

National Economic  
⊕ Social Forum NESF

# Mental Health & Social Inclusion

Report 36 · October 2007

Report on Mental Health and Social Inclusion  
Forum Report No. 36

**Published by the National Economic and Social Forum**

Copies of the Report may be obtained from the  
**Government Sales Office**

Sun Alliance House, Molesworth Street, Dublin 2.

*or*

**The National Economic and Social Forum**

16 Parnell Square, Dublin 2.

Price €10.00

(PN A7/1458) ISBN 1-899276-44-0

# Mental Health and Social Inclusion

NESF Report 36 · October 2007

*“Mental health is about the **whole** of being, about being socially, emotionally, physically and spiritually well. Mental health has to do with how we feel about ourselves and how we are able to meet the demands of life. It is fundamental to physical health, to happiness and to success at work and school, in our families and the health of our communities. We all have mental health needs even if we don’t have current mental health problems.”*

*Submission to the Project Team*

# Contents

<b>Glossary</b>		<b>vi</b>
<b>Executive Summary</b>		<b>ix</b>
<b>Section I</b>	<b>Context and Issues</b>	
Chapter 1	<b>Introduction</b>	<b>1</b>
Chapter 2	<b>Current Perspectives on Mental Health</b>	<b>9</b>
Chapter 3	<b>Mental Health Policy Context</b>	<b>25</b>
Chapter 4	<b>Barriers to Social Inclusion</b>	<b>43</b>
<b>Section II</b>	<b>Strategies and Initiatives</b>	
Chapter 5	<b>Improving Mental Health</b>	<b>61</b>
Chapter 6	<b>Mental Health in the Workplace</b>	<b>83</b>
Chapter 7	<b>Work, Training and Meaningful Occupation</b>	<b>109</b>
Chapter 8	<b>Towards an Integrated Model of Services Delivery</b>	<b>125</b>
Chapter 9	<b>Strengthening Communities</b>	<b>147</b>
<b>Section III</b>	<b>Conclusions</b>	
Chapter 10	<b>Recommendations</b>	<b>165</b>
<b>References</b>		<b>177</b>
<b>Annexes</b>		
Annex 1	<b>Terms of Reference</b>	<b>193</b>
Annex 2	<b>Summary of Submissions</b>	<b>194</b>
Annex 3	<b>Additional Figures</b>	<b>215</b>
Annex 4	<b>COPE Map of Drumchapel</b>	<b>217</b>
Annex 5	<b>Seminar Attendance, Plenary Attendance and Consultation List</b>	<b>218</b>
Annex 6	<b>NESF Terms of Reference and Publications</b>	<b>225</b>

## List of Figures

Figure 1	Key Perspectives in Mental Health	x
Figure 2	Improving Mental Health	xiii
Figure 3	Six Strategic Areas: Recommendations	xiv
Figure 4	Implementation Structures	xvi
Figure 2.1	Key Messages on Health Promotion	12
Figure 2.2	The Scope of Health Promotion	13
Figure 2.3	Number of Admissions to Psychiatric Units and Hospitals 1965-2005	18
Figure 3.1	Framework for a Comprehensive Mental Health Policy	27
Figure 3.2	Expenditure across the EU on Mental Health Services	38
Figure 4.1	The Structural Model of Mental Health	44
Figure 4.2	Determinants and Protective Factors of Mental Health	45
Figure 5.1	English National Inclusion Programme for Mental Health	66
Figure 6.1	Workplace and Mental Health Policies	88
Figure 6.2	Key Stages in the Development of a Mental Health Policy	89
Figure 6.3	The Mental Health-Friendly Workplace Circle	94
Figure 6.4	Reasons for not Disclosing Mental Ill-health among Employees	98
Figure 8.1	<i>A Vision for Change</i> : Proposed Structure of HSE Mental Health Services	127
Figure 8.2	Percentage of GPs Referring Patients to Specialist Mental Health Services	128
Figure 8.3	Jigsaw Model	140
Figure 9.1	Factors Influencing the Mental Well-Being of Communities	148
Figure 9.2	Sources of Support for People with Mental Ill-Health	152
Figure 10.2	Implementation Structures	168
Figure A.1	Selected Recommendations from <i>A Vision for Change</i>	215
Figure A.2	Making a Recovery Map	216

## List of Tables

Table 4.1	Contributory Factors to Social Exclusion	49
Table 5.1	Examples of Strategies to Increase Social Inclusion and Mental Health	63
Table 6.1	Incidence of Bullying by Gender	91
Table 7.1	Relevant FÁS Schemes and Programmes	111

## Glossary

<b>Mental health</b>	<i>“A state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (WHO, 2001:1).</i>
<b>Well-being</b>	Well-being is used here to mean “more than just happiness. As well as feeling satisfied and happy, well-being means developing as a person, being fulfilled, and making a contribution to the community” (New Economics Foundation, 2004:2).
<b>Mental illness</b>	<i>Mental illness</i> refers here to specific conditions such as schizophrenia, bi-polar disorder and clinical depression.
<b>Social exclusion</b>	<i>“People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society” (NAPinclusion, Government of Ireland, 2007:20).</i>
<b>Social capital</b>	<i>“Networks together with shared norms, values and understandings that facilitate co-operation within or among groups” (NESF Report No. 28, 2003:3).</i>
<b>Service user</b>	A person who has personal experience of mental ill-health and mental health services.
<b>Advocacy</b>	Advocacy is speaking up for, or acting on behalf of, oneself or another person. It is a practice carried out by or on behalf of an individual or a group, whereby others (peers, community groups, family members, professionals) supports them to participate fully in society.
<b>Recovery approach</b>	A social process of recovering a fulfilling life regardless of the presence or absence of symptoms (Kruger, 2000).
<b>PCCC</b>	Primary Community and Continuing Care (PCCC), within the Health Service Executive (HSE), provides health and personal social services including primary care, mental health, disability, child, youth and family, community hospital, continuing care services and social inclusion services.



<b>Community Mental Health Teams (CMHTs)</b>	Community-based, multidisciplinary teams providing mental health services.
<b>A Vision for Change</b>	<i>A Vision for Change</i> (Department of Health and Children, 2006) sets out the policy framework for mental health in Ireland and was produced by an Expert Group on Mental Health. The Expert Group, established in 2003, consisted of 18 people drawn from a range of backgrounds within the mental health services.
<b>NAPinclusion</b>	<i>The National Action Plan for Social Inclusion 2007–2016 (NAPinclusion)</i> is a strategic plan to combat poverty and social exclusion (Government of Ireland, 2007).
<b>Towards 2016</b>	<i>Towards 2016</i> is a Ten Year Framework Social Partnership Agreement that adopts a lifecycle framework focusing on children, people of working age, older people and people with disabilities (Government of Ireland, 2006).



The relationship between mental health and social inclusion is examined in the report in terms of: strengthening positive mental health and well-being for the whole population; the impact of poverty and social exclusion on mental health; and access to services and better recovery rates.

The focus on community and its contribution beyond the location and the provision of services provides a fresh dimension to policy debate and evaluation in this country. With the institutional model of mental health care still lingering<sup>2</sup>, it is important to recognise more fully the potential value and contribution of individuals, community-led groups and the wider voluntary and community sector in enhancing positive mental health for all, as well as protecting and supporting those in recovery.

### **Mental Health is Everybody's Business**

The consequences of mental ill-health are far-reaching for Irish society, in terms of reduced economic performance, human and social capital and increased health and social welfare costs. The World Health Organisation (WHO, 2005b) argues that these are increasing at global level. According to Jané-Llopis and Anderson (2005), the social and economic costs for societies are wide-ranging, long-lasting and enormous, representing 3-4% of GDP in Europe.

### **Inequality and Social Exclusion**

While everyone has mental health needs, many people experience mental ill-health at some stage in their lives (Wittchen and Jacobi, 2005; WHO, 2001). The burden falls disproportionately on certain sections of the population (Quin and Redmond, 2005). Within low income and unskilled occupational groups, there are both higher levels of common mental disorders than for other groups, as well as higher rates of admissions to psychiatric hospitals (Daly et al, 2005; European Commission, 2003). Poverty, gender inequalities and ethnicity play a role in mental health, both in the onset of illness but also in terms of access to services and recovery rates (Laffan, 2006; Mind, 2002).

### **Key Findings**

The report therefore analyses the broad factors which determine mental health for the whole population as well as the key strategies for protecting and supporting people with mental ill-health to recovery and increased social inclusion. The following distinct areas are examined in the report (see Figure 2):

- **Mental Health can be strengthened**

- Co-ordinated action is needed at all levels to increase social inclusion. These include action at a society level, at an organisational level, at the community and at the individual level. International evidence suggests that strategies have to focus on all these levels.
- Vulnerable groups require particular action.

---

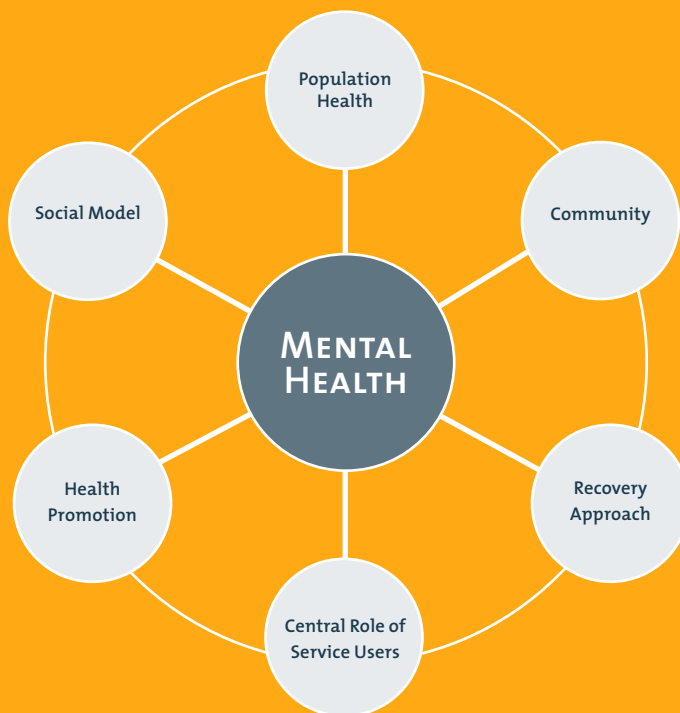
<sup>2</sup> Refers to care with psychiatric institutions, rather than within the community.

**There is no Health without Mental Health**

A *Vision for Change* (Department of Health and Children, 2006) sets out the policy framework for mental health in Ireland and this report seeks to underpin this with a focus on social inclusion, recovery and population health. As increasingly understood, mental health<sup>1</sup> is shaped by our social, cultural, economic and physical world. In recognition of this, there has been a welcome shift in policy from a purely medical focus, to the promotion of mental health and well-being in many policy arenas.

