delighted to have been invited to steer, advise and be a part of Amnesty International Ireland's current campaign which views mental health as a human rights issue. We have a vision of a society that respects differences and where people can be proud to be themselves.

We think everyone should be treated with dignity and respect. We are not asking for anything more than for the human rights of people experiencing mental health problems to be respected. For everyone to be given a choice in relation to treatment and support to challenge in a positive manner the predominant medical model. We want a system that supports everyone's right to housing, employment and education – all essential to recovery and well-being.

EXPERTS BY EXPERIENCE ADVISORY GROUP
Liz Brosnan, John McCarthy, Paddy McGowan, Caroline McGuigan, Colette Nolan, Maeve O'Sullivan, John Redican, Diarmuid Ring, Jim Walsh, Mike Watts

EXECUTIVE SUMMARY

Amnesty International Ireland (AI) is campaigning to ensure that all people in Ireland have their right to the highest possible standard of mental health fulfilled. This right is not limited to mental health services but extends to what are known as the underlying determinants of health, such as housing, employment, social security and education. This report sets out why coordinated, interdepartmental action is necessary in order to implement the recommendations in *A Vision for Change,* the Government's national mental health policy, and realise individuals' human rights.

In Ireland, there is increasing evidence that people living with mental health problems experience social exclusion. Those who have a mental health disability participate in the labour force at a much lower rate than the general population. They are also more likely to have left their job and to have stopped education because of their mental health problems than people with other disabilities. People with mental health problems are the most stigmatised of any disability group, with many avoiding fully participating in society because of how others will react. It is not only appropriate services that are important to people with mental health problems but also other crucial supports and rights. Galway service users highlighted that employment and long-term appropriate accommodation are important to them[1], while teenagers have highlighted how the school environment, social spaces for young people and reform of the exam system are important for supporting mental health.[2]

Everyone with experience of a mental health problem should enjoy the same rights to housing, employment, social security, education and cultural life on an equal basis with others. These rights have been affirmed in particular for individuals disabled by reason of a mental health problem through the UN Convention on the Rights of Persons with Disabilities that the Irish Government has signed but not yet ratified.

International good practice guidance makes clear that mental health should be an interdepartmental concern. The World Health Organisation (WHO) has stated that mental health is an intersectoral issue requiring the involvement of the education, employment, housing and social services sectors, as well as the criminal justice system[3]. The EU's Mental Health Pact sets out that action on mental health should include relevant policymakers and stakeholders, including those from the health, education, social and justice sectors[4]. This approach is

well reflected in national mental health plans in England and Scotland as in plans published by the Finnish and American governments. In each of these countries, governments have brought together a range of departments and agencies in addition to health in order to develop mental health action plans. All have planned specific actions on employment and education. In England, this has resulted in a set of actions on mental health and social inclusion that addressed access to welfare benefits, education and housing as well as a dedicated strategy on mental health and work. Similarly, Scotland's national mental health programme has adopted a cross-sectoral approach since 2001. Their current programme includes improving links between education settings and mental health services, increased arts and mental health opportunities and an objective that the Scottish Government become an 'exemplar employer' in supporting health and well-being.

The Irish Government's mental health policy *A Vision for Change* adopts an interdepartmental approach but this has not been adequately followed up with action. The policy includes a social inclusion chapter with ten recommendations that relate to employment, housing, education, income and community development. However it does not fully explore the gender dimensions of mental health. Also, children and adolescents were not consulted in its preparation. The policy recommends a 'framework for interagency action'.

The Office for Disability and Mental Health has responsibility for driving implementation of this policy; it has a remit to coordinate policy across the departments covering health, employment, education and justice/equality. It has brought a welcome focal point for interdepartmental action, though its remit does not cover all of the departments relevant to *A Vision for Change*. The Independent Monitoring Group (IMG) also has an important role in monitoring both the health recommendations of *A Vision for Change* and those for other departments. However, the IMG has been hindered in this role by the lack of action plans from the non-health departments as well as inadequate reporting on some of the recommendations. The National Economic and Social Forum published 32 recommendations on social inclusion and mental health that are intended to complement *A Vision for Change*[5]. The Mental Health Commission's Quality Framework also provides some support for interagency working at local service level.

The National Disability Strategy (NDS) contains some elements that support interdepartmental action. While many people with a mental health problem do not consider themselves to have a disability, the strategy is relevant to people who have an enduring mental health problem if this substantially restricts their capacity to carry on a profession, business or occupation or to participate in social or cultural life. There is potential for the six departmental Sectoral Plans under the strategy to have a mental health focus. This has already occurred in the Department of Environment, Heritage and Local Government where a chapter of the housing strategy for people with disabilities has been developed with a mental health sub-group. However, most departments have not taken substantial, specific mental health action through the NDS. Also it is not possible to deliver all of the Government's mental health policy through the NDS since some important departments such as the Department of Justice, Equality and Law Reform, the Department of Education and Science, the Department of Community, Rural and Gaeltacht Affairs and the Department of Arts, Sport and Tourism do not prepare Sectoral Plans.

While the Office for Disability and Mental Health and the NDS are welcome it is clear that critical gaps remain. It is important that Government make a renewed commitment to *A Vision for Change* as a whole of Government policy.

AI RECOMMENDS THE FOLLOWING PRIORITY ACTIONS:

THE GOVERNMENT AS A WHOLE MUST:

- commit to prioritising mental health and ensure that all departments implement *A Vision for Change*;
- ensure that the sectoral plans under the National Disability Strategy have a specific mental health focus;
- ensure regular coordination across all relevant departments under the leadership of the Office for Disability and Mental Health.

EACH RELEVANT GOVERNMENT DEPARTMENT MUST:

- publicly name the senior official with responsibility for driving implementation *A Vision for Change* within the department and report on progress to the Independent Monitoring Group;
- publicly set out the recommendations for which it will take primary responsibility;
- publicly set out how it will implement each recommendation;
- ensure that all measures taken to deliver *A Vision for Change* are proofed for gender equality and their impact on children.

HOUSING

THE DEPARTMENT OF ENVIRONMENT HERITAGE AND LOCAL GOVERNMENT SHOULD:

- ensure that the housing strategy mental health actions are implemented with timelines;
- ensure that people with mental health-related housing needs can be prioritised by Local Authorities under housing schemes.

EDUCATION

THE DEPARTMENT OF EDUCATION AND SCIENCE SHOULD:

- extend the existing Social Personal Health Education (SPHE) Support Service;
- ensure that SPHE has a dedicated and mainstreamed focus on mental health and well-being for students in every school year;
- develop guidelines for schools on mental health;
- use the National Educational Psychological Service (NEPS) more effectively.

These recommendations are supported by the 42 organisations that make up the Children's Mental Health Coalition.[6]

EMPLOYMENT

THE DEPARTMENT OF ENTERPRISE, TRADE AND EMPLOYMENT SHOULD:

- ensure that the Comprehensive Employment Strategy for people with disabilities has a specific strand on mental health.

SOCIAL WELFARE

THE DEPARTMENT OF SOCIAL AND FAMILY AFFAIRS SHOULD:

- ensure that when it explores introducing partial capacity benefit, it respects and fulfils the rights of people with partial employment capacity due to a mental health concern.

JUSTICE

THE DEPARTMENT OF JUSTICE, EQUALITY AND LAW REFORM SHOULD:

- identify and train a senior Garda in each Garda division to act as a resource and liaison mental health officer.

THE ARTS

THE DEPARTMENT OF ARTS, SPORT AND TOURISM SHOULD:

- ensure that people with experience of a mental health problem are encouraged to participate in their programmes.

INTRODUCTION

—INTRODUCTION TO THE REPORT
—THE COSTS TO INDIVIDUALS AND SOCIETY OF MENTAL HEALTH PROBLEMS

INTRODUCTION TO THE REPORT

A Vision for Change, the national mental health policy adopted in 2006, contains a number of important recommendations that fall outside the remit of the Department of Health and Children and the Health Service Executive (HSE). These recommendations are vital to improving the lives of people affected by mental health problems, many of whom experience discrimination and social exclusion in their daily lives. Recovery is a key focus of *A Vision for Change* and each department has a role to play. This interdepartmental approach is a vital hallmark of a national mental health policy that meets international good practice standards.[7] It is also required under the right of everyone to the highest possible standard of mental health.[8]

It has been estimated that the costs of mental health problems in Ireland are three to four per cent of Gross National Product annually.[9] Importantly, the bulk of the €3 billion cost per annum occurs outside the health sector, in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement as well as in premature mortality.[10]

Amnesty International Ireland (AI) is campaigning to ensure that all people in Ireland can have their right to the highest possible standard of mental health fulfilled. One of AI's campaign objectives is that, in addition to the Department of Health and Children, other relevant Government departments take action to fulfil this right. AI will campaign for each of the Government departments with direct responsibilities under *A Vision for Change* to set out the specific, time-framed actions they will take to implement recommendations. Other aspects of AI's campaign focus on the need for new legislation to drive comprehensive, community-based services and the need to review the Mental Health Act 2001 against the most recent human rights standards, however this report is not covering those areas.

This report sets out why coordinated, interdepartmental action is necessary in order to implement the recommendations in *A Vision for Change* and gives an analysis of implementation progress to date on the policy's social inclusion recommendations. Drawing on international good practice and human rights, the Irish policy context and Irish examples, the report assesses the potential for more joined-up action and the gaps in implementation thus far. The report concludes with over-arching recommendations for how the Government can progress interdepartmental action as well as specific recommendations for the key departments identified in *A Vision for Change.*

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH

THE COSTS TO INDIVIDUALS AND SOCIETY OF MENTAL HEALTH PROBLEMS

Mental health problems can affect anyone at any time.[11] Most households will be impacted by serious mental or emotional distress at some point. Furthermore, the social determinants that can result in mental health problems are likely to be increasing in Irish society, given the recent economic crisis that has led to an increase in unemployment, and which could be putting households at greater risk of poverty and homelessness. This is of concern since evidence has shown that common mental health problems are significantly more frequent in socially disadvantaged populations.[12] The way that mental health problems develop also increases the risk of social exclusion, since three quarters of mental health problems arise before the age of 25, at a time when exit from the labour force can have significant long-term negative effects in terms of loss of earning capacity.[13] This is quite different from the majority of people with a physical or sensory disability, for whom disability generally increases with age.

In Ireland, there is increasing evidence that people living with mental health problems experience social exclusion. Statistics show that:

- people with a mental health disability participate in the Irish labour force at a rate less than half that of the general population.[14]
- adults with a mental health disability are more likely to have left their job due to their disability than people with other disabilities. A higher proportion of adults with a mental health disability left their previous job because of reasons related to their disability (77 per cent) than for any other disability.[15]
- half of adults whose main disability relates to mental health and who are not at work have said they would be interested in starting employment if the circumstances were right.[16]
- "In 2006, about a third of individuals with a mental health disability that affected them before the age of 65 and who were working worked one to 24 hours per week.17"
- almost a quarter of the 77,665 people in receipt of illness benefit in 2009 cited mental health issues as the reason they were unfit for work.[18]
- people with mental health problems are the most stigmatised of any group with a disability. In 2006 in Ireland, only seven per cent of the public thought employers would be willing to higher someone with a mental health problem, and people were less comfortable living near a person with a mental health problem than a person with any other type of disability.[19]

- people with a mental health disability avoid doing things because of how others react at a rate higher than any other disability, with just under half (45 per cent) of adults whose main disability was emotional, psychological and mental health avoiding doing things because of how others react.[20]
- Over half (53 per cent) of people whose mental health disability arose before completing their full time education stopped education due to their disability and this is significantly higher than any other disability.[21]
- almost half (47 per cent) of mental health service users surveyed for the Expert Group on Mental Health had at best a Junior Certificate,[22] while in 2006, forty-five per cent of people with experience of a mental health problem surveyed in one study said that they stopped working or studying due to their condition.[23]
- almost eight per cent of male remand prisoners in Ireland have current or recent psychotic symptoms, 10 times the community rate. Most of those with major mental health problems remanded to custody are charged with non-violent, often relatively trivial, public order offences, which would ordinarily qualify for bail. However, people with mental health problems face greater obstacles to receiving bail, such as inability to provide an address (due to homelessness), pay a bail bond (due to poverty), have a family member to vouch for them (due to social disconnection) or failure to give a coherent account of their actions (due to symptoms such as thought disorder).[24]
- mental health problems are associated with poverty, and women in Ireland have been consistently at greater risk of falling into poverty than men.[25]
- in a survey of people using Simon Community homeless services in Cork, 58 per cent had a diagnosed mental health condition.[26]
- of more than 4,000 people living in long-stay residential mental health care in 2007, one quarter were in accommodation that did not suit their needs.[27]

These statistics paint a startling picture of the daily disadvantages faced by individuals with a mental health problem. In addition to the personal challenges to self-esteem of severe mental distress, too many individuals must cope with negative attitudes and social isolation, denial of work opportunities, low educational attainment and low income. These issues cannot be addressed by individuals themselves, nor can they be addressed through improvements in mental health treatments alone.

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH

HUMAN RIGHTS AND INTERNATIONAL GOOD PRACTICE

—THE HUMAN RIGHTS BASIS FOR INTERDEPARTMENTAL ACTION ON MENTAL HEALTH
—INTERNATIONAL GUIDANCE ON AN INTERDEPARTMENTAL APPROACH TO MENTAL HEALTH
—INTERNATIONAL EXAMPLES OF GOOD PRACTICE

THE HUMAN RIGHTS BASIS FOR INTERDEPARTMENTAL ACTION ON MENTAL HEALTH

The human right to the highest possible standard of mental health is not limited to mental health services but extends to what are known as the underlying determinants of health, such as housing, employment (including access to employment, and safe and healthy working conditions), social security and education.

All of these rights should be enjoyed equally and without discrimination by all persons, including persons with mental health problems. This is reinforced by the UN Convention on the Rights of Persons with Disabilities (CRPD), which Ireland has signed but not yet ratified. The CRPD adopts a 'social model' approach to disability that emphasises the role society plays in creating barriers for individuals who have impairments. It expresses an intent to redress the "profound social disadvantage of persons with disabilities" and to promote their participation in civil, political, economic, social and cultural spheres.[28] The prohibition on discrimination covers both direct and indirect discrimination and places an obligation on the State to take positive action such as ensuring that Government departments and agencies as well as private parties provide reasonable accommodation for individuals where necessary to secure the realisation of their rights.[29]

HOUSING

The human right to adequate housing, (Article 11 International Covenant of Economic, Social and Cultural Rights (ICESCR), Article 28 CRPD), is of central importance in the enjoyment of all socio-economic rights, including the right to health. It means more than a right to a roof over one's head; rather it is the right to live somewhere in security, peace and dignity. The right to adequate housing has a number of important aspects including security of tenure, affordability, habitability and accessibility. An adequate dwelling must contain basic facilities and must be in a location that allows access to employment options, healthcare services, schools, childcare centres and other social facilities. The UN Committee on Economic, Social and Cultural Rights has expressly stated that disadvantaged groups, including persons with mental health problems, should be ensured some degree of priority consideration in the housing sphere in order to ensure that they can enjoy their right to housing. Accordingly, both housing law and policy must take the special housing needs of this group fully into account.[30]

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH

EMPLOYMENT

The right to work is a human right recognised in numerous international treaties to which Ireland is a party, including Articles 6 and 7 ICESCR and Article 27 CRPD.[31] The right to work requires States to have specialised services to assist and support individuals in order to enable them to identify and find available work. Importantly in the context of people with mental health problems, discrimination in access to and maintenance of employment is prohibited. States must pursue national policies designed to promote equality of opportunity and treatment in respect of employment and occupation, with a view to eliminating any discrimination in those areas. The right to work also requires States to implement technical and vocational education plans to facilitate access to employment. Even in times of severe resource constraints, disadvantaged and marginalised individuals and groups such as people with mental health problems must be protected by the adoption of relatively low-cost targeted programmes. In essence the human rights framework recognises the important role of employment in ensuring integration into society and in combating social exclusion.[32]

CASE STUDY EMPLOYMENT

"If you were to get a history of work from most service users it would be, 'unemployment, Disability Benefit, voluntary work, invalidity pension, hospital, occupational therapy', all in a rigmarole. This is the reality for most service users who I have known. I was lucky – I was employed for 20 years as a hotel porter/receptionist in my parents' hotel. So I had secure employment for a long time, but as soon as they sold the hotel, my employment prospects dropped considerably because I didn't have training in anything. Basically, because I have a mental illness, it destroyed my whole future with regard to employment. Since then I have had various occupations, including working as a gardener, in a homeless project and attending FÁS courses. This has been interspersed with periods of unemployment. The last thing I was doing was a FÁS course in accounts from September to January.
I loved it but the other participants were ten times more accurate then me. My local support group has a regular meeting of about 12-16 men and one woman once a week. All are unemployed. This position has remained unchanged for the last six years and longer. We have to move away from the medical model. It is universally agreed that social contact and work are the most beneficial ways of helping service users. Indeed they actually improve mental health. We must demand that the mentally ill get a fair share of employment. We must act. We can no longer be gentle. We must demand that mental health service users be given a fair chance."
Louie, aged 54

SOCIAL SECURITY

The right to social security (Article 9 ICESCR and Article 28 CRPD) encompasses the right to access and maintain benefits, whether in cash or in kind, without discrimination, in order to secure protection inter alia from lack of work-related income, unaffordable access to healthcare and insufficient family support, particularly for children and adult dependents. Due to the way that social security can redistribute income from higher to lower income households, social security plays an important role in reducing and alleviating poverty as well as promoting social inclusion. Denial of, or lack of, access to adequate social security can undermine the realisation of other rights, such as the right to health. In the case of persons with disabilities, including mental health problems, income support must be provided in a dignified manner and must reflect the special needs for assistance and expenses associated with disability.[33]

CASE STUDY SOCIAL WELFARE

"Nothing prepares you for the financial struggle that comes on top of having to deal with a mental health problem. I always worked and I had never been on the dole or had a medical card, so I didn't realise I was entitled to anything when I was diagnosed. I only found out when someone mentioned it in passing. I had been out of work for about a year, and although my partner was working, we had had to rely on others to help us out financially, as we had only just bought the house and we had to pay the mortgage.I didn't want to be on disability benefit – it wasn't through choice that I had to stop work. I was worried I would lose my house. No one told me about the help that might have been available, but when you are in a distressed state, you really need someone to point this out to you. It doesn't need to be complicated, just a few bullet points to point you in the right direction. It would make all the difference if you knew your home was secure and that your medication was paid for.To keep your benefit there was an ongoing monitoring process to assess your capability to work. I lost my job, I was under the care of a psychiatrist, I was attending a day centre and I was on medication – what more did they need from me? I was under pressure to fit into one of their boxes. I was riddled with panic attacks and had a fear of going into crowded places. I had to fill myself with Valium to go in. It was very intimidating and frightening. I didn't know what they were looking for and I was afraid I wasn't going to be able to fulfil it. I really understand there has to be an assessment, but could there not be another way at times."

Caroline, aged 43

EDUCATION

The right to education (Article 13 ICESCR and Article 24 CRPD) is both a human right in itself and an indispensable means of realising other human rights. The right to education is the primary vehicle by which economically and socially marginalised adults and children can participate fully in their communities and so is crucial for their empowerment. In reiterating the right to education in Article 24, the CRPD clarifies some of the steps States must take to ensure that persons with disabilities can enjoy the right to education on an equal basis with others. States must ensure that:

- persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
- reasonable accommodation of the individual's requirements is provided;
- persons with disabilities receive the support required, within the general education system, to facilitate their effective education; and
- effective individualised support measures are provided in environments that maximise academic and social development, consistent with the goal of full inclusion. States Parties must also ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination.[34]

The UN Committee on the Rights of the Child has emphasised the importance of good quality education in the "development of the child's personality, talents and mental and physical abilities to their fullest potential".[35]

It is clear that under the international human rights framework, all individuals with experience of a mental health problem have a right to adequate income, housing, employment and education on an equal basis with others. This right has been affirmed in particular for individuals disabled by reason of a mental health problem through the CRPD, but it also applies to anyone who experiences a mental health problem.