This report adopts a ‘population health’ approach to the development of mental health policy through improvements to the health of the entire population and reducing health inequities among population groups. This approach is particularly important for vulnerable groups and individuals, to reduce their stigmatisation, discrimination and marginalisation and to support their fuller participation in community life. It further places recovery and service user involvement at the centre of its deliberations. Of critical importance also is the emphasis in the report on placing the community at the heart of its strategy for greater inclusion and positive mental health. Furthermore, the report focuses on the social model of mental health with an emphasis on recovery. The main perspectives which underpin the report are presented in Figure 1.

**Figure 1 Key Perspectives in Mental Health**



<sup>1</sup> Mental health is used here to refer to “a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (World Health Organisation, 2001:1).

The relationship between mental health and social inclusion is examined in the report in terms of: strengthening positive mental health and well-being for the whole population; the impact of poverty and social exclusion on mental health; and access to services and better recovery rates.

The focus on community and its contribution beyond the location and the provision of services provides a fresh dimension to policy debate and evaluation in this country. With the institutional model of mental health care still lingering<sup>2</sup>, it is important to recognise more fully the potential value and contribution of individuals, community-led groups and the wider voluntary and community sector in enhancing positive mental health for all, as well as protecting and supporting those in recovery.

### **Mental Health is Everybody's Business**

The consequences of mental ill-health are far-reaching for Irish society, in terms of reduced economic performance, human and social capital and increased health and social welfare costs. The World Health Organisation (WHO, 2005b) argues that these are increasing at global level. According to Jané-Llopis and Anderson (2005), the social and economic costs for societies are wide-ranging, long-lasting and enormous, representing 3-4% of GNP in Europe.

### **Inequality and Social Exclusion**

While everyone has mental health needs, many people experience mental ill-health at some stage in their lives (Wittchen and Jacobi, 2005; WHO, 2001). The burden falls disproportionately on certain sections of the population (Quin and Redmond, 2005). Within low income and unskilled occupational groups, there are both higher levels of common mental disorders than for other groups, as well as higher rates of admissions to psychiatric hospitals (Daly et al, 2005; European Commission, 2003). Poverty, gender inequalities and ethnicity play a role in mental health, both in the onset of illness but also in terms of access to services and recovery rates (Laffan, 2006; Mind, 2002).

### **Key Findings**

The report therefore analyses the broad factors which determine mental health for the whole population as well as the key strategies for protecting and supporting people with mental ill-health to recovery and increased social inclusion. The following distinct areas are examined in the report (see Figure 2):

- **Mental Health can be strengthened**

- Co-ordinated action is needed at all levels to increase social inclusion. These include action at a society level, at an organisational level, at the community and at the individual level. International evidence suggests that strategies have to focus on all these levels.
- Vulnerable groups require particular action.

---

<sup>2</sup> Refers to care with psychiatric institutions, rather than within the community.

● **Work is the best route to recovery**

- Employment is the best protection against social exclusion. However, only a fifth of people with severe and enduring mental ill-health in Ireland are employed.
- Only one in five Irish companies has a written policy on mental health, yet nearly all employers would welcome information and guidance in this area.

● **Social supports protect against mental ill-health**

- There is a strong association between positive mental health and social supports in the community.

● **Integrated services play a key role in recovery**

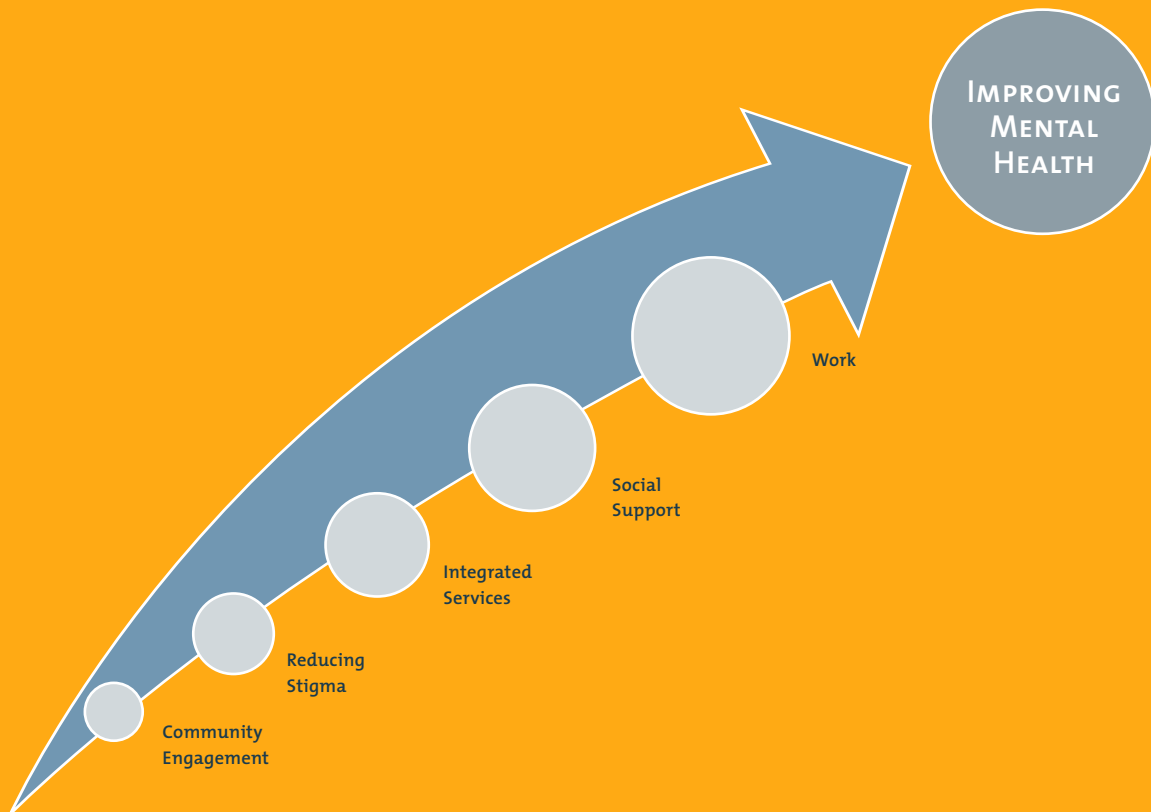
- To ensure a continuum of care from early intervention to recovery, the links to non-health sectors need to be included and strengthened at every service point. A co-ordinated approach is needed to meet the housing and support needs of service users.

● **Reducing stigma contributes to social inclusion**

- Stigma and discrimination have been identified as the greatest barrier to social inclusion, quality of life and recovery for people with mental ill-health.

● **Strengthening communities supports mental health**

- Community engagement and community development are key to building social capital, particularly in facilitating a self-help approach within communities, so that they can provide solutions to collective problems such as ill-health.

**Figure 2 Improving Mental Health****Summary of Recommendations**

The report concludes that mental health is a resource for living which contributes to and enhances the social, human and economic capital of our society. As such, the impacts have to be considered across the breadth of all social, economic and health policies.

The recommendations and the key actions under each of these strategic areas are presented in Figure 3 overleaf.

**Figure 3 Six Strategic Areas: Recommendations**

1. Institutional and Budgetary Issues	2. Raising Awareness and Challenging Stigma	3. Young People	4. The Workplace and Supported Employment	5. Integrated Services	6. Community Development
Health Impact Assessments  Healthy Public Policy Strategy	Holistic health education in schools	Specific gateways to access health services	Health and Well-being Framework Strategy for the workplace	Integrated services with vocational support	Support community development approaches
Action on vulnerable groups	Continuing health education and mental health literacy	Early intervention initiatives	Develop Supported Employment Schemes and Clubhouses	Integrated Community Mental Health Teams, Outreach Services and Primary Care	Audit of public services and community groups
Action on barriers to social inclusion	Media awareness campaigns		Strategic plan for training, work and employment services	Case management approach	Guide for structured work
Responsibility for vocational and social outcomes			Improved staff training, Increased employment targets	Staff training in recovery model	Greater support and recognition of community and voluntary sector
Cost-benefit analyses of proposals			Review pay and conditions for sheltered employment schemes	Step-down services  Co-ordinated action on housing	Social support initiatives

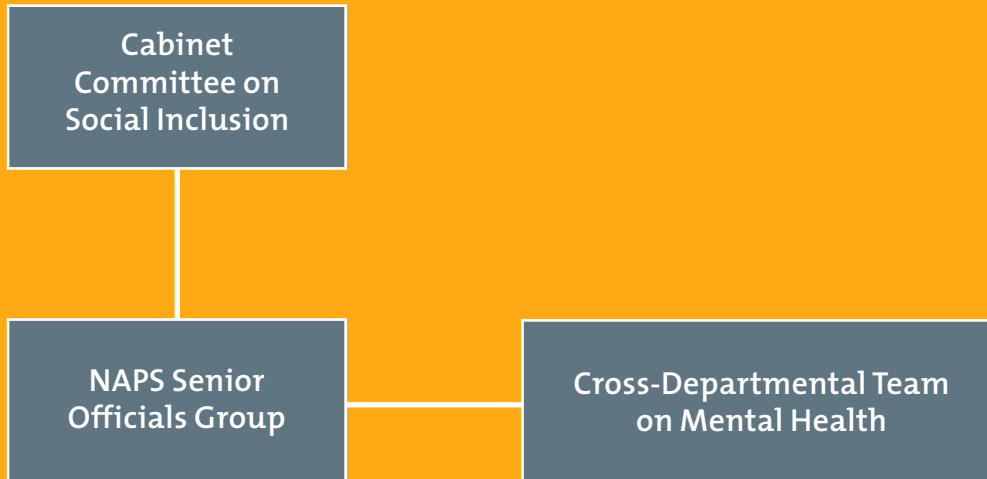


## Implementation

As underlined in the current social partnership agreement *Towards 2016* (Government of Ireland, 2006), public services must continue to modernise and at a faster pace if they are to better respond to the expectations and requirements of today's society. In keeping with this, the underlying thrust of this report is to move our mental health support services to a new more service-user focused system that is geared to meeting individual needs and with a case-management approach to setting clear targets and outcomes. But for this new approach to be successful, it must be underpinned by a set of guiding principles (NESF Report No. 34, 2007a), namely:

- a whole-of-government approach with improved co-ordination and integrated provision of services;
- a focus on early intervention/prevention;
- a strategic medium-term perspective for the planning, funding and provision of services;
- greater autonomy, with innovative and pilot approaches at local level, and a built-in evaluation culture to determine what is or is not working; and
- more use of user-consultation models to better inform the development and delivery of services on key aspects such as rights and quality standards, complaints and appeals procedures.

Responsibility to drive forward and oversee follow-up on the report's recommendations should be given to the Senior Officials Group under the Government's *National Action Plan for Social Inclusion* (Government of Ireland, 2007). For this purpose, targets, implementation schedules, performance indicators and outcomes should be established and regular reports prepared and published by that Group for public information and debate. Within this framework, a cross-departmental team should be established to ensure detailed implementation on the ground of the policy changes proposed in the report. This team should, in turn, report at regular intervals to the Senior Officials Group.