CULTURAL LIFE

Cultural rights are an integral part of human rights and are recognised in a number of human rights treaties, including Article 15 ICESCR and Article 30 CRPD. 'Culture' in this context is broadly defined and includes oral and written literature, music and song as well as recreation, leisure and sporting activities. States should ensure that everyone has the opportunity to utilise their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society. Thus human rights recognises that full promotion and respect for cultural rights is essential for the maintenance of human dignity and positive social interaction between individuals and communities.[36]

THE CRIMINAL JUSTICE SYSTEM

The fact that people are inappropriately caught in the criminal justice system when they need mental health care raises serious human rights concerns. It is widely accepted that prisons are "toxic and inappropriate environments" for people with severe mental health problems.[37] Individuals with serious mental health problems should be diverted from the criminal justice system to the mental health services where appropriate. Experts have identified several points on the pathway through the criminal justice system where an individual with severe mental health problems can be identified and diverted to appropriate treatment including the point of arrest, the holding Garda station, the first or subsequent court appearance, and the prison to which the person is committed.[38]

INTERNATIONAL GUIDANCE ON AN INTERDEPARTMENTAL APPROACH TO MENTAL HEALTH

The World Health Organisation (WHO) highlights that "mental health is necessarily an intersectoral issue requiring the involvement of the education, employment, housing and social services sectors, as well as the criminal justice system".[39] While acknowledging that the ministry of health must be a driver of mental health policy across Government, the WHO recommends that a mental health plan should distribute rights and responsibilities between different ministries and specify the role that each related department will play in each action.[40] It refers to the establishment of a 'Commission' or 'Council' in order to overcome the disadvantages of assigning responsibility for mental health to the health ministry. It suggests that such a council include representatives from agencies covering welfare, religious, education, housing, labour, criminal justice, police and other social services.[41] The WHO states that a mental health policy should define the roles of ministries along the following lines:

- Health: development of policy, regulation, evaluation, prevention and treatment;
- Education: promotional and preventive activities concerning mental health in schools;
- Employment: promotional and preventive activities in workplaces;
- Social welfare: rehabilitation, support for special needs and pension plans;
- Housing: supported housing for persons with disabilities;
- Justice: treatment and rehabilitation of persons in prisons, diversion of persons with mental health problems from the judicial system.[42]

This division of responsibilities does more than make aspirational recommendations for sectors outside of health; it assigns ownership to ministries who have important roles to play in delivering the mental health of the population.

The WHO particularly highlights the roles of employment and education ministries in mental health. In relation to employment, the WHO refers to the role that employment plays in personal identity, self-esteem and social recognition and identifies a number of action areas in the employment sector.[43] In education, the WHO states that:

> *"Like the workplace, schools are an important environment for the prevention of mental ill-health. They need to be committed to improving or sustaining the mental and physical health of children.*

Mental health promotion in schools includes teaching about coping skills, improving self-esteem, learning to say 'no' to involvement in risk behaviours, and education about parenting and child-rearing skills."[44]

At the European level, the European Union's Green Paper on mental health, published in 2005, also recommends a cross-sectoral approach to mental health. It states that "a comprehensive approach is needed", that "involve[s] many actors, including health and non-health policy sectors and stakeholders whose decisions impact on the mental health of the population".[45]

The Green Paper identifies mental health promotion as a priority and states that workplaces and schools are "crucial settings for action".[46] Following on from the Green Paper, the EU's Mental Health Pact published in 2008 also recognised the need for a cross-sectoral approach to mental health among member countries. The pact was drafted at a high level EU conference in 2008 that included Ireland's Minister for Disability and Mental Health and other Irish officials. Participants at the conference agreed that action on mental health should involve relevant policymakers and stakeholders "including those from the health, education, social and justice sectors".[47]
Of the five priority areas identified for action by member countries, three focused on areas beyond mental health services. The education sector was selected as a priority area particularly in relation to youth mental health. The workplace was selected as a priority area for adults of working age. Under the priority area of 'combating stigma and social exclusion', one recommendation is to:

"Promote active inclusion of people with mental health problems in society, including improvement of their access to appropriate employment, training and educational opportunities."[48]

The priority area of older people in the pact also involves advancing social inclusion, recommending that countries promote the active participation of older people in community life. Thus it is clear that at the EU level, ministers from all member countries have committed to a cross-sectoral approach to mental health.

INTERNATIONAL EXAMPLES OF GOOD PRACTICE

ENGLAND'S NATIONAL SOCIAL INCLUSION PROGRAMME

The National Social Inclusion Programme in England was developed in order to further the findings of the Government's report *Mental Health and Social Exclusion*. This report set out a 27-point action plan to achieve the vision that people with mental health problems would have the same opportunities to work and participate in their communities as others. It included actions for the Department for Education and Skills, the Department of Work and Pensions, the Department of Environment, Food and Rural Affairs, the Home Office and other agencies. The National Social Inclusion Programme was established to implement this action plan and has involved more than 20 Government departments as well as other agencies in its implementation to date. Some of the achievements of the inclusion programme so far have been:

- publishing commissioning guidance for vocational services;
- publishing a framework document for the development of a mental health and work strategy and, on foot of this, publishing the national mental health and work strategy, *Working Our Way to Better Mental Health: A Framework for Action*[49];
- setting a national level indicator on the proportion of adults in contact with secondary mental health services who are in employment;
- establishing an Employer Engagement Network to share best practice;
- changes to the welfare benefits system;
- incorporating educational outcomes into the Care Programme Approach;
- producing mental health briefing documents for housing, health and social care staff on rent arrears management and 'Choice Based Lettings', and;
- coordinated revision of the Code of Guidance for local authorities and setting out revised definitions of those in priority need of housing.

SCOTLAND: TOWARDS A MENTALLY FLOURISHING SCOTLAND

Scotland initiated its first national programme on mental health in 2001 and adopted a cross-sectoral approach. Priority areas in its programme for 2003 to 2006 included education, employment and working life, improving community mental health and well-being and improving public services' capacity to act in support of mental health promotion and prevention of mental illness.[50] The Executive's updated plan for 2009-11 continues a cross-sectoral, mental health promotion approach and adopts as its overall aim a 'mentally flourishing Scotland'.[51] This plan notes that most council services, including education, community care, employment and social inclusion, are directly relevant to mental health improvement. Some of the non-health commitments are:

- the National Union of Students Scotland will deliver a three year project aimed at long term gains in mental health improvement practice;
- implementation of the framework document for children and young people. This includes actions in relation to pre-school and childcare settings, establishing better linkages between pre-school, school and community development staff, and child and adolescent mental health services, involving children and young people in the development of support systems and resources, anti-bullying activities and a large number of other initiatives;
- the Scottish Arts Council will develop increased arts and mental health improvement opportunities and promote increased access and participation;
- the Scottish Government will continue to support the Mental Health and Employment Network which raises awareness and disseminates messages about the benefits of employment to mental health;
- the Scottish Government will work to become an 'exemplar employer' in supporting health and well-being, and;
- in 2007, the Scottish Government published *With Inclusion in Mind* that sets out guidance for local authorities about their duties to promote the social inclusion of people who have experienced mental illness.

These initiatives demonstrate a Government-wide commitment to mental health promotion and prevention of mental health problems. Due to its persistent determination to reduce mental health problems, prejudice and discrimination, the Scottish Government is widely acknowledged as a role model for how governments can lead on mental health.

FINLAND'S 'MIELE' NATIONAL PLAN

In 2009, the Finnish Government produced its first national plan for mental health and substance abuse. The plan was developed with a range of stakeholders and through a public consultation. A number of the recommendations reflect social inclusion objectives:

- social assistance supports re-entry to the labour market;
- social cohesion is improved and citizens are empowered;
- each local authority (i.e. municipality) has a mental health and substance abuse strategy and full time staff is recruited to co-ordinate promotion and prevention actions;
- local authorities co-ordinate public services, NGO activities and private services to become a well-functioning comprehensive service system for the residents;
- promotion, prevention and treatment of children and adolescents are implemented in their everyday setting through basic services supported by specialised services;
- working ability is supported by health checks, occupational rehabilitation and access to the labour market is improved for people with disability due to mental disorders, and;
- mental health impact assessment is done in all sectors of society and at all levels.

Furthermore, in the consultation on the plan's implementation, respondents emphasised the need to work across sectors to promote mental health.[52]

While the Finnish mental health plan is in the early stages of implementation, already a national mental health and employment project, the Masto project has shown cross-sectoral working improves the quality of life of people with mental health problems. The Masto project was set up to:

- promote work/life practices that increase well-being at work;
- enhance depression prevention;
- improve care and rehabilitation;
- promote staying on at work and return to work in the context of depression, and;
- reduce depression induced disability.

Key administrative sectors, the social partners and the community and voluntary sector are represented in the project steering group. The project has brought a mental health focus to occupational health and safety training. Thus far, 2,000 workplace supervisors and occupational

health professionals have participated in training seminars. The project also developed a legislative proposal on partial capacity benefit that will shortly come into force.[53]

THE AGENDA FOR TRANSFORMING MENTAL HEALTH CARE IN THE UNITED STATES

On foot of the report of the President's New Freedom Commission on mental health in the US, published in 2003, an 'agenda' for transforming the mental health services was produced by the US Government in 2005.[54] This action agenda was produced in collaboration with a range of government agencies including the Departments of Education, Housing and Urban Development, Justice, Labour, Veterans Affairs and the Social Security Administration. These departments undertook actions under the agenda, many of which involved collaborative cross-sectoral work. Furthermore, a Federal Executive Steering Committee on Mental Health was established to progress the action plan that encompassed senior representatives from these and other departments as well as other relevant agencies including the Equal Opportunities Commission. Divisions under the Department of Health and Human Services covering ageing, substance abuse, disability and public health, among others, were also included on this Committee.

As stated in the progress report published in 2008:

> *"This level of commitment and collaboration among high-level, senior staff across multiple Federal departments is unprecedented. Yet, it is absolutely essential to support the wholesale changes required to make the mental health system consumer and family driven, culturally and linguistically appropriate, recovery focused and results oriented."*[55]

New resources were invested in this cross-sectoral collaboration through the Mental Health Transformation State Incentive Grant programme. In order to obtain these grants, States were required to produce a Comprehensive Mental Health Plan. One of the requirements of this plan is that:

> *"Since transformation must occur in collaboration with other systems that serve people with mental illnesses, the plan must take a cross-systems approach, not only across the child and adult mental health treatment systems, but also across the systems represented on the Transformation Working Group."*[56]

The Transformation Working Group includes the same range of departments as those on the Federal Executive Steering Committee.

In its report after one year, the Substance Abuse and Mental Health Services Administration (SAMHSA) found that significant progress had been achieved towards delivering actions. Transformation grants were awarded to nine states to cover a five year programme. A number of national level collaborative programmes were also initiated. These included, among others:

- programmes for children and young people affected by mental health problems involving collaboration between health, education and justice agencies;
- employment programmes such as specialised grants for individuals transitioning from health care to employment, and an initiative that produced an employer's guide to mental health services, and;
- initiatives to improve access to benefits for people with mental health problems.

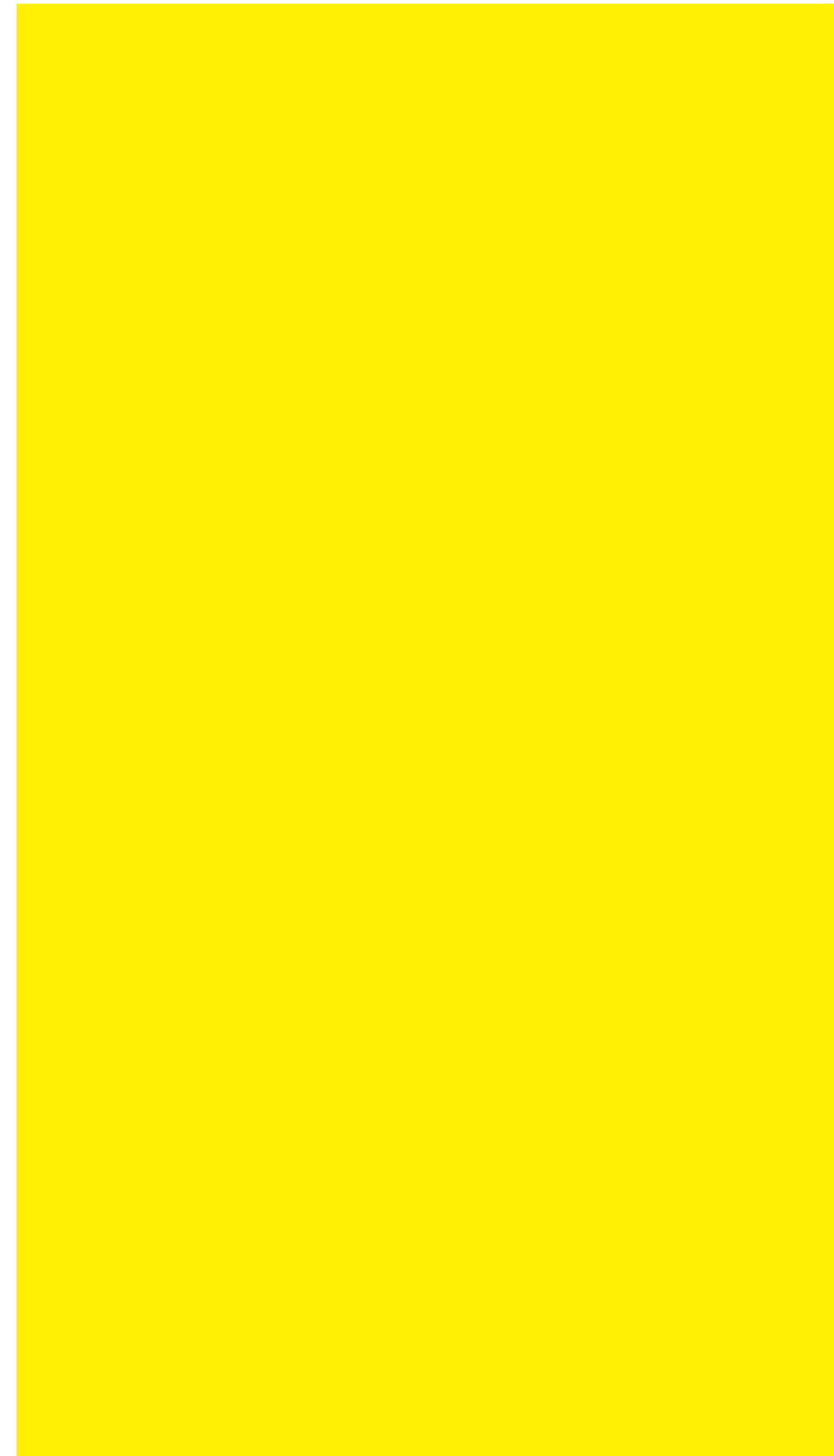
The US Government's decision to adopt a cross-sectoral approach reflects a belief that this is necessary to bring about mental health service reform. While Ireland's system of delivering mental health care is substantially different to that of the US, there may be useful lessons for the Irish Government from the "transformation agenda" since many of the same challenges in relation to mental health and social inclusion apply here.

CONCLUSION

This section has provided an overview of international human rights and policy guidance on an interdepartmental approach to mental health. Under international human rights law, the right to health is not limited to a right to mental health services; it extends to housing, employment, social security, education and cultural rights all of which can influence an individual's mental health. In order to avail of the right to the highest attainable standard of mental health, a person must be able to enjoy these, and all, human rights. EU-member States have accepted this inter-dependency by adopting a cross-sectoral approach in both the Green Paper on mental health and the Mental Health Pact. Other countries engaged in mental health service reform also appear to be adopting a cross-sectoral approach. These approaches emphasise the need for:

- action to improve employment and educational opportunities as well as access to welfare and housing for people with experience of a mental health problem;
- work with children and adolescents to promote mental health and combat prejudice;
- guidance for improving local authority service delivery to people with mental health problems.

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH



THE IRISH CONTEXT

- —THE IRISH CONTEXT FOR INTERDEPARTMENTAL ACTION
- —THE OFFICE FOR DISABILITY AND MENTAL HEALTH
- —THE NATIONAL OFFICE FOR SUICIDE PREVENTION
- —THE INDEPENDENT MONITORING GROUP
- —A VISION FOR CHANGE
- —THE NATIONAL ECONOMIC AND SOCIAL FORUM'S SOCIAL INCLUSION REPORT
- —THE NATIONAL DISABILITY STRATEGY
- —THE GAPS LEFT IN THE NATIONAL DISABILITY STRATEGY IN RELATION TO MENTAL HEALTH
- —THE MENTAL HEALTH COMISSION QUALITY FRAMEWORK
- —A SAMPLE OF POLICY RECOMMENDATIONS FROM PEOPLE WITH MENTAL HEALTH PROBLEMS
- —GAPS IN INTERDEPARTMENTAL ACTION
- —IRISH EXAMPLES OF INTERDEPARTMENTAL PRACTICE

THE IRISH CONTEXT FOR INTERDEPARTMENTAL ACTION

In Ireland there are a range of strategies that have the potential to underpin cross-sectoral action on mental health. Some of these are directly focused on mental health such as *A Vision for Change*, the Mental Health Commission's Quality Framework and the National Economic and Social Forum's (NESF) report *Mental Health and Social Inclusion*. The National Disability Strategy has a wider remit but, as will be explained, can underpin certain cross-sectoral actions for some people with mental health problems. The Independent Monitoring Group for *A Vision for Change* monitors overall implementation. Finally, the Office for Disability and Mental Health has the lead responsibility for driving implementation of *A Vision for Change* across Government and thus has a very important role to play.

THE OFFICE FOR DISABILITY AND MENTAL HEALTH

The establishment of the Office for Disability and Mental Health in 2008 has brought a welcome focal point for development and implementation of interdepartmental action on mental health. It has a remit to coordinate policy across the departments covering health, employment, education and justice.

Its stated responsibilities are to:

- formulate policy in the area of mental health and suicide prevention;
- facilitate and monitor implementation of *A Vision for Change* and '*Reach Out*' – the National Strategy for Action on Suicide Prevention;
- monitor and evaluate HSE performance in relation to mental health services;
- monitor of the Mental Health Acts 2001 and 2008 and the appropriateness of the mental health legislative framework;
- oversee the Mental Health Commission.

According to the third IMG Annual Report, quarterly meetings are held between the Minister and the secretary generals of the relevant departments to review progress. Monthly meetings take place at senior management level between the Department of Health and Children, the Department of Education and Science, the Department of Enterprise, Trade and Employment and the Department of Justice, Equality and Law Reform. Progress on *A Vision for Change* is a standing item on the agenda. In addition, it was reported that bilateral meetings with officials from other Government departments have been held.

THE NATIONAL OFFICE FOR SUICIDE PREVENTION

The National Office for Suicide Prevention was established in 2005, it plays the lead role in suicide prevention nationwide and coordinates relevant actions across a wide range of statutory and non-statutory agencies, as well as overseeing delivery of the suicide prevention strategy *Reach Out*. An example of cross-departmental engagement is that a mental health subgroup of the interdepartmental subcommittee on health between the Department of Health and Children and the Department of Education and Science has been established. This group oversees suicide prevention and mental health promotion activities between the health and education sectors. The HSE has also worked with the Irish Prison Service to develop a suicide prevention and mental health promotion training programme for prison service personnel.

THE INDEPENDENT MONITORING GROUP

While the Office for Disability and Mental Health leads in overseeing implementation of *A Vision for Change*, the IMG is responsible for monitoring its implementation. The IMG is appointed by the Minister for Disability and Mental Health. Its role is to:

- monitor and assess progress on implementation of *A Vision for Change*;
- make recommendations in relation to how the policy is implemented, and;
- report to the Minister and publish its report.