**Figure 4** Implementation Structures

Finally, some of the recommendations made here will require increased resources, but many of these will be cost-neutral and all that will be needed is more effective co-ordination and integration in the provision of services. In this regard, and bearing in mind that we are now among the richest countries in the EU, the Project Team recommends that increased expenditure be allocated, as necessary, to support the implementation of *A Vision for Change*. In addition, the Project Team recommends a cost-benefit analysis should be conducted to quantify those expenditures beyond the provision of mental health services, as the basis to provide additional resources for the implementation of the recommendations made in this report.

SECTION I

# Context and Issues

1

## Introduction

- 1.1 ● This report presents the findings of the NESF Project Team on Mental Health and Social Inclusion. It includes recommendations and key strategies to increase the social inclusion of people with mental ill-health as well as identifying broader actions for the promotion of mental well-being across Irish society. This chapter sets out the context of this report and introduces the key concepts being examined. This is followed by an overview of the work methods of the Project Team.
- 1.2 ● While examining macro policy issues in relation to mental health and social inclusion, this report also draws from examples of good practice internationally and nationally and from the submissions the Team received as part of its Consultation and Research Phase (see Section 1.13). An overarching aim of the report is to explore integrated strategies for policy implementation on mental health.
- 1.3 ● Mental health and well-being are as fundamental to everyday life as physical health, and indeed, they are interwoven in complex and emerging ways. It is known that mental well-being, social support and social networks are protective factors for physical health (Sturgeon, 2007). As the World Health Organisation argues, “*there is no health without mental health*” (WHO, 2005:6).
- 1.4 ● Mental health is now at the centre, not the periphery, of current international health debates. In 2005, the WHO European Ministerial Conference on Mental Health concluded that “*mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment*” (WHO Europe, 2005:3). In a European review of mental health promotion, Jané-Llopis and Anderson (2005:3) argue that “*a lack of positive mental health is a threat to public health, the quality of life and the economy of Europe.*”
- 1.5 ● Mental health is everybody’s business (WHO, 2005). International research has shown that mental health can be affected by non-health policies and practices, for example in housing, education and child care. Jané-Llopis and Anderson (2005:6) argue that action for mental health is “*an issue of shared responsibility and health and economic gains can be*

*achieved by the support and action of many different sectors and actors in society.”* Creating a mentally-healthy society entails addressing the broader socio-environmental and political influences and working across diverse sectors in order to address the upstream determinants of mental health (Barry, 2005).

- 1.6 ● This report seeks to identify effective strategies and measures which will promote positive mental health for all and increase the social inclusion and well-being of people, of all ages, with experience of mental ill-health. The overall goal is greater social inclusion which, as one submission made to the Project Team noted, is fundamental: *“Integrating people with mental ill-health into mainstream society is an important mechanism for recovery and it can also provide a catalyst for change in attitudes, and public perception of mental illness.”*
- 1.7 ● A ‘Population Health’ approach, adopted here, aims to improve the health of the entire population and to reduce health inequities among population groups. It is particularly important for the protection and inclusion of vulnerable groups and individuals to reduce their stigmatisation, discrimination and marginalisation and to support their full participation in community life. Those concerned are strongly at risk of social exclusion and are more likely to have low income, be unemployed and have low social status (WHO, 2005). An important implication of the population health perspective is that governments and social institutions must move away from an emphasis on health care policy per se to healthy public policies in all their dimensions (Dunn, 2002).
- 1.8 ● The blueprint at present for mental health policy development in Ireland is *A Vision for Change*. There is no doubt that the provision of proper mental health services is vital for the prevention, care and recovery of those experiencing mental ill-health. As *A Vision for Change* already provided a comprehensive overview and framework for mental health services, this will not be duplicated here. Rather, this report focuses instead on the complex and dynamic relationship between social inclusion and mental ill-health.
- 1.9 ● A lifecycle approach to mental health difficulties and mental ill-health is necessary as particular age groups experience different mental health issues and require age-sensitive solutions. Particular ages are examined in the report; for working adults, Chapters 6 and 7 examine employment and the workplace and for young people, Chapter 8 focuses on integrated services. Finally, Chapter 9 considers older people, in relation to community development approaches. Furthermore, a gender approach underpins this report as it is widely accepted that women and men are affected by different problems and experience them in different ways (Women’s Health Council, 2005).

- 1.10 ● The consequences of mental ill-health are far-reaching for Irish society, in terms of reduced economic performance, human and social capital and increased health and social welfare expenditure. Ireland has seen unprecedented economic growth in recent years alongside rapid social and cultural changes. This rising prosperity has, however, brought many costs with it, impacting on the quality of life such as housing and childcare pressures, increased levels of commuting, imbalance between work and home life and the challenges of a diverse and multicultural society. This has increased inequality with a greater divide between rich and poor (Joint Committee on Health and Children, 2006) and may have increased risks and challenges to mental health and well-being (Fitzgerald, 2007). However, Fahey (2007:22) argues that caution is needed against *“assuming that the Ireland of the Celtic Tiger era is a high-stress environment which is more damaging to our mental well-being.”*

## Scope of Project and Terms of Reference

- 1.11 ● An early scoping document prepared by the NESF Secretariat outlined potential key areas of focus. Three key overlapping aspects were proposed as being central: (i) towards recovery and the integration of services; (ii) inclusion of those experiencing mental ill-health through social supports and strengthening communities; and (iii) fighting stigma through broader mental health promotion and prevention. The Project Team agreed the Terms of Reference which included a focus on these three areas:
- (i) Prevention and recovery: What could integrated public services (health, social welfare, employment, education, training and housing) contribute to positive mental health, from timely identification through to recovery? What more can be done to support those with mental ill-health in the workplace?
  - (ii) Supports: What complementary individual, social and community supports are needed to strengthen positive mental health and social capital for the population generally?
  - (iii) Stigma: What practical steps can be taken to tackle prejudice, discrimination and disadvantage in Irish society?

The full Terms of Reference can be found in Annex 1.

## Methods of Work

- 1.12 ● The Project Team comprised representatives from the Oireachtas, the social partners, mental health professionals and also service users.

---

**CHAIRPERSON** Professor Cecily Kelleher, UCD

---

**STRAND ONE**

---

**Dan Neville T.D.** Fine Gael

---

**Senator Geraldine Feeney** Fianna Fail

---

**Liz McManus T.D.** Labour

---

**STRAND TWO**

---

**Danny McCoy** IBEC

---

**Liam Doran** ICTU

---

**Breda McDonald** Irish Country Women's Association

---

**STRAND THREE**

---

**Sheila Cronin** CORI

---

**Frances Byrne** OPEN

---

**Maria Fox** Disability Federation of Ireland

---

**STRAND FOUR**

---

**Frank Mills** HSE

---

**Dr Pat Bracken** West Cork Mental Health Services

---

**John Saunders** Schizophrenia Ireland

---

**Alessandra Fantini** Women's Health Council

---

**David Moloney** Department of Health and Children

---

**Prof. Eadbhard O'Callaghan** St John of God Hospital Services

---

**Mike Watts** GROW

---

**John Redican** Irish Advocacy Network

---

NESF Secretariat **Dr Jeanne Moore**

---

## Consultation and Research Phase

- 1.13 ● As part of the work of the Project Team, a Public Call for Submissions resulted in 80 submissions from a wide-reaching cross-section of mental health organisations, service users, voluntary and community groups, health professionals, academics and researchers among others. These have informed the work of the Project Team and are referenced in the report. A Summary of Submissions can be found in Annex 2.



- 1.14 ● The Secretariat also consulted widely with experts and key stakeholders in the area and the Project Team met directly with service users and representatives from youth and children's organisations. In addition, as Scotland is a leading example of mental health promotion, the Secretariat visited Scotland and met with representatives of the Scottish National Programme for Improving Mental Health and Well-being. A list of all those consulted can also be found in Annex 5.
- 1.15 ● A seminar was held by the Project Team in the Mansion House on the 3rd October, 2006. This was well attended and guest speakers were Dr David Morris, National Social Inclusion Programme, National Institute for Mental Health in England; Dr Maria Duggan, a UK consultant in mental health and Dr Pauline Prior, Queen's University Belfast. A list of attendees is presented in Annex 5.
- 1.16 ● As part of the work of the Project Team, research was commissioned from Millward Brown IMS Consultancy Limited on workplace attitudes and experiences of mental health issues. Key results from this are included in Chapter 6. A discussion paper on the role of the community in mental health was commissioned from Dr Michelle Millar of NUI, Galway. Finally, a legal briefing on mental health and the workplace was commissioned from Mason, Hayes and Curran and was taken into account in the preparation of Chapter 6.
- 1.17 ● The Team presented a draft of this report at a Plenary Session of all NESF members, and invited individuals and organisations interested in this area of work, on 17th May 2007 in the Royal Hospital Kilmainham. This Plenary Session was addressed by Mr Gregor Henderson, Director of the Scottish National Programme for Improving Mental Health and Well-being. The Plenary was well attended and provided valuable feedback to the Team. A list of those who attended is presented in Annex 5.

## Outline of the Report

- 1.18 ● The report is structured in three main sections.

- Section I** This sets out the key issues in relation to mental health and social inclusion and places the work within the current policy context.
- Section II** This identifies strategies and initiatives from national and international evidence to increase social inclusion for those experiencing mental ill-health, particularly focusing on: the workplace, employment, training and meaningful occupation; integrated services and the role of community.
- Section III** This presents the recommendations of the Project Team.

## Acknowledgements

- 1.19 ● The Project Team would like to thank all those who contributed to this report. It is particularly grateful to those who made written submissions, and to those who took time to meet the Team and Secretariat. The Team would like to thank Millward Brown IMS, Dr Michelle Millar and Mason Hayes and Curran for their contributions to the Project. In particular, the Team would like to thank its Chair, Professor Cecily Kelleher for her leadership and insight and the NESF Secretariat for the quality of its work.



2

## Introduction

- 2.1 ● This chapter outlines the context to mental health and social inclusion policies. It begins with Section (i) definitions, key terms and an overview of the concept of mental health, followed by a brief description of the perspectives adopted in the report. Section (ii) goes on to profile the incidence of mental ill-health in Ireland.

### (i) Definitions and Perspectives

#### Definitions

- 2.2 ● Mental health is used here to refer to *“a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community”* (WHO, 2001a:1). Mental health is a positive concept which is embedded in the social, economic and cultural life of the community (Barry and Jenkins, 2007). Mental health is shaped by many individual, interpersonal, social and cultural factors and influenced by a person’s biological makeup; emotional resilience; sense of harmony; hardiness; access to resources; sense of belonging; level of social support; resistance to stress; autonomy; competence and spirituality (Vaillant, 2003). *Well-being is used here to mean “more than just happiness. As well as feeling satisfied and happy, well-being means developing as a person, being fulfilled, and making a contribution to the community”* (New Economics Foundation, 2004:2).
- 2.3 ● The term, *mental ill-health*, is used here to describe the full range of mental health problems that might be encountered, from psychological distress to severe and enduring *mental illness*. Mental illness refers to specific conditions such as schizophrenia, bi-polar disorder and clinical depression.