The IMG has made several recommendations regarding interdepartmental implementation. In its first report, it called for the establishment of an interdepartmental working group and recommended that this group develop an action plan and agree how progress would be reported to the IMG. The IMG also called on other Government departments to report on a three monthly basis through the interdepartmental working group.

A number of departments report to the IMG annually regarding their implementation of *A Vision for Change* recommendations. However, to date it has been difficult for the IMG to monitor progress since

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH

there have been no plans for implementation by departments other than that for the HSE, and no time-framed targets or annual milestones against which such progress could be measured. Furthermore, some departments' reporting has lacked comprehensive detail. The Department of Justice, Equality and Law Reform has not reported on all recommendations relevant to its remit. Some information provided by departments including the Department of Education and Science, the Department of Social and Family Affairs and the Department of Enterprise, Trade and Employment has not specified how their mainstream programmes specifically impact on people affected by mental health problems or at risk of mental health problems. These gaps in information provision have meant that it has not been possible for the IMG to measure progress on many of the non-health recommendations of *A Vision for Change*.

A VISION FOR CHANGE

A Vision for Change adopts an interdepartmental approach to mental health policy in a number of ways. It recognises that mental health policy must be addressed to the whole population because mental health problems are a universal experience. Therefore, the policy states that a comprehensive mental health policy cannot rely solely on specialist mental health services.[57] In this regard the policy reflects the WHO's policy guidance. The Expert Group incorporated into the policy framework a role for the community as a partner. The group devoted a chapter to social inclusion which set out ten recommendations that concern employment, housing, education, income, stigma, discrimination and community development as well as cultural acceptability of mental health services. The group also made some recommendations for the criminal justice system. The group also recognised that mental health promotion requires an inter-sectoral and inter-agency approach across the lifespan and identified the need for a 'framework for interagency action'. The group stated that programmes should promote greater integration of vulnerable groups such as travellers, the refugee and asylum-seeking population and other immigrant populations. It recommended that a National Mental Health Service Directorate be established to advise on implementation of *A Vision for Change* and recommended that the Directorate be represented in the institutional structures for the National Action Plan against Poverty and Social Exclusion.[58]

While *A Vision for Change* supports a cross-sectoral approach to mental health, some of its non-health recommendations are less specific than those for the mental health services. Therefore, in some instances there is a need to further specify recommendations, for example in relation to equality, income, housing, education, community development and stigma reduction.

It is also important to note that children and adolescents were not consulted during the development of *A Vision for Change* and therefore the policy recommendations in relation to children and adolescents do not reflect their input. In 2008 however, the Minister for Children and Youth Affairs conducted a consultation with teenagers aged 12 to 18 in order to gather their views about mental health. The Minister stated that the results of this consultation should be considered by those developing policies for children and adolescents.[59]

Furthermore, *A Vision for Change* does not fully explore the gender dimensions of mental health, despite the fact that there are significant gender differences in the risks and experience of a mental health problem as well as in avenues for mental health promotion. According to the WHO, mental health policies must be "based on an explicit analysis of gender disparities in risk and outcome".[60] The WHO highlights the need for an intersectoral approach to gendered mental health responses:

> *"Reducing the overrepresentation of women who are depressed must be tackled as a matter of urgency in order to lessen the global burden caused by mental and behavioural disorders by 2020.This requires a multi-level, intersectoral approach, gendered mental health policy with a public health focus and gender-specific risk factor reduction strategies, as well as gender sensitive services and equitable access to them."*[61]

The Women's Health Council (WHC) produced a report in 2005, *Woman and mental health: Promoting a gendered approach to policy and service provision,*[62] this report addresses a broad range of disparities in men's and women's experiences of mental health problems and needs, and recommends that a gendered approach be adopted in order to understand and treat mental health problems effectively. The WHC also advocated an intersectoral approach in order to "truly safeguard mental health and provide effective services for those who require them".[63] The WHC recognised the need for "gender-specific risk factor reduction strategies".[64]

The National Women's Strategy 2007-2016 commits the Government to incorporating a gender dimension in health policy planning as well as ensuring women's representation at all decision-making levels of health service reform. However, there has yet to be a Government commitment to incorporating a more developed gender analysis into *A Vision for Change*. The Government's suicide prevention strategy *Reach Out* makes a commitment to developing appropriate services, supports and information/education for marginalised groups as well as having a specific focus on mental health promotion for young men, but lacks a focus on suicide and self-harm prevention for women despite statistics showing a higher rate of self-harm among women in most age groups. This is particularly true for younger women aged 15 to 19, where the rate of self-harm is more than double that of young men.[65]

SOCIAL INCLUSION RECOMMENDATIONS IN A VISION FOR CHANGE

1. All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.

2. Evidence-based programmes to tackle stigma should be put in place, based around contact, education and challenge.

3. The flexible provision of educational programmes should be used to encourage young people to remain engaged with the education system and to address the educational needs of adults with mental health problems.

4. Measures to protect the income of individuals with mental health problems should be put in place. Health care access schemes should also be reviewed for this group.

5. Mental health services should take account of local deprivation patterns in planning and delivering mental health care.

6. Evidence-based approaches to training and employment for people with mental health problems should be adopted and such programmes should be put in place by the agencies with responsibility in this area.

7. The provision of social housing is the responsibility of the Local Authorities. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.

8. Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters.

9. Community and personal development initiatives which impact positively on mental health status should be supported, e.g. housing improvement schemes, local environment planning and the provision of local facilities. This helps build social capital in the community.

10. The National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.

11. Forensic mental health services should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place.

12. Education and training in the principles and practices of FMH should be established and extended to appropriate staff, including An Garda Síochána.

13. A senior garda should be identified and trained in each Garda division to act as resource and liaison mental health officer.

THE NATIONAL ECONOMIC AND SOCIAL FORUM'S SOCIAL INCLUSION REPORT

The NESF further developed Irish social inclusion policy in relation to mental health in its report *Mental Health and Social Inclusion* published in 2007. As a national social partnership body including membership from the Oireachtas, the business community, trade unions, the community and voluntary sector, and the Government, the NESF represents the views of stakeholders across Irish society. Its recommendations embody agreement from the breadth of policymakers, service providers and social actors, and therefore should have a good prospect of implementation.

The NESF's report described the social exclusion consequences of mental health problems and also the role the community can play in promoting mental well-being. It also sought to develop recommendations that supported implementation of *A Vision for Change*. In that sense, the document can be viewed as complementary to the Government's mental health policy. The NESF's report concluded that

> *"...actions in mental health have to be considered across the breadth of all social, economic and health policies. Mental ill-health is costly in economic and social terms for society as a whole, as much as for the individuals affected, and is deserving of greater policy focus and priority than has been the case up to recently"*.[66]

In its report, the NESF recognised the importance of human rights to health and well-being, and the social and economic determinants of the right to health. The project team called upon agencies with responsibility for vulnerable groups to prioritise policy and action to address mental health needs. The NESF report further stated that strategies need to be developed to address the inequalities in mental health experienced by vulnerable groups. The team also recognised the value of the arts and sport for both strengthening social capital and supporting recovery.

The NESF made 32 separate recommendations in its report. A key recommendation was that a cross-departmental team on mental health and social inclusion be established, reporting to the Senior Officials Group under the National Action Plan for Social Inclusion, with specific responsibility to draw up targets, priorities, an implementation schedule and budgets for the recommendations it had.[67] In addition, it recommended:

- health and well-being education for children and adolescents to be embedded in school curricula;
- training for teachers, Gardai and medical personnel to promote positive images of mental ill-health and change attitudes;
- a Health and Well-being Framework Strategy for the Workplace to be developed by the social partners;
- a FÁS review to investigate the low take up of some of its training and employment schemes and introduce more effective programmes for people recovering from mental ill-health;
- review of the pay and working conditions of those in sheltered employment;
- development of supported employment schemes;
- development of integrated services at primary care level;
- provision of step-down services by both statutory and voluntary bodies that include housing, day-care facilities, social outlets, training and social supports for individuals recovering from mental ill-health;
- a stronger role for the Department of Environment, Heritage and Local Government and local authorities to ensure increased housing accommodation, with greater flexibility;
- further development of community and local support networks, with greater links between mental health services and the wider community, and;
- support for creative projects and art therapies by local authority Arts Officers and the HSE.

Unfortunately, despite the then Taoiseach's commitment to referring the report to relevant ministers for their consideration, few of its recommendations have been implemented. The result has been that the social inclusion consequences of mental health problems, including stigma and discrimination but also disadvantage in income, housing, education and employment, are persisting.

THE NATIONAL DISABILITY STRATEGY

The National Disability Strategy (NDS) is a Government strategy that aims to support and reinforce equal participation in society by people with disabilities. While many people who have experienced a mental health problem do not consider themselves to have a disability, the Disability Act 2005's definition of a person with a disability includes those with enduring mental health problems if this substantially restricts their capacity to carry on a profession, business or occupation or to participate in social or cultural life. Thus, in essence, individuals with a mental health problem that substantially limits their ability to participate in society are covered by the NDS.

The NDS consists of:

- The Disability Act 2005
- The Citizens Information Act 2007
- Six sectoral plans by six Government departments
- A commitment to a multi-annual investment programme
- The Education for Persons with Special Educational Needs Act 2004 (EPSEN)

There are several aspects of the NDS that support interdepartmental action. Firstly, the Disability Act 2005 provides for a right to an Independent Assessment of Need by any person who considers that they have health or education needs in relation to their disability. If implemented, this would have underpinned coordination between the health and education sectors in responding to mental health and related needs. However, unfortunately implementation of this provision for individuals five years old and over has been postponed. Furthermore, the definition of disability for the purpose of this section is more restrictive than that applying to the rest of the NDS and therefore the right to an assessment of need does not extend to everyone who has a disabling mental health problem.

In a complementary way, the EPSEN Act 2004 provided for 'education plans' for students with special educational needs. As with the Independent Assessment of Need, the intention was to address the educational and related support needs of students with special needs arising from a disability. To date, the Government has not fully implemented the EPSEN Act, though there is a commitment under the 2009 Renewed Programme for Government to proceed with developing an implementation plan.

Six departments are required under the Disability Act 2005 to produce sectoral plans that address what each department will do for people with disabilities. The six departments are:

- Health and Children
- Environment, Heritage and Local Government
- Social and Family Affairs
- Enterprise, Trade and Employment
- Transport
- Communications, Energy and Natural Resources

The Act also requires coordination between certain departments and their agencies. For example, local authorities are required to coordinate with health services to provide housing services for people with mental health problems. The Act also requires all public bodies to ensure that access to their services for people with and without disabilities are integrated.

The monitoring mechanism for the NDS is the National Disability Strategy Stakeholders Monitoring Group, jointly chaired by the Office of An Taoiseach and the National Disability Authority. The group consists of senior officials from each department who prepare a sectoral plan, plus representatives from the Department of Justice, Equality and Law Reform, the Department of Finance and the Department of Education and Science. Six national disability federation organisations, including the Irish Mental Health Coalition, are also represented on this group. A senior official has been assigned to take lead responsibility within each of the six sectoral plan departments and they are required to report on a six monthly basis to the monitoring group. This structure has provided leadership and a coordinating, organisational focus within each department for implementation of the NDS.

While the NDS has the potential to drive interdepartmental action in relation to individuals disabled through a mental health problem, several of its components have not been implemented. The Personal Advocacy Service provided for in the Citizens Information Act 2007 has not been implemented. As a result the entitlement to a personal advocate who would assist individuals with a mental health problem to apply for services, including housing, education, employment and social welfare services, is still missing. The Independent Needs Assessment has not been implemented for children and adults over five years old and this has hindered the development of coordinated responses to individuals' disability related needs between agencies covering health, education and housing. So too, the education plans

provided for under the EPSEN Act have not been implemented and this has meant an absence of a coherent system for responding to the educational needs of children and young people with mental health problems.

HOW MENTAL HEALTH IS COVERED UNDER THE NATIONAL DISABILITY STRATEGY

Many of the programmes, services and entitlements under departments' sectoral plans are delivered to people with mental health problems as part of their services to people with the disabilities. Some examples of this include:

- people who are unable to work due to a mental health problem are entitled to social welfare payments under the disability category (they obtain Disability Allowance, Sickness Benefit, etc.).
- people with mental health problems participate in the pilot activation programme under the Department of Social and Family Affairs. They are substantial participants in vocational training and education programmes provided to people with disabilities.
- they are significant participants in the Community Employment Scheme and Supported Employment.
- they also may be in receipt of housing supports, although housing support on the basis of a mental health need has not been available consistently in all local authorities.

However, to date most Government departments have failed to recognise the overlaps between *A Vision for Change* and the NDS. For example, despite a submission by AI, the Department of Social and Family Affairs' most recent draft sectoral plan fails to mention *A Vision for Change* and makes almost no specific commitments in relation to mental health. More worryingly, the secretary general as well as the minister have stated in writing that implementation of *A Vision for Change* is a matter for the Department of Health and Children. This is despite the fact Social and Family Affairs has lead responsibility in Government for social inclusion.

One exception to this lack of ownership has been the Department of Environment, Heritage and Local Government. The preparation of a housing strategy for people with disabilities has included a dedicated strand for people with mental health problems. This has resulted in a separate chapter on mental health in the draft strategy that includes; a re-statement of the relevant recommendations of *A Vision for Change*; a commitment to ensure mental health representation on local disability steering groups; and a set of mental health-specific

actions, among them the preparation of a protocol between local authorities and the HSE on information sharing to enable better service delivery for people with mental health-related housing needs. This mental health focus is most welcome.

THE GAPS LEFT IN THE NATIONAL DISABILITY STRATEGY IN RELATION TO MENTAL HEALTH

A Vision for Change is a broad mental health policy that addresses not only people disabled through mental health problems, but also the service response to any level of mental health problem as well as mental health promotion for the entire population. The NDS focuses on people who have a disability. It also does not require a sectoral plan from the Department of Education and Science, the Department of Justice, Equality and Law Reform, the Department of Community, Rural and Gaeltacht Affairs or the Department of Arts, Sport and Tourism.

The areas of mental health policy not covered by the NDS are:

- the overriding vision and principles for mental health services in Ireland;
- partnership in services, including the development of the National Service User Executive and service user involvement at every level of the mental health services;
- mental health promotion and suicide prevention;
- mental health responses in primary care;
- all specific recommendations on the development of mental health services;
- initiatives under the remit of the Department of Education and Science;
- initiatives under the remit of the Department of Community, Rural and Gaeltacht Affairs;
- initiatives under the remit of the Department of Justice, Equality and Law Reform;
- initiatives under the remit of the Department of Arts, Sport and Tourism.

While it is clear that the NDS should be used to improve services and supports for people with mental health problems where relevant, and that a particular focus on people with mental health problems may be required in some parts of the NDS, it is not possible to deliver all of Government's mental health policy through the NDS. Further action from departments is essential.

THE MENTAL HEALTH COMMISSION QUALITY FRAMEWORK

While the Mental Health Commission's Quality Framework[68] is focused on improving the quality of mental health services in line with its statutory remit, the framework contains a number of standards that could promote cross-sectoral action and coordination. Some relevant standards are:

- the community mental health team will develop positive partnership and active communication with key agencies in the community. All community resources should be used effectively to maximise real integration (1.5.5);
- the mental health service has established formal links with:
  - Mainstream health services
  - Social welfare services
  - Education services
  - Housing authorities (1.5.6);
- the mental health service works with service user groups and community agencies to promote meaningful integration within local communities (2.3.1);
- the mental health service implements mental health promotion activities (2.3.3);
- service users experience a recovery approach to care and treatment that focuses on self-determination, empowering relationships based on trust, understanding, respect and meaningful roles in society (3.5.2);
- service users receive a mental health service in settings that foster and maintain links with his/her community and retain as much control over his/her life as possible (3.5.4).

If realised, such standards could result in greater collaboration between mental health services and other public sector agencies as well as community organisations. However, without a similar push from non-health agencies, it may be difficult for mental health services to implement these standards.

A SAMPLE OF POLICY RECOMMENDATIONS FROM PEOPLE WITH MENTAL HEALTH PROBLEMS

While not extensive, there has been some research that documents recommendations by people with a mental health problem on social inclusion issues. Three successive user-led research reports conducted in the Galway region have identified social inclusion as a priority issue for people with mental health problems. The first *Pathways* research among service users in Galway city recommended, among other things, that training centres provide relevant training and qualifications that directly improve service users' employment prospects. The report also emphasised that employment is important to mental health service users, stating, "it is essential this issue is researched further and an inter-agency approach adopted to deal with employment difficulties". The report also advocated that secure appropriate accommodation be made a priority for all agencies involved.[69]

The East Galway *Pathways* report similarly recommended that a multi-agency approach be adopted for employment issues and added that further research is needed on this issue. It also recommended that long term appropriate accommodation be a priority for all relevant agencies.[70]

Research conducted among Galway City service users published in 2009 also found that there is still "a need to develop a clearer focus on the importance of employment for mental health service users", and that "employment schemes need to be assessed to establish if they are meeting the needs of mental health service users".[71]

These reports show that in at least one region, service users have specific and strategic recommendations to improve both policy and practice. Wider participation by mental health service users and ex-service users in social inclusion policy is needed in order to ensure that efforts will be effective.

In relation to young people, the 2008 consultation by the Minister for Children and Youth Affairs with teenagers on mental health identified six key areas that would support mental health:

- school environment and the exam system;
- facilities for young people;
- supports for young people;
- relationships with boyfriends and girlfriends;
- self-image;
- family.

Having safe, youth-dedicated spaces for socialising and reforming the exam system towards continuous assessment were key recommendations. The report contains a number of other detailed suggestions for how schools can be a more mentally healthy environment for students.[72]

Headstrong, the National Centre for Youth Mental Health, also published information on the views of its Youth Advisory Panel about mental health in 2009.[73] Panel members considered that it was important for schools to promote young people's well-being and mental health, with teachers better trained to support young people as well as more mental health education in the curriculum. They recommended that specialist mental health services work with the "natural supports" in communities.

GAPS IN INTERDEPARTMENTAL ACTION

While Ireland's mental health policy includes recommendations that are relevant to departments other than health, no representative from a department other than health was a member of the expert group that formulated the policy. The assignment of responsibility for overseeing implementation of *A Vision for Change* to the Office for Disability and Mental Health is a welcome step insofar as this office, though situated within the Department of Health and Children, is led by a Minister whose remit extends to the departments covering education, employment and justice/equality. However, this remains an incomplete intersectoral mechanism since the Office does not have within its remit the key Government departments responsible for social welfare and community programmes, nor arts and sport. An interdepartmental implementation plan has not been produced that sets out ownership and delivery of actions by departments outside of health since the publication of *A Vision for Change*. The only implementation plan produced to date has been for mental health services, produced by the HSE and because of this does not contain detail on the other departments. It is clear, then, that there have been gaps in relation to cross-sectoral collaboration in the development of Ireland's mental health policy and many of these gaps remain in the mechanisms and plans for its implementation.

AI has conducted a detailed analysis of actions undertaken to date by non-health departments in relation to the recommendations of both *A Vision for Change* and the NESF's *Mental Health and Social Inclusion* report (see the detailed chart available at www.amnesty.ie/mentalhealth). At a high-level, there is a lack of structural and policy level commitment to mental health by non-health departments. Thus far, key non-health departments have largely failed to:

- publicly name a senior official with lead responsibility for driving *A Vision for Change* within the department;
- act comprehensively on all relevant recommendations;
- set out a programme of actions to deliver on the relevant recommendations, apart from the Department of Environment, Heritage and Local Government's work on the mental health chapter of the housing strategy;
- explain how their implementation of mainstream services fulfils the recommendations of *A Vision for Change*. By and large, departments provide information to the IMG on their ongoing activities that may relate to or impact on mental health service users. However, they often do not specify how these particularly deliver on the recommendations or impact on people with experience of a mental health problem. Also, in some cases departments have not reported on relevant recommendations. For example, the Department of Justice, Equality and Law Reform has not, to date, reported on implementation of some relevant recommendations;
- report on the numbers of individuals with a mental health problem assisted by their services.