- 2.4 ● As the World Health Organisation (WHO, 2005:13) argues, “*mental health for each person is affected by individual factors and experiences, social interaction, societal structures and resources and cultural values. It is influenced by experiences in everyday life, in families and schools, on streets and at work*” (Lahtinen *et al*, 1999). It is argued that mental health and mental illness are different concepts and that mental health is more than the absence of illness (Keyes, 2005). This is conceptualised by Downie and others in terms of a two-factor/axes model in which people can consider their own levels of mental illness while at the same time assess their mental health levels (Downie *et al*, 1990). In this way, “*many individuals otherwise free of mental disorder do not feel healthy or function well and are ‘languishing’ as opposed to those with high mental health levels, coined by Keyes as ‘flourishing’*” (Keyes, 2005: 540). In this way, someone who is recovering from mental illness can have periods when they have positive mental health and well-being.
- 2.5 ● It is important to note that the meaning of mental health and mental ill-health is, to an extent, culturally determined. According to Dein (1997: 474), “*in the West emphasis is placed on psychological factors, life events, and the effects of stress, but in many parts of the Third World explanations of mental illness take into account wider social and religious factors.*” With increasing diversity in Irish society, any discussion of mental health and ill-health needs to take this into consideration.
- 2.6 ● Primary care is used here, as in the Department of Health and Children (2001:15) *Quality and Fairness: A Health System for You*, as “*an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.*”
- 2.7 ● Research evidence confirms that those who experience poverty, disadvantage and exclusion are at an increased risk of suffering from poor mental health (Payne, 2000). There is a consistent relationship between poor mental health and social exclusion indicators such as low income, poor education, unemployment and low social status (Fryers *et al*, 2003; WHO, 2005). In 2005, those with a chronic illness had a significantly higher risk of poverty than those without a chronic illness (15.3%), and they were almost twice as likely to be in consistent poverty (9.5% compared with 4.8%) (CSO, 2006).
- 2.8 ● There is evidence of the impact in both directions, with social exclusion itself damaging mental and physical health and contributing to inequalities (Mentality, 2003). The inter-relatedness of social exclusion problems is mutually reinforcing and in combination, they create a fast-moving, vicious and complex cycle (Morris, 2006). The processes of social exclusion are, therefore, both dynamic and multifaceted.

- 2.9 ● There are three aspects to the focus on social inclusion in this report: (i) taking the broadest view, positive mental health and well-being for the whole population is underpinned by social inclusion, social cohesion and social capital. Strengthening individual and community resilience supports people to positively manage periods of transition throughout life; (ii) those who experience enduring mental ill-health are among the most socially excluded in Irish society; and (iii) at the same time, poverty and social exclusion impact on mental health, in terms of illness levels but also in terms of access to services and recovery rates.

### Shifting Perspectives

- 2.10 ● There has been an international shift in perspectives on mental health away from narrow medical models towards more social ones, in which the individual's recovery and integration into the community is promoted and developed. Current policy in mental health as outlined by *A Vision for Change* adopts many of these as central to its policy vision for mental health services in Ireland, including a bio-psychosocial model, a population health approach, an emphasis on recovery and the central role of service users.

### Social Model of Mental Health

- 2.11 ● As already mentioned, there has been a shift from a medical model towards a social model of mental health. The medical model focuses on prevalence of mental illness, treatment and stabilisation. It has been argued that this is a reductionist model, presenting a narrow and limited view of mental health. In contrast, the social model, (or social models), focus on wider determinants of broader health and well-being, and the role of relationships and the wider community in supporting mental health (Duggan, 2002). They are viewed as constructionist approaches which recognise that health and well-being are shaped by both individual experiences and through living in a socially constructed social world. The social model recognises gender and cultural differences in the meaning of mental health and places responsibility for policy development across all sectors.

### Recovery Approach

- 2.12 ● The *recovery approach*, which underpins this report, emphasises the expectation of recovery from mental ill-health. This can be understood as a social process of recovering a fulfilling life regardless of the presence or absence of symptoms (Kruger, 2000). It promotes both enhanced self-management for mental health service users and the development of services which facilitate the individual's personal journey towards recovery and ultimately, finding a meaningful role in society (Mental Health Commission, 2005b).

- 2.13 ● The challenge in using the recovery approach is that it has a multiplicity of definitions and is used to mean a process, an outcome and a relationship with the wider social environment (Onken *et al*, 2002). Some of the core principles of recovery include: the need for hope, direction and to have dreams; the need to have people who believe in you; the need to take small risks and to take small steps (from a submission made to the Project Team). At the outset, the Team particularly welcomes the inclusion of a recovery-focused approach to treatment and support/care as a key standard for mental health services (Mental Health Commission, 2007).

### Health Promotion

- 2.14 ● *Mental health promotion* is an under-resourced aspect of health care (Quin and Redmond, 2005) and is essentially concerned with making changes to society that will promote people's health and mental well-being. Health promotion programmes which emphasise the whole person, with mental health and well-being just one component, tend to be more effective (Sturgeon, 2007). The health promotion approach views individual positive health as an individual developmental process nested within specific cultural, historical, socio-political and economic settings (WHO, 2005). Figure 2.1 outlines some of the key messages from a health promotion perspective.

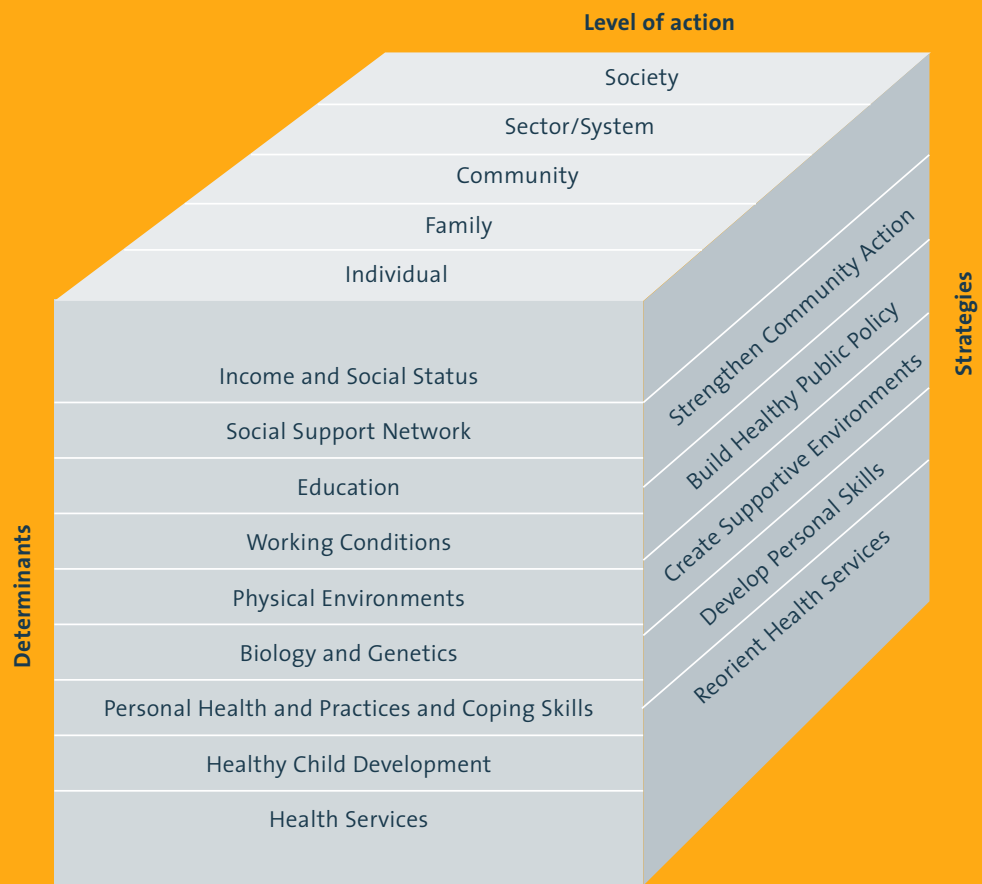
### Figure 2.1 Key Messages on Health Promotion

- There is no health without mental health.
- Mental health is everybody's business.
- Mental health is more than the absence of mental illness: it is vital to individuals, families and societies.
- Mental health is determined by socio-economic and environmental factors.
- Mental health is linked to behaviour.
- Mental health can be enhanced by effective public health interventions.
- Collective action depends on shared values as much as the quality of scientific evidence.
- A climate that respects and protects basic civil, political, economic, social and cultural rights is fundamental to the promotion of mental health.
- Intersectoral linkage is central to mental health promotion.



- 2.15 ● The underlying principle of mental health promotion is that mental health is an integral part of overall health and is therefore of relevance to all (Barry and Jenkins, 2007). The *Ottawa Charter for Health Promotion* (WHO, 1986) enshrined empowering, participative and collaborative processes and outlined a systems approach spanning individual, social and environmental areas for action to promote health. Most recently *Health in All Policies: Prospects and Potential* (Finnish Ministry of Social Affairs and Health, 2006) provides an encompassing approach which goes beyond the boundaries of the health sector. It addresses all policies such as transport, housing, the environment, education, fiscal policies, tax policies and economic policies.
- 2.16 ● Figure 2.2 shows the multi-dimensional nature of health promotion and its application to mental health (adapted from Evans and Stoddart, 2003). It outlines three dimensions: determinants, levels of action, and strategies. It further indicates the role of evidence-based policy in shaping the work of health promotion. Gender is a further determinant of health, although not listed here.

Figure 2.2 The Scope of Health Promotion



## Human Rights

- 2.17 ● Increasingly in Ireland and elsewhere, access to and equity of mental health services, care and recovery have been examined in terms of fundamental human rights. While the policy implications of this are examined in Chapter 3, it is important to note that the rights perspective is increasingly voiced in support of greater social inclusion and equality for those with experience of mental ill-health (Who, 2005a). Amnesty International (2003c) argue that recovery — i.e. individuals being empowered to live productive, dignified and meaningful lives — is a human right and includes an obligation to prevent and address the discrimination and social exclusion experienced by people with mental health problems.

## Quality of Life and Happiness

- 2.18 ● Other prevailing approaches focus on specific aspects of well-being such as happiness and broader concepts such as quality of life. While these are still emerging and the source of much discussion, they are worth noting here as a reflection of the increased emphasis in policy debates on the non-economic aspects of development.
- 2.19 ● The quality of life perspective focuses on non-medical aspects such as subjective well-being and satisfaction with different areas of life, objective functioning in social roles and environmental living conditions (Katschnig, 1997). Key to this approach are the perspectives of service users and their own assessment of their improvements and changes. With the growth of community-based care, there is increasing attention being paid to the impact of service provision on the quality of life of service users (Katschnig *et al*, 2006). This emphasis on the whole person, quality of life and well-being has also been to the fore with a focus on work-life balance and family-friendly policies.
- 2.20 ● There has been increasing debate on the relationship between happiness and economics with some measures introduced internationally, such as Gross National Happiness and the Happy Planet Index (Layard, 2005; Mustafa, 2005; National Economics Foundation, 2006). Ireland has been recently rated third across Europe in happiness levels as well as third highest GDP per capita (Aslam and Corrado, 2007). Ostir *et al* (2000) found that happy people were half as likely to die early or become disabled as unhappy people. In Ireland, an analysis of happiness in relation to social capital found that the distribution of happiness was very uneven with those who are unemployed and disadvantaged well below average (Healy, 2005; NESF Report No.28, 2003). However, happiness was not due to income or education levels but was more to do with not being unemployed, having social support, not feeling isolated, marital status and trust of others.