The gaps in implementation also vary from department to department. Action and gaps to date are summarised below.

DEPARTMENT OF EDUCATION AND SCIENCE

ACTION SO FAR

The department has reported to the IMG on its mainstream programmes and services that may benefit people with mental health problems, including the Adult Education Guidance Initiative, the National Plan for Equity of Access to Higher Education 2008-13, second-level guidance and counselling services, the National Educational Psychology Service, and disability services for students. It reported that 79 out of 3,000 students who received funding under the Fund for Students with Disabilities in 2007-8 had a mental health difficulty, while a further 90 were granted funding on the basis of shared group applications. The department supported the Specialist Certificate in Youth Health Promotion and training of youth workers on dealing with bullying and mental health promotion. It also reported that Social Personal and Health Education (SPHE) is part of the curriculum for all pupils in primary schools. The mental health promotion resource pack *Mental Health Matters* developed by Mental Health Ireland is also available for schools.

GAPS SO FAR

The department has not yet set out a comprehensive programme to promote mental health in schools for students of all ages and ensure better liaison between schools and mental health services.

DEPARTMENT OF ENTERPRISE, TRADE AND EMPLOYMENT

ACTION SO FAR

The department reported to the IMG that employment access for people with mental health problems is progressed under the NDS. It reported that a protocol is in place between the HSE and FÁS. It reported that a pilot bridging programme is being discussed between the HSE and FÁS.

GAPS SO FAR

The department has not published plans to implement the recommendations of *A Vision for Change* and the NESF report. It has not yet committed to a mental health focus in its Comprehensive Employment Strategy for People with Disabilities.

THE DEPARTMENT OF ENVIRONMENT, HERITAGE AND LOCAL GOVERNMENT

ACTION SO FAR

The department is developing a national housing strategy for people with disabilities, which includes a chapter on people with mental health problems. A protocol has been developed between the HSE and local authorities to facilitate information sharing for people with mental health-related housing needs. The department also reported its progress in implementing the strategy to address adult homelessness.

GAPS SO FAR

The department has not yet agreed with the Department of Health and Children and the HSE on how supports will be provided to individuals with mental health-related housing needs in order to enable them to maintain independent living. The department has not set out how it will ensure that people with a mental health-related housing need can be allocated housing to enable their recovery.

THE DEPARTMENT OF SOCIAL AND FAMILY AFFAIRS

ACTION SO FAR

The department has reported to the IMG on its support for advocacy services for people with disabilities and the Citizens Information Board advocacy service to the general public. The department reported that it had provided funding of €15,000 to Mental Health Ireland for the production of an information leaflet on social welfare entitlements. Under its revised sectoral plan, the department has committed to exploring the introduction of partial capacity benefit.

GAPS SO FAR

The department has not reported on the take up of welfare supports by people with mental health problems or the specific funding provided to mental health advocacy projects. The department has yet to set out how it will ensure that any introduction of partial capacity benefit will respect individuals' human rights and support their recovery.

THE DEPARTMENT OF JUSTICE, EQUALITY AND LAW REFORM

ACTION SO FAR

The department has reported to the IMG that it is considering amendments to the Criminal Law (Insanity) Act 2006 in relation to court diversion services. It has also reported on training provided to student/probationer gardai on mental health awareness and the Mental Health Act 2001 as well as a mental health module in the Garda Negotiator and On Scene Command courses.

GAPS SO FAR

The department has not published a programme of work to implement the relevant recommendations of *A Vision for Change*. It has not implemented the recommendation to appoint a senior Garda in each division to be the key liaison person on mental health. It has yet to publish plans to implement a statutory basis for court diversion services.

THE DEPARTMENT OF COMMUNITY, RURAL AND GAELTACHT AFFAIRS

ACTION SO FAR

The department has reported to the IMG on its mainstream local and community development programmes. These include support for personal development.

GAPS SO FAR

The department has not published specific plans to implement recommendation 11.1 of *A Vision for Change* on promoting mental health in the general community nor the relevant recommendations of the NESF's *Mental Health and Social Inclusion* report.

THE DEPARTMENT OF ARTS, SPORT AND TOURISM

ACTION THUS FAR

While there is no specific recommendation in *A Vision for Change* pertaining to the arts and sport, the NESF report recognises the role that the arts and sport can play in mental health promotion and recovery and makes a specific recommendation in this regard.

GAPS THUS FAR

There is a lack of published information on mental health-specific arts programmes in Ireland. The department has not published plans to implement the NESF's recommendation that local authority Arts Officers and the HSE develop mental health-related creative projects and art therapy programmes.

IRISH EXAMPLES OF INTERDEPARTMENTAL PRACTICE

While not comprehensive, the below initiatives have been selected in order to highlight how interdepartmental and/or inter-agency action is being undertaken in Ireland.

THE CLOVERHILL PRISON DIVERSION SCHEME

A prison in-reach and court liaison service (PICLS) has been developed at Cloverhill Prison, which takes approximately 80 per cent of all remand prisoners nationally, to identify persons with major mental illness and arrange treatment care plans in appropriate settings. It is delivered from the HSE's National Forensic Mental Health Service at the Central Mental Hospital (CMH). Diversion is either to the CMH or community mental health services; where the mental health problem is minor - this can be managed within the prison. The service also prepares reports for the Courts on what is available in the event of a custodial or non-custodial disposal of the case. A recent article by Dr Conor O'Neill states that the time spent in custody for those individuals deemed suitable for treatment in local psychiatric services, reduced from an average of 57 days in 2005, to 19 days in 2006 and 21 days in 2007.[74] The service has facilitated diversion of over 300 persons with major mental health problems since 2006.[75]

However, the PICLS service only deals with people on remand, and therefore not all people coming before the courts. It also does not deal with children. Dr O'Neill has said: "The necessity to locate the court liaison service in Cloverhill Prison inevitably means that an opportunity is missed to divert to hospital before entering prison…Inappropriate

custodial periods for persons with major mental illness and minor offending behaviour may be further reduced by extending the service in the future to intervene at the point of the Garda station or the Court."[76]

THE HOME FOCUS PROJECT

The Home Focus Project began as a pilot project funded under the *Enhancing Disability Services Project Funding* from the Department of Justice, Equality and Law Reform. It has now been mainstreamed through funding provided by the HSE. The project involves a collaborative approach between the National Learning Network West Cork, West Cork Mental Health Services, the Irish Advocacy Network, HSE Disability Guidance Services, Work Start West Cork and West Cork Community Partnership. The project provides outreach and individualised support to people with mental health problems who are isolated and not accessing centre-based services. The aim of the project is to deliver a service that will "enabl[e participants] to enhance their mental health and well-being, independent living skills, levels of connection to their own communities, access to training, education and employment opportunities, improved quality of life and future planning."[77] The programme is innovative in its involvement of users of mental health services in programme design and delivery as well as its emphasis on community, outreach and home-based interventions. Some of the relevant findings from the evaluation of the pilot phase were:

- reduced hospital days by 47 per cent over 12 months for participants who engaged with the project;
- specific health and social gains in participants, improved social engagement, linking with community groups and support organisations, improved mental health, improved independent living skills, employment, and further training and certification;
- a new, unique experience of service provision that was more hopeful; and
- a community development approach to mental health.[78]

The evaluation found that "it is possible to move supports for people with mental health problems beyond the territory of mental health services to the broader community".[79] This partnership approach also facilitated improved coordination between services.

CASE STUDY LOCAL INTER-AGENCY INITIATIVE

HOME FOCUS

"I have a long history of mental health problems, but managed to get my life back together on a number of occasions. In 2003 I had a complete physical and mental breakdown. I split with my partner and my whole world collapsed. I was desperate and suicidal. Over the years a number of people have promised me the earth in terms of help and support after one visit, but then I never saw them again. Home Focus was different. The first time they sat with me for five hours. They didn't just talk, they listened to me, and even more importantly, they heard me. They said they would come back the following week at the same time – and they did. In fact they visited once a week for a number of months. They assess your needs and they slowly try to get you back into life. For example, one day they brought me a computer. I didn't want to use it, but slowly I learnt how. Now, thanks to Home Focus, I have a computer, an email address and use it regularly. They also noticed I wouldn't go out, so one time they suggested taking me out for lunch. I was reluctant at first, but I went. It took about four months until I was ready to enrol in a course with the National Learning Network which they organised, and the support of Home Focus didn't end there. Home Focus help people living in their communities who are isolated and desperate, struggling with their lives through mental illness. Before they came to me I used to wake up and just sit and listen to the clock, dreading how to get through the day. Without their help I wouldn't be in the position I am in. There should be more support for such initiatives."

Dick, aged 57

THE DETECT SERVICE

The DETECT early intervention for psychosis service is funded by the Department of Health and Children through the HSE and has also received funding from the National Office for Suicide Prevention. The service currently works collaboratively with the education system through contact with teachers and with Án Garda Siochana.

In order to minimise disruption to the productive role of people who use DETECT, the service has implemented strategies to reduce delays in accessing effective treatment. Research indicates that those with shorter delays are less likely to be unemployed when they present to mental health services. However even with shortened delays many people with psychosis will require assistance to return to their work role and this is provided through the DETECT occupational therapy service and a FÁS funded FETAC level 3 employment and vocational skills training programme. A total of 46 people commenced the REACH programme in 2009 and 35 completed the full 21 weeks, 100 per cent attained their FETAC certificate. Progression to employment has declined since the economic downturn however positive progression, which includes moving on to further training and education, remains very high.

CLUBHOUSE TRANSITIONAL EMPLOYMENT PROGRAMME

EVE Ltd. has pioneered the Clubhouse model in Ireland. The Clubhouse offers an innovative member-run and centred service with clients gaining self-confidence by participating in a work oriented programme. In Clubhouse, participants are known as "members", as opposed to patients or clients. The sense of membership, support and belonging are at the very heart of the Clubhouse. Clubhouse communities recognise, encourage and focus on the inherent value and potential of each member involved. They believe that every member can recover from the effects of mental health difficulties and lead personally satisfying and socially contributing lives.

Unique to the Clubhouse is the Transitional Employment Programme (TEP), which makes it possible for members to work at jobs where they can focus on regaining basic work skills and confidence. The Clubhouse model places a strong emphasis on employment that can actively contribute towards someone's recovery. TEP is a type of employment programme that is specifically designed to assist people with mental health problems to enter, or re-enter, the workforce. The Clubhouse supports the person in both obtaining and maintaining placements in normal places of business and therefore TEP is intrinsically linked to the Clubhouse model. Transitional employment is part of the 'real world' of work. Jobs are usually entry level, quite structured and routine orientated and in most cases require minimum training or skills. Clubhouse members are paid the same wage rate as any other person working in the job and enjoy the support of Clubhouse staff who are also trained in the job and can provide back-up if the person is unable to work. Importantly, the employer is guaranteed that the work station will be covered at all times. All transitional employment jobs are time limited, usually providing employment for six to nine months. At the end of this period another member will get the opportunity to try the transitional employment. Some of the advantages of TEP are that:

- a history of hospitalisation does not prevent a member from securing employment;
- no attention is given to the length or number of a member's hospitalisation(s);
- the absence of a work history or lack of a job reference does not prevent a member from trying Transitional Employment;
- it is an effective tool to tackle discrimination in the workplace as employers get to know the members well during the programme.

Thus TEP offers an opportunity for employment experience to individuals who otherwise might find it very difficult to obtain a job opportunity.

CASE STUDY EMPLOYMENT

TRANSITIONAL EDUCATION PROGRAMME

"I haven't worked for three or four years and I had also been hospitalised during that time. I was attending the Platinum Clubhouse every day and helping out in the office but it wasn't a paid job. Before I had become unwell I had worked in finance, so I was interested in that area. It was always my intention to return to work. Through the Transitional Employment Programme I got a job with Permanent TSB. My interview was with three people, the manager of the clubhouse, the branch manager of the bank and someone from the HR department at the headquarters. It was great because it was in the clubhouse, so it was on my home patch. I would be at a lower level than I had been before I became unwell, but that was fine, as I knew I wouldn't be able to manage that. I worked two hours the first week, then four the next week, and worked up to 10 hours per week. It has most definitely made a big difference to me and given me more confidence. I'm back in the community and I'm speaking to customers over the phone. My self-esteem has improved and I wouldn't have made so much progress if I hadn't had the job. It was the perfect stepping stone job as I wasn't ready to do the type of job I had done before. It was mutually beneficial because they knew my situation and accommodated doctor's appointments, and equally if they were short staffed I could do more hours.My contract finishes this week and I am ready to increase my hours - I have already started working on my CV to find my next job."
Clive, aged37

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH

CONCLUSIONS AND RECOMMENDATIONS

—RECOMMENDATIONS FOR THE WHOLE OF GOVERNMENT
—PRIORITY ACTIONS FOR INDIVIDUAL DEPARTMENTS
—CONCLUSION

RECOMMENDATIONS FOR THE WHOLE OF GOVERNMENT

This report has set out evidence that supports a coordinated, interdepartmental approach to implementation of Ireland's mental health policy *A Vision for Change*. There is a strong case for coordinated action by departments including, but also other than health, to deliver the social inclusion recommendations of Ireland's mental health policy. Mental health is not only a health issue – it is influenced by social and economic factors; recovery depends not only on good quality mental health services but also on having economic security, sustainable and appropriate housing and opportunities to contribute to society. Today in Ireland too many people with mental health problems face barriers to participation in terms of negative attitudes, lack of employment opportunities, curtailed education and low income. These barriers cannot be addressed through the health services alone.

The human rights framework clearly underpins interdepartmental action. Under international human rights standards and laws, all individuals with experience of a mental health problem have a right to adequate income, housing, employment and education on an equal basis with others. Ireland is legally obliged under international law to uphold these rights. So too, international guidance from the WHO and the EU supports a cross-sectoral approach. Some countries have adopted such an approach in their mental health policies and programmes, recognising that it is essential in order to deliver mental health service reform and to improve the lives of people with mental health problems.

While Ireland's mental health policy includes recommendations that are relevant to departments other than health, no representative from a department other than health was a member of the expert group that formulated the policy. The assignment of responsibility for overseeing implementation of *A Vision for Change* to the Office for Disability and Mental Health is a welcome step insofar as this office, though situated within the Department of Health and Children, is led by a Minister whose remit extends to the departments covering education, employment and justice/equality. However, this remains an incomplete intersectoral mechanism since the Office does not have within its remit the Government departments responsible for social welfare, community programmes, and arts and sport. Nor has any cross-sectoral implementation plan been produced that sets out ownership and delivery of actions by departments outside of health since publication of *A Vision for Change*. The only implementation plan produced to date has been for mental health services, produced by the HSE.

Furthermore, there needs to be a mechanism by which civil society can hold other Government departments to account for delivery on their responsibilities. Thus far, the IMG has not been able to fulfil this role due to the inadequate reporting by non-health departments. There is a need for specific action plans from these departments in order to be able to monitor progress.

In order to develop action plans for *A Vision for Change*, it will not be adequate for departments to simply restate its recommendations. Some of these recommendations were widely drawn and unspecific. In order to provide a basis for action departments, where necessary, should further specify the recommendations in consultation with mental health stakeholders. Departments should set out any dedicated programmes they will develop that are focused on mental health. Where a mainstream programme will be used to implement a recommendation, the department should set out a measurable mental health-specific target. All recommendations should be broken down into targets, annual milestones and key performance indicators. Wherever resources will be required, these should be estimated in terms of human and financial resources.

AI RECOMMENDS THE FOLLOWING PRIORITY ACTIONS:
THE GOVERNMENT AS A WHOLE MUST:

- commit to prioritising mental health and ensure that all departments implement *A Vision for Change*;
- ensure that the sectoral plans under the National Disability Strategy have a specific mental health focus;
- ensure regular coordination across all relevant departments under the leadership of the Office for Disability and Mental Health.

EACH RELEVANT GOVERNMENT DEPARTMENT MUST:

- publicly name the senior official with responsibility for driving implementation of *A Vision for Change* within the department and report on progress to the Independent Monitoring Group;
- publicly set out the recommendations for which it will take primary responsibility;
- publicly set out how it will implement each recommendation;
- ensure that all measures taken to deliver *A Vision for Change* are proofed for gender equality, and their impact on children, Lesbian, Gay, Bisexual and Transgender people, Travellers and other vulnerable groups.

These departmental commitments can provide a framework and performance indicators against which the IMG can monitor the non-health recommendations of *A Vision for Change.*

With regard to reporting on the impact of mainstream programmes, AI recognises that all departments must adhere to the requirements of Irish data protection law. Nevertheless, appropriate data collection methods such as anonymous surveys, focus groups and national data collection exercises (e.g. the Census and the EU-SILC) should be explored as options for verifying the impact of programmes on people with mental health problems. For example, the results of the National Disability Survey have provided some baseline data on the social inclusion of people disabled due to a mental health problem. Further regular national data collection should include a mental health question in order to assess the social inclusion impact of *A Vision for Change* over time. Agencies can also conduct specific focus groups with mental health service users to obtain feedback on their services.

PRIORITY ACTIONS FOR INDIVIDUAL DEPARTMENTS

HOUSING
THE DEPARTMENT OF ENVIRONMENT, HERITAGE AND LOCAL GOVERNMENT SHOULD:

- ensure that the housing strategy mental health actions are implemented with timelines;
- ensure that people with mental health-related housing needs can be prioritised by Local Authorities under housing schemes.

EDUCATION
THE DEPARTMENT OF EDUCATION AND SCIENCE SHOULD:

- extend the existing Social Personal Health Education (SPHE) Support Service. The service should have a specific role in supporting teachers by providing training on mental health and how to appropriately respond to students who are presenting difficulties, including making appropriate supportive interventions. This extended service should develop recommendations for schools on effective mental health promotion in consultation with stakeholders, including children and young people;
- ensure that SPHE has a dedicated and mainstreamed focus on mental health and well-being for students in every school year. This should be delivered to all students in every school year. Some schools are delivering this but the focus on 'emotional well-being' needs to be strengthened to have a dedicated mental health promotion focus;
- develop guidelines for schools on mental health. The guidelines should provide clear procedures on how teachers can raise concerns about individual students' mental health difficulties, along the lines of the Children First guidelines. A designated member of staff should have responsibility, based upon reasonable judgement, for raising such concerns to the appropriate agency, parent or family member. Training should be provided for this designated liaison person; and,
- use the National Educational Psychological Service (NEPS) more effectively. NEPS is a key cross departmental initiative, and so it is essential that the Government addresses ambiguities about appropriate referral to, and the role of, NEPS, including as a point of referral to children's mental health services.

These recommendations are supported by the 42 organisations that make up the Children's Mental Health Coalition.[80]

EMPLOYMENT
THE DEPARTMENT OF ENTERPRISE, TRADE AND EMPLOYMENT SHOULD:

- ensure that the Comprehensive Employment Strategy for People with Disabilities has a specific strand on mental health.

SOCIAL WELFARE
THE DEPARTMENT OF SOCIAL AND FAMILY AFFAIRS SHOULD:

- ensure that when it explores introducing partial capacity benefit, it respects and fulfils the rights of people with partial employment capacity due to a mental health concern.

JUSTICE
THE DEPARTMENT OF JUSTICE, EQUALITY AND LAW REFORM SHOULD:

- identify and train a senior Garda in each Garda division to act as a resource and liaison mental health officer.

THE ARTS

THE DEPARTMENT OF ARTS, SPORT AND TOURISM SHOULD:

- ensure that people with experience of a mental health problem are encouraged to participate in their programmes.

CONCLUSION

Separately, these actions can make a real difference to the lives of people who have experienced a mental health problem. But implemented together, they could help to ensure that people experiencing mental health problems can participate as full members of Irish society and help Ireland keep its promise to its citizens to recognise their right to the highest possible standard of mental health. People with mental health problems want more than to recover their health; they want to recover their lives.

THE MISSING LINK
COORDINATED GOVERNMENT
ACTION ON MENTAL HEALTH

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ACTION ON MENTAL HEALTH

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