### The Increased Role of Community<sup>3</sup>

- 2.21 ● Local communities have a potentially key role to play in supporting and fostering positive mental health. Good mental health is sustained in part through social networks, community engagement, purposeful activity and inter-personal skill development.
- 2.22 ● The ultimate goal of recovery is inherently linked to community; to maintain a stable purposeful life in a local area, developing social networks and positive relationships. *“Ultimately, the success or failure of efforts in community care will depend less on mental health professionals’ ability to create supportive environments or to teach specific skills and more on the ability to find and encourage naturally occurring niches. These niches are where people find meaning in life, mutual rather than uni-directional relationships and consistent ongoing structures on which to depend (Salem et al, 1998)”* (from a submission made to the Project Team by GROW).
- 2.23 ● However, there has been insufficient discussion of the nature and diversity of communities and what can be done to facilitate successful community care. What are the tensions inherent in community, and how do some communities engage in the process of community care more effectively than others?
- 2.24 ● The concept of community is itself, contested and no single definition exists (Kagan and Lewis, 1998). In a general sense, community can be defined as *“a group of people who live in a common territory have a common history and shared values, participate together in various activities and have a high degree of solidarity”* (Phillips, 1993:14). However, there can also be communities of interest, such as those fostered in on-line support groups. Community can also be explored as a value (Frazer, 2000). When community is discussed in relation to mental health, it is often used in largely positive terms as a good thing, without tension, diversity or conflict. However, there may be multiple communities of interest, neighbourhoods and, rather than co-exist in harmony, these may compete for limited resources.
- 2.25 ● Furthermore, strong communities may emerge from adversity and inequality, rather than from consensus and commonality. As Sprigings and Allen (2005:398) argue *“community life is a mechanism that arises to cope with lack of opportunity rather than one that creates opportunities.”* Communities with high levels of economic and social disadvantage can develop strong and active engagement in civic life, for example, Dublin’s Ballymun or Tallaght. However, strengthened communities may exclude vulnerable people they perceive as undesirable (King’s Fund, 2000). So strengthening communities, and in turn, social capital have to go hand in hand with issues of diversity and equal citizenship (Dept of Health, 2001).

<sup>3</sup> Some of this work on communities is drawn from the paper, “Community and Mental Health” by Dr Michelle Millar, commissioned by the NESF. The full text of this paper is available from the NESF website [www.nesf.ie](http://www.nesf.ie).

- 2.26** ● There is a relationship between mental health and social capital, albeit a complex and disputed one (Care Services Improvement Partnership (CSIP), 2007; McKenzie *et al*, 2002). The NESF (Report No. 28, 2003:3), in a report on the policy implications of social capital, defined it as “*networks together with shared norms, values and understandings that facilitate co-operation within or among groups.*” Sociologists have been examining the apparent link since Durkheim found that suicide and the degree to which individuals have a sense of belonging to the community are related (Durkheim, 1897). More recently, the *All-Ireland Survey on Social Capital and Health* found indicators of social capital have significant independent effects on perceived health including social contacts, social support networks and whether or not a person is civically engaged (Institute of Public Health in Ireland, 2003).
- 2.27** ● Social capital can help to mitigate the insidious effects of socio-economic disadvantage (Putnam, 2000). However, social capital cannot overcome the negative effect of structural socio-economic factors on physical and mental health problems. Kay argues “*there are limitations to what social capital can do. Social capital alone cannot build the social economy and develop communities. It has to be used in conjunction with the other forms of capital — financial, human, environmental and cultural*” (Kay, 2006:168).

## (ii) Incidence of Mental Ill-health in Ireland

- 2.28** ● While everyone has mental health needs, there is a smaller proportion of the population with mental ill-health. This section sets out existing research and data on its incidence in Ireland. In presenting such data, the Project Team recognises that there are tensions and disputes on the value and validity of measurement of mental ill-health.
- 2.29** ● It is further noted that many existing measurements tend to be focused on levels of illness rather than on well-being. However, the General Health Questionnaire is used to measure psychological well-being in Ireland and new scales are emerging elsewhere, such as the Warwick-Edinburgh Mental Well-being Scale (Stewart-Brown, 2006; CSIP, 2007).
- 2.30** ● There are ad-hoc surveys of mental ill-health incidence which have been conducted in Ireland<sup>4</sup>. Existing figures are drawn from (i) self-reported surveys, the census and ad-hoc research studies; (ii) in-patient admissions and databases; and (iii) comparative surveys. In England, psychiatric morbidity surveys are conducted regularly and can examine the relationships between mental ill-health and social exclusion, but this is not the case here.

---

<sup>4</sup> Several national surveys that focus on mental health, will be available by the end of 2007 including the SLÁN survey (N=10,000 adults); the NDA National Disability Survey; and the HRB Psychological Well-being Survey. Also, the All-Ireland Traveller Health Needs Assessment and Health Status Study will be completed in 2007.

(i) Irish self-report surveys have consistently found that one in ten respondents reported personally suffering from a mental illness (National Office for Suicide Prevention, 2007; Mental Health Ireland 2005; 2003). In the most recent of these, the surveys commissioned by the National Office for Suicide Prevention (2007), this level increased to 13% for women and 8% for men. In the Mental Health Ireland Surveys, of those reporting a mental illness, over two-thirds of had suffered from some form of depression; 3% reported eating disorders and 9% experienced anxiety disorders, phobia or panic attacks. In 2005, 68% reported having some experience of people with mental illness, reducing from 73% in 2003. This was mainly in the extended family (35%) and among friends and acquaintances (23%) (Mental Health Ireland, 2003; 2005).

CSO (2004) found that 30,500 adults aged 15 - 64 years describe themselves as having a “*mental, nervous or emotional problem*” including intellectual disability, representing 10.2% of the total with disabilities of working age in Ireland<sup>5</sup>. Of those, 71.8% were single, widowed or separated as compared to 45.9% of those with all types of disability overall. Only 13.7% were in employment compared with 37.1% of those with all types of disability. In broader terms this represents a fifth of the employment rate of the general adult population (64% in 2004) (Conroy, 2005).

*The Survey of Lifestyle Attitudes and Nutrition (SLÁN)*, (Centre for Health Promotion Studies Galway, 2003), found that 19.5% of women surveyed reported they had been told by a doctor they had difficulties with anxiety or depression as did 13.4% of men. This is contrasted with results from a pilot study which suggested that 25% of patients attending general practice in Ireland have mental health problems (Coptly and Whitford, 2005).

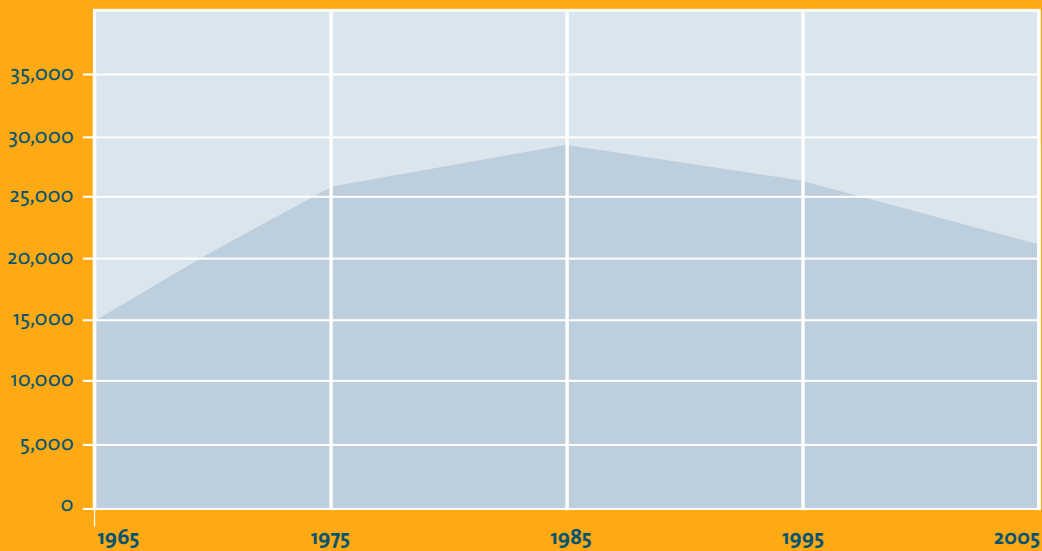
Stress levels have also been measured but are difficult to confirm; one study found over a third (35%) of the population had experienced notable stress levels (Mental Health Ireland, 2001), whereas another noted that 14% ‘often’ experienced stress (Amárach Consulting, 2004). Recently, Layte *et al* (2007) have argued that psychological stress has declined substantially in Ireland since 1987.

(ii) Data from the *National Psychiatric In-Patient Reporting System (NPIRS)*, as produced by the Health Research Board, shows a decline in admissions since 1985 (Daly and Walsh, 2006) (see Figure 2.3). The most common mental illness reported in admissions was depression (31%). The level of readmission remains at 72%, a fairly constant figure over the last 25 years. Despite the lack of comparative data on readmission levels from other countries, and the episodic nature of some forms of mental ill-health which result in repeated admittance, nevertheless, this represents a disturbingly high percentage.

<sup>5</sup> 10.9% (298,300) of those aged 15 to 64 indicated that they had a long-standing health problem or disability (CSO, 2004). 23.8% of the population reported a chronic illness or disability in 2005 (CSO, 2006).

**Figure 2.3** Number of Admissions to Psychiatric Units and Hospitals 1965–2005

## All Psychiatric Unit and Hospital Admissions



Source: Daly and Walsh, 2006.

In addition to this information on psychiatric units and hospitals, there are also community residences which provide accommodation for people with mental ill-health needs. The most recent figure available is from 2004 which shows that there were 3,065 residents in community residences, a figure which has risen from 900 in twenty years (Health Research Board, 2007). In the future, more comprehensive data on community-care will be available as COMCAR, a database to record activity at community care level, is being piloted in numerous sites around the country, prior to national roll-out by the Health Research Board.

An estimated 8% of all children in Ireland have a special educational need arising from mental ill-health (National Council for Special Education, 2006).

- (iii) 1 in 4 people will experience mental ill-health at some point in their lives (WHO, 2001). This figure has also been applied to Ireland (Dept of Health and Children, 2001). WHO (2001) estimates at least 5% globally suffer from severe and enduring mental illness and between 15-20% experience broader mental ill-health. However, this may under-estimate how common mental illness is over the course of life as one large American study found about half of the population would experience a mental illness at some time in their life (Kessler *et al*, 2005; McGorry, 2005).

European comparative data indicates an incidence of 27% of mental ill-health for the adult population. Wittchen and Jacobi (2005) found that, in a sample of adults from 16 European countries, 27% had or had been affected by at least one mental disorder in the past 12 months.

Barry *et al* (2002), comparing levels of psychological ill-health across Europe, using the General Health Questionnaire, found that Ireland came out with the lowest levels. Northern Ireland showed the highest levels of psychological morbidity of all countries. Levels of stress, depression and anxiety were self-reported by fewer workers in Ireland (0.65%), compared to the EU average (1.18%) (European Commission, 2004). However, this low incidence is contrasted by suicide levels, which remain relatively high in Ireland, with 431 suicides reported in 2005<sup>6</sup>. This was more than the number of fatalities on the roads, 399 in 2005.

Similarly, Ireland emerged second highest in a comparison of well-being scores in a recent *Eurobarometer Survey* for the European Commission (2006), with 82% of the sample feeling happy most or all of the time during the past four weeks, compared with the EU average of 65%. 78% of the Irish sample never or rarely felt downhearted or depressed, while the EU average was 71%. However this was contrasted by 67% saying they feel calm and peaceful all or most of the time compared with an EU average of 63%.

- 2.31 ● There is value in supporting rigorous qualitative research to add to current understanding of the nature and experience of mental health and well-being. In particular the Project Team feels that more research on the service user experience, the routes in and out of mental ill-health, and the recovery process, is badly needed for policy purposes. An example of work in this area is the Narrative Research Project conducted by the Scottish Recovery Network, which included the collection of 67 stories from those with experience of mental ill-health and recovery<sup>7</sup>. Currently underway at the Health Research Board, and welcomed by the Project Team, is a three-year qualitative study on the users' perceptions of their journey to recovery.

### Differences and Inequalities in Incidence

- 2.32 ● As already mentioned, while mental health impacts on the overall population, the burden of ill-health falls disproportionately on certain sections of the population (Quin and Redmond, 2005). See Wren (2003) for a discussion of the key issues in the debates on accessibility and equality in Irish health care.
- 2.33 ● Kelleher *et al* (2006) 'Life-ways' research has demonstrated the relationship between socio-economic status and health which stretches over generations. Poverty, gender inequalities and ethnicity play a role in mental health, both in the onset of illness but also in terms of access to

<sup>6</sup> The provisional figure for 2006 is 409 (CSO, 2007). Males accounted for 78% of suicide deaths registered in 2006.

<sup>7</sup> <http://www.scottishrecovery.net>

services and recovery rates (Laffan, 2006; Mind, 2002). An overview of current research evidence argues that ‘common mental disorders’ are significantly more frequent in socially disadvantaged populations (Melzer *et al*, 2004). Those who are socially excluded have an increased incidence of mental ill-health and vice versa, so that it can develop into a cycle of exclusion (Social Exclusion Unit, 2004). In Ireland, the highest rates of admission to psychiatric hospitals and units are for those from unskilled occupational groupings (Daly *et al*, 2005). Across Europe, common mental disorders are about twice as frequent in the lowest income groups compared to the highest (European Commission, 2003).

- 2.34 ● The National Office for Suicide Prevention (2007:1) found that “*the lowest quality of life reported (64%) was by those who have experienced mental health problems themselves.*”
- 2.35 ● The Institute of Public Health (2003) outlined the inequalities in health and found that mental health scores vary with education level and social class across Ireland. Those with the highest mental health scores were more likely to be economically inactive; on the lowest level of income; renting in the public sector and under 40 years of age. They further found, in their analysis of the health implications of social capital, that positive mental health levels were more likely among people who also reported feelings of safety in the local area; knowing and trusting neighbours; having contact with friends and neighbours; and active involvement in local organisations. In overall terms, they found that social contact had a very positive effect on general mental health.
- 2.36 ● The impact of mental health problems over time has been found to vary among social groups significantly. About half of people with common mental health problems are no longer affected after eighteen months, but those with lower socio-economic status, the long-term sick and unemployed are more likely still to be affected (Singleton and Lewis, 2003).
- 2.37 ● Age, living circumstances and gender also play a factor. HARP, an all-Ireland study of older people, found that those over age 75 were more likely to show levels of depression than other groups (Institute of Public Health, 2005). However, mental health problems are not an inevitable part of the ageing process but can sometimes be treated as such (The Healthy Ageing Project, 2007).

The Clonmel Project, a study of the mental health service needs of children and adolescents in the South East, found that 18.71% of children and adolescents had at least one psychological disorder in a study of three quarters of those under 18 years in the area (Martin *et al*, 2006). Another study found poor economic situation, being widowed or separated or living in a large city were related to poor mental health (Lehtinen *et al*, 2005).

In Ireland, over half of all admissions to psychiatric units and hospitals in 2005 were of single people (Daly and Walsh, 2006). In addition, many studies show that women experience greater mental ill-health (Women’s



Health Council 2005). Depression is twice as likely to be experienced by women as men (Maguire, 1995). This is a treatable illness and most patients recover, but a poor prognosis is associated with being female among other factors (Cryan, 2000).

### Vulnerable Groups

- 2.38 ● A survey of prisoners found high rates of mental ill-health among male and female prisoners but higher for women: 27% of sentenced men and 60% of sentenced women (Kennedy *et al*, 2004). Most prisoners with a mental illness were also noted to have problems with drugs and alcohol.
- 2.39 ● International and Irish studies show a high incidence of psychiatric illness among the homeless population. However, these studies show huge variations in the prevalence rates. Scott's (1993) review of existing studies indicated that between 30% and 50% of homeless people was suffering from mental ill-health. This is supported by Irish research: the Royal College of Surgeons in Ireland study of 171 homeless men in Dublin (Feeney *et al*, 2000) indicated that over 50% of them suffered from depression or anxiety. A further study by the College (Smith *et al*, 2001) of 100 homeless women in Dublin indicated a much higher level of depression (70%) among this group. Condon (2001) screened 254 homeless people in Dublin and found that 46% had depression.
- 2.40 ● There is no clear picture of the mental health needs of Travellers. However, in recent years, mental health and suicide have strongly emerged from work on the ground as key issues (Pavee Point, 2005). In an early study, Pavee Point (1997) found that 34% of Traveller women interviewed suffered from long-term depression, compared with a finding of 9% among their settled peers. More recently, in the Traveller Health Survey (Pavee Point, 2004), one third, out of a total of 365 respondents, reported depression in their family. According to the submission from Pavee Point, *“the Women’s Health Study also showed that GPs and hospital doctors felt levels of depression reported by Travellers were much higher than the general population.”*
- 2.41 ● While much of what is known about migrants in Ireland and mental ill-health is anecdotal, there is a growing awareness of the particular difficulties faced by asylum seekers and refugees, as well as the broader issues arising from different cultures. Pierce (2003) found there was little data available in her Report for the Equality Authority on disabilities but noted that SPIRASI (2002), the Asylum Services Initiative, estimate that at least 10% of the asylum seeking population in Ireland has survived torture. More recently, in a study of asylum seekers in Galway, Stewart (2006) also found that past traumas and fears for the future had an impact on their perception of mental health and well-being, as did length of time living under the direct provision accommodation system, and language barriers.

## Conclusions

- 2.42** ● Mental ill-health is a population-wide issue with increasing economic and social consequences. Adopting a population health and recovery approach draws attention to health promotion strategies to improve general health and well-being for everyone. The role of communities has been examined briefly here and this will be expanded in later chapters. In addition, there is a need for holistic strategies to support and include those individuals and vulnerable groups who experience inequalities in mental health and are at risk of social exclusion. It is clear that inequality and mental ill-health combine to form a vicious cycle of social exclusion. The following chapter will examine the policy issues involved.



3

## Introduction

- 3.1 ● Health is increasingly at the centre of public policy in Ireland but, as yet, mental health remains on the periphery. This chapter outlines the key policies which impact on mental health and the wider legal and policy framework within which mental health policy is situated. This is followed by a brief overview of developments at international policy levels. Finally, there is a discussion on the economic and social costs involved.

## Changing Policy Context

- 3.2 ● The significance of broader understandings of health in Irish policy is reflected in the recently created posts of Minister of State for Disability Issues and Mental Health, and Minister for State for Health Promotion and Food Safety within the Department of Health and Children. This shift in the direction of health policy has emerged in tandem with considerable organisational changes in both Irish mental health and primary care policy and services.
- 3.3 ● *Quality and Fairness: A Health System for You* (Department of Health and Children, 2001) put increased focus on adopting a population health approach, tackling health inequalities and placing health more at the centre of public policy. It also emphasised partnership and integration as themes. Primary Community and Continuing Care (PCCC) was established in the new structure of the HSE to provide health and personal social services including primary care, mental health, disability, child, youth and family, community hospital, continuing care services and social inclusion services.
- 3.4 ● *Quality and Fairness* further outlined that health impact assessment (HIA) would be introduced as part of the public policy development process. According to the *Action Plan Progress Report* (Department of Health and Children, 2006a) pilot HIAs were to be initiated in a number of Government Departments. One of the roles of the recently-established Health Information and Quality Authority (HIQA) is to promote quality nationally. This includes the promotion of formal health impact assessment programmes. However, in general terms, HIAs have not been actively pursued and as an indication of its lower profile, it is mentioned

only once in *NAPinclusion* (Government of Ireland, 2007) in relation to their use by the Office for Social Inclusion at a local level and in the context of a planned HIA of the *Integrated Homeless Strategy*.

- 3.5 ● The Primary Care Strategy outlined in *Primary Care: A New Direction* (Department of Health and Children, 2001a) proposed the delivery of a broad range of generalist services in the community by integrated multi-disciplinary primary care teams and primary care networks. Although still under development, one recent initiative is the distribution of Mental Health in Primary Care Resource Packs to all General Practitioners.
- 3.6 ● Other policies which impact on mental health include the Department of Health and Children's (2000) *National Health Promotion Strategy 2000-2005* which includes the promotion of positive mental health through identifying models of best practice, and initiating research into the development of a national positive mental health strategy. The strategic aim for mental health is "to promote positive mental health and to contribute to a reduction in the percentage of the population experiencing poor mental health" (p. 53). However, there has been an absence of models of good practice in this regard, despite the *Review of the National Health Promotion Strategy* (Dept of Health and Children, 2004) identifying the need for greater dissemination of models of best practice on mental health promotion (Elliot, 2005).

### Irish Mental Health Policy

- 3.7 ● There has been a gradual broadening out of policy in relation to mental health so as to focus more on its wider social value and its economic, social and cultural implications. There has also been increasing public interest in issues related to mental health and well-being, e.g. 'happiness', life satisfaction, the economics of well-being, work/life balance and quality of life (Eckersley, 2006; Layard, 2005).
- 3.8 ● Mental health policy is outlined in *A Vision for Change*, the Report of the Expert Group on Mental Health. This ambitious document, with over 160 recommendations, provides a broad framework for action to implement a shift from institutionalised service delivery to community-based services over the next 7 to 10 years (see Figure 3.1).

**Figure 3.1** Framework for a Comprehensive Mental Health Policy



Source: Adapted from *A Vision for Change*.

- 3.9** ● The emphasis, in *A Vision for Change*, is firmly on restructuring mental health services to provide an integrated multi-disciplinary approach and addressing the biological, psychological and social factors involved. It focuses on a holistic, person-centred treatment approach through a recovery-oriented, integrated care plan, based on best practice agreed with service users and their carers. It refers to the importance of community, social networks and the difficulties of stigma. Widely welcomed and developed from 18 months of consultation with key organisations, individuals and service users, it is the Government's current policy position on the development of mental health services. It builds on earlier policy, *Planning for the Future* in 1984, which recommended an accelerated move towards the provision of care in community settings and the closure of all large psychiatric hospitals but this was never fully pursued and implemented (Mental Health Commission, 2007).
- 3.10** ● According to a submission received by the Project Team: "A true shift to a community-oriented model requires a change in culture and systems described and purported in *A Vision for Change*. The culture must change from illness to mental health."
- 3.11** ● As regards social inclusion, there were several central recommendations outlined in *A Vision for Change*. While a fuller list is presented in Figure A.1, Annex 3, the most significant recommendations in this area, are:

- Equal access to employment, housing and education for people with mental health problems;
- Evidence-based approaches to training and employment;
- Community and personal development initiatives which impact positively on mental health status; and
- The National Mental Health Service Directorate, represented in the institutional arrangements, to implement the National Action Plan against Poverty and Social Exclusion.

- 3.12** ● There was an initial euphoria and widespread support for such a wide-ranging programme of reform. However, in recent months, there has been a critical debate on the speed of implementation, for example, in the *Report of the Inspector of Mental Health Services 2006* (Inspectorate of Mental Health Services, 2007)<sup>8</sup>. With such a radical agenda, it is as yet unclear how many of the social inclusion recommendations will be implemented and within what time-frame. An internal HSE implementation group, an independent monitoring group to monitor progress and an expert advisory group were established in 2006.
- 3.13** ● The *First Annual Report of the Independent Monitoring Group* (Independent Monitoring Group, 2007) concludes that there has been little evidence of a systematic approach to implementation to date and recommends that the HSE should finalise and adopt an implementation plan as a matter of urgency. It further recommended that a recovery approach should inform every aspect of service delivery and that areas of responsibility for the implementation of *A Vision for Change* be clarified between the National Office for Mental Health and the Primary, Continuing and Community Care Directorate (PCCC) within the HSE. In relation to Government Departments, the Monitoring Group recommends the establishment of an inter-departmental group within the Department of Health and Children, to progress the implementation of non-health recommendations.
- 3.14** ● The *Report of the Inspector of Mental Health Services 2006* (Inspectorate of Mental Health Services, 2007) provides a critical assessment of the psychiatric care and community services, with much more investment necessary to bring forward the changes outlined in *A Vision for Change*. These annual reports repeatedly raise serious and alarming concerns about mental health services (Sapouna, 2006). Despite Government promises going back over twenty years to close psychiatric hospitals and improved community-based care, the *Report of the Inspector of Mental Health Services 2006* found that the numbers of long-stay patients are slowly decreasing but the conditions of many remaining wards are entirely inadequate. It further reports that the staffing levels of multidisciplinary teams in most parts of the country remain low. It

---

<sup>8</sup> Minister Harney recently expressed disappointment at “the slow pace” at which change was taking place since the publication in January 2006 of *A Vision for Change*. (The Irish Times 21/6/07)



mentions that there are only 120 community mental health teams, the majority serving populations of between 20,000 and 50,000. Only 2 catchment areas out of 32 are in a position to offer multi-disciplinary services. In short, services in most parts of the country are limited by staff shortages, poor management and inadequate resources.

- 3.15 ● The Irish Psychiatric Association has also been critical of the speed and extent of implementation of *A Vision for Change* (Irish Psychiatric Association, 2007). They report that the National Mental Health Service Directorate has yet to be established, that no psychiatric hospitals have been sold and it is unclear if the resources needed for its full implementation will be forthcoming. Since its publication, the HSE has argued that its National Office for Mental Health is to replace the planned Mental Health Service Directorate (Independent Monitoring Group, 2007). The Monitoring Group has commented that the roles and authority of the staff of this Office in relation to implementing *A Vision for Change* are unclear.
- 3.16 ● Actions by the HSE also include the establishment of an interim National Service Users Executive and 18 Community Mental Health Teams, with the planned recruitment of 250 new staff this year and a total allocation for mental health services of just over €1 billion. The Programme for Government 2007-2012 outlines a commitment “*to invest in and fully implement the Vision for Change Strategy and provide further additional funding to support the recovery model of Mental Health service provision.*”
- 3.17 ● Some of the submissions noted there had been a number of progressive policy initiatives, announced in the past, but which had not been realised, a point also made by Sapouna (2006) in her review of mental health policy in Ireland. For example, *Planning for the Future* (Department of Health and Children, 1984) outlined a multi-disciplinary model of community-oriented care. As one submission argued, “this seemed like a revolution in mental care but which due to consistent cuts in funding has petered into further hospitalisation of the community.” Sapouna argues that mental health services in Ireland “are still dominated by institutional patterns of thinking and practicing” (Sapouna, 2006:89).

### Move Towards Community Care

- 3.18 ● A community care approach to mental health originated in Ireland with the 1966 *Commission of Inquiry on Mental Illness* which recommended the need for change from sole reliance on psychiatric hospitals to a community-based service (Department of Health, 1966). *A Vision for Change* has further developed this shift to community care, and over the next ten years, services are to move in this direction, in which “*people with mental health problems should be cared for where they live and if inpatient care is necessary, it is to be provided in the least restrictive setting*” (p. 15). We are nevertheless, behind many of our European neighbours in this transition, who are already developing and supporting housing and vocational/employment facilities for people with mental ill-health (Fakhoury and Priebe, 2002). However, this shift is neither easy nor

without tension. While public opinion supports this movement, with 91% of respondents agreeing that as far as possible, mental health services should be provided through community-based services (Mental Health Ireland, 2003), nevertheless, 18% felt (12% slightly and 6% strongly) that locating facilities in residential areas downgrades the neighbourhood. As Chapter 2 has argued, greater understanding of the barriers to community care and community engagement is needed here.

- 3.19 ● The National Primary Care Steering Group's *Guidelines for Community Development in Health: Position Paper* recommends prioritising and resourcing community involvement in health as an essential element in all health programmes/actions and service, including training courses, code of practice and an inclusive process of engagement, as well as performance indicators (Department of Health and Children, 2004a).
- 3.20 ● *A Vision for Change* (p.22) discusses community 'as a partner' in which the support of families and communities can improve outcomes in mental health. Key elements include "community involvement in the planning and delivery of services, harnessing of social support and involvement of providers with a diversity of skills in stepped services (Battersby, 2004)." The challenges to greater community provision are not simply about change or the difficulties of relocating services, but include barriers in terms of stigma, system inertia and multiple funders, professional vested interests and boundaries, and inadequate resources for prevention rather than treatment (Battersby, 2004). Some of the community-based services already in place have been criticised for bringing the institutionalised medical model care to the community setting (Bergin, 1998). In this sense, a successful move towards community care will not take place, therefore, without a shift in thinking among those delivering the service at all levels of planning and delivery (Bergin and Clarke, 2005).

### Policy on Suicide Prevention

- 3.21 ● A National Strategy for Action on Suicide Prevention, *Reach Out*, was published in 2005 (Department of Health and Children, 2005) and a National Office for Suicide Prevention was established within the Health Services Executive. This aims to co-ordinate suicide prevention activities across the country; disseminate and commission research; and consult with those working to reduce suicide. This Office is developing a national mental health awareness campaign, following on from a recommendation in *Reach Out*. This will be launched before the end of 2007, informed by a steering committee and research survey. The *Programme for Government 2007-2012* commits to a target of reducing suicide by 20% by 2012. It further aims to "increase services and supports for marginalised groups, particularly those with mental health difficulties (p.39)."

### Key Agencies, Organisations and Bodies

- 3.22 ● Key statutory agencies working in the area of mental health policy are the Department of Health and Children, now with a Minister of State for Disability Issues and Mental Health; the Mental Health Commission, the Health Service Executive (HSE) and the National Disability Authority (NDA). While the Mental Health Commission is responsible for quality in mental health services, the NDA has a policy role on disability which includes mental ill-health and has a Mental Health Advisory Committee to assist in this area.
- 3.23 ● The largest voluntary agencies include Schizophrenia Ireland, Mental Health Ireland, Aware, GROW, Irish Advocacy Network, Samaritans, Bodywhys, Alzheimer Society of Ireland, Irish Association of Suicidology and the National Federation of Voluntary Bodies. The Irish Mental Health Coalition and Action on Suicide Alliance are umbrella groups.

### Legal Context

- 3.24 ● While a detailed legal overview is beyond the scope of this report, it is important to place current mental health policy within its general legal framework. The most significant recent law is the *Mental Health Act, 2001* (Government of Ireland, 2001). This Act defines mental illness as “*a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons*”. The Act established the Mental Health Commission as an independent statutory body whose “*mandate is protect the interests of any person admitted involuntarily*” and “*to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services*” (Mental Health Commission, 2005a:13). The Inspector of Mental Health Services, appointed by the Commission, monitors the standard of care of mental health services.
- 3.25 ● The driving force of the Act was to ensure that Ireland is compliant with the European Convention on Human Rights and Fundamental Freedoms. Those who are admitted involuntarily have an automatic right to review through Mental Health Tribunals, which are independent legal entities appointed by the Mental Health Commission “*to ensure the protection of the rights of patients.*” However, the remit of the Act is wider than dealing with involuntary patients and refers to codes of practice applying to all who use mental health services. The remit of the Mental Health Commission covers the broad spectrum of mental health services. For example, the *Quality Framework for Mental Health Services in Ireland* (Mental Health Commission, 2007) provides a framework for the provision of quality mental health services.

- 3.26 ● However, critics of the Act argue that, in part, it “*represents a narrow, medical view of mental health services*” and “*fails to provide for the inclusion of people with mental health problems in Irish society*”... “*making no reference to the rights of voluntary clients and the rights of people receiving treatment in the community*” (Sapouna, 2006:93).
- 3.27 ● While the Act has been welcomed by many through its inclusion of service users in the Mental Health Commission as well as the establishment of Mental Health Tribunals, it is not as comprehensive as legislation elsewhere. Compared with Scottish legislation in this area, for example, there is no obligation on the State to prevent or promote the mental health and well-being of those experiencing mental ill-health.
- 3.28 ● The human rights perspective is based on Ireland’s obligation under United Nations rules and covenants to protect and support those with mental ill-health, most recently outlined by Amnesty International (2003). The *UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* states that “*all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person*” (Office of the United Nations, 1991; Principle 1). Prior to that, the *UN International Covenant of Economic, Social and Cultural Rights* (1966; Article 12) articulated “*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*” Most recently, the *UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* as outlined by Amnesty International (2003:10) sets out the obligation of States to “*enable persons with disabilities to exercise their rights including their human, civil and political rights on an equal basis with other citizens.*” The Council of Europe is in the process of developing a European reference tool for ethics and human rights in mental health. Another positive development is the inclusion of mental health in the Strategic Plan of Ireland’s Human Rights Commission. Amnesty International has also been campaigning here to advocate for improved mental health services in the context of international human rights obligations.
- 3.29 ● Equality for those experiencing mental ill-health also comes under disability as one of nine grounds covered under recent equality legislation, *Equal Status Act 2004* (Government of Ireland, 2004a) and the *Employment Equality Act 1998* (Government of Ireland, 1998) and *Equality Act* (Government of Ireland, 2000). Disability is used broadly to include people with all physical, sensory and intellectual disabilities and mental health issues.
- 3.30 ● *The Safety, Health and Welfare at Work Acts, 1989 and 2005*, (Government of Ireland, 1989; 2005) requires employers to put in place systems of work which protect employees from hazards which could lead to mental or physical ill-health. In addition, the voluntary *EU Framework Agreement on Work Related Stress, 2004* aims to increase awareness by employers and workers to prevent and manage work-related stress. Chapter 6 examines workplace issues in relation to mental health.

## The Disability Policy Context

- 3.31 ● Mental ill-health falls under the heading of disability and is, therefore, included under the *National Disability Strategy*. This Strategy includes the *Disability Act 2005* (Government of Ireland, 2005a); *Comhairle (Amendment) Bill 2004*, now the *Citizens Information Bill, 2006* (Government of Ireland, 2006); six outline *Sectoral Plans*<sup>9</sup> by Government Departments and the commitment to a multi-annual Investment Programme for disability support services; and the *Education for Persons with Special Educational Needs Act, 2004* (Government of Ireland, 2004).
- 3.32 ● *The Disability Act, 2005* seeks to ensure that public bodies must deliver integrated accessible services and assistance; accessible information; purchase of accessible goods/services and accessible premises by 2015. *The Citizens Information Bill, 2006*, introduces personal advocacy services specifically for people with disabilities. It includes the provision of a personal advocate to those with a disability who have difficulty in obtaining, without assistance or support, a social service. The *Education for Persons with Special Educational Needs Act, 2004* provides that children with special educational needs are educated in an inclusive environment and have the same right to avail of and benefit from education. It established the National Council for Special Education (NCSE) on a statutory basis and gave statutory functions to the Health Services Executive on the education of people with special educational needs.
- 3.33 ● The National Educational Psychological Service, under the aegis of the Department of Education and Science, operates a primary care service for children in school and currently has 121 educational psychologists<sup>10</sup>. Only half of all primary schools and three quarters of post-primary schools have direct access to this service.
- 3.34 ● A *National Disability Strategy Stakeholder Monitoring Group* has been established to review progress on this Strategy. Despite the evidence that those experiencing mental, emotional and intellectual disabilities are at greater risk of social exclusion due to lower employment rates (CSO, 2004), they have not, as yet, been specifically targeted in the Strategy. In broader terms, the Project Team notes with serious concern that mental ill-health remains on the periphery of disability policy and implementation. However, the Project Team welcomes the establishment of two sub-committees of the NDA Mental Health Advisory Committee on Housing and Employment.
- 3.35 ● *Disability Sectoral Plans* (July 2006) have been prepared by six Government Departments<sup>11</sup>: Communications, Energy and Natural Resources; Enterprise, Trade and Employment; Environment, Heritage and Local Government; Health and Children; Social and Family Affairs; and

9 These plans, for six Government Departments, set out clear goals for delivering key mainstream services to people with disabilities, provided under the *Disability Act, 2005*.

10 The Programme for Government (2007-2012) outlines an increase in the number to 200 educational psychologists by 2009.

11 <http://www.taoiseach.gov.ie>

Transport and the Marine. Across the Plans, effective cross-departmental co-operation is acknowledged as critical for the achievement of many of the goals identified. While the Plans are broad ranging in scope, some of the key points include the following:

- *Employment*: Developing a strategic integrated approach to rehabilitation services; greater focus on pathways into work and education and removal of disincentives and benefits traps that create barriers to taking up employment; promoting awareness regarding the employment of people with disabilities and the suite of materials developed under the Workway initiative, (see Chapter 7) to inform future policy and best practice (Department of Health and Children and Department of Enterprise Trade and Employment);
- *Services*: The focus is on person-centered supports for long-stay residents in psychiatric hospitals; 100 new places annually in community-based mental health facilities, including mental health day centres, day hospitals and community residential facilities, giving a total of 400 new places (Department of Health and Children);
- *Housing*: The development of a new *Housing Strategy for People with Disabilities* (Department of Environment, Heritage and Local Government); and
- *Carers*: Improving income supports for carers is planned (Department of Social and Family Affairs).

### Broader Social Policy Context

- 3.36 ● Most aspects of Government policies have some impact on mental health in terms of employment, education, transport and the creation of healthy social and physical environments for all. The National Development Plan 2007-2013 *Transforming Ireland: A Better Quality of Life for All* (Government of Ireland, 2007a) emphasises the social aspects of development and has specific social inclusion measures. However, these do not include particular reference to mental health or mental illness. A total of €18.8 billion is allocated to the *National Disability Strategy* but no breakdown is given for mental health.
- 3.37 ● *The National Action Plan for Social Inclusion (NAPinclusion)* (2007-2016) refers to the life-cycle rather than vulnerable groups (including disability) as the previous *National Anti-Poverty Strategy* did, but does include reference to mental ill-health and that “a strong body of evidence linking poverty and poor mental health and poverty is associated with greater use of mental health services” (Government of Ireland, 2007: 45). In particular it sets out a target of “the delivery, under the framework of the *Vision for Change Strategy*, of child and adolescent Community Mental Health Teams (CMHTs) in the order of 1 CMHT per 100,000 of the population by 2008 and 2 CMHTs per 100,000 of the population by 2013” (p.34).

- 3.38 ● *Towards 2016*, the Ten-Year Framework Social Partnership Agreement, adopts a lifecycle framework focusing on children, people of working age, older people and people with disabilities (Government of Ireland, 2006). This endorses *A Vision for Change* and supports its implementation. In broader terms it recognises that “*social capital can make an important contribution to healthy and sustainable communities*” (p.53). It sets out priority actions that include “*putting in place enhanced policies to support families in a changing society*” (p.44). In particular, it calls for:
- Person-centred supports to be developed for long-stay residents in psychiatric hospitals, with a view to their movement back into community living;
  - Developing a strategic integrated approach to rehabilitation services within the context of the multi-annual investment programme with a view to supporting people back into employment, as appropriate, through early intervention and enhanced service provision;
  - Consolidating and progressing vocational training and employment services for people with disabilities; and
  - Developing the *National Housing Strategy for People with Disabilities* (by 2009), to provide tailored housing and housing support to people with disabilities, “*with particular regard for people who experience mental illness*” (p.64).
- 3.39 ● *The National Women’s Strategy 2007-2016* (Government of Ireland, 2007) sets out its objectives under the themes of equalising socio-economic opportunity for women, ensuring the well-being of women; and engaging as equal and active citizens. The proposed actions on mental health include: (i) expand information on mental health in the Social Personal and Health Education (SPHE) programme in schools; (ii) institute a regular community survey to monitor progress on mental health development; (iii) provide counselling services through primary care referrals; and (iv) consider the introduction of awareness campaigns relating to mental health among women in the peri-natal period.

### EU International Context

- 3.40 ● In 2005, the European Commission Green Paper, *Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union* sought consultation on the establishment of an EU strategy on mental health. Mental ill-health affects nearly 30% of the EU population and costs the economies an estimated 3-4% of GDP mainly through lost productivity. Key issues that emerged included “*a greater emphasis on mental health promotion and prevention, as well as enhancing the situation of those with mental health problems through reducing stigma and discrimination*” (European Commission, 2005). The consultation process stressed that any EU policy framework should include a focus on social inclusion, prevention, participation and the recognition of gender as a key factor. Another key point made was that an “*effective mental health*

*strategy needs to engage policy sectors beyond health.*” These issues will now be considered and taken into account in the development of a strategy, due to be submitted to the Council of Ministers later in 2007.

### World Health Organisation

- 3.41 ● The Ministers of Health of Member States in the European Region of WHO produced the *Mental Health Declaration for Europe: Facing the Challenges, Building the Solutions* (WHO Europe, 2005). It argues that mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience meaningful lives and to be creative and active citizens. It contains five priorities: (i) foster awareness of the importance of well-being; (ii) collectively tackle stigma, discrimination and inequality and empower and support people with mental health problems and their families to be actively engaged in this process; (iii) design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery; (iv) address the need for a competent workforce, effective in all those areas; and (v) recognise the experience and knowledge of service users and carers as an important basis for planning and developing services.
- 3.42 ● This WHO Declaration goes on further to call for action to “*assess the potential impact of any new policy on the mental well-being of the population before its introduction, and evaluate its results afterwards*” (WHO Europe, 2005:4). This call for mental health impact assessments is reiterated in the Green Paper on mental health, mentioned above, which is likely to make a further contribution to raising the profile of mental health (European Commission, 2005).
- 3.43 ● There are several projects which are currently underway which, when completed, will give greater guidance on best practice in this area. A project funded by the European Commission is underway, *Best Practice in Promoting Mental Health in Socially Excluded Marginalised People in Europe (PROMO)* and will review current policy and legislation across countries to identify best ways to promote mental health among those socially excluded (from a submission made to the Project Team). Another project, *Good Practices for Combating Social Exclusion of People with Mental Health Problems*, run by Mental Health Europe, will also conclude its work in 2007.

### Northern Ireland

- 3.44 ● *The Mental Health and Learning Disability (Bamford) Review* (2006) produced comprehensive reports on different aspects of mental health. One report on health promotion, *Mental Health Improvement and Well-being: A Personal, Public and Political Issue*, took as its vision that: “*everyone has mental health needs; mental well-being underpins all aspects of health and well-being; and mental health, like physical health,*



is a resource to be promoted and protected” (Bamford Review, 2006:i). It identified the following as central to the success of mental health promotion: cross-sector partnership and working; co-ordination; dedicated resources, both additional and with a realignment or reconfiguration of existing resources to facilitate mental health promotion and prevention; compliance with equality and human rights legislation; capacity-building; prioritisation of key risk groups; and research. Northern Ireland also has a targeted health promotion strategy, *Promoting Mental Health: Strategy and Action Plan 2003-2008*, which emphasises the importance of prevention and early intervention as well as the relationship between mental well-being and poverty (Department of Health, Social Services and Public Services, 2003).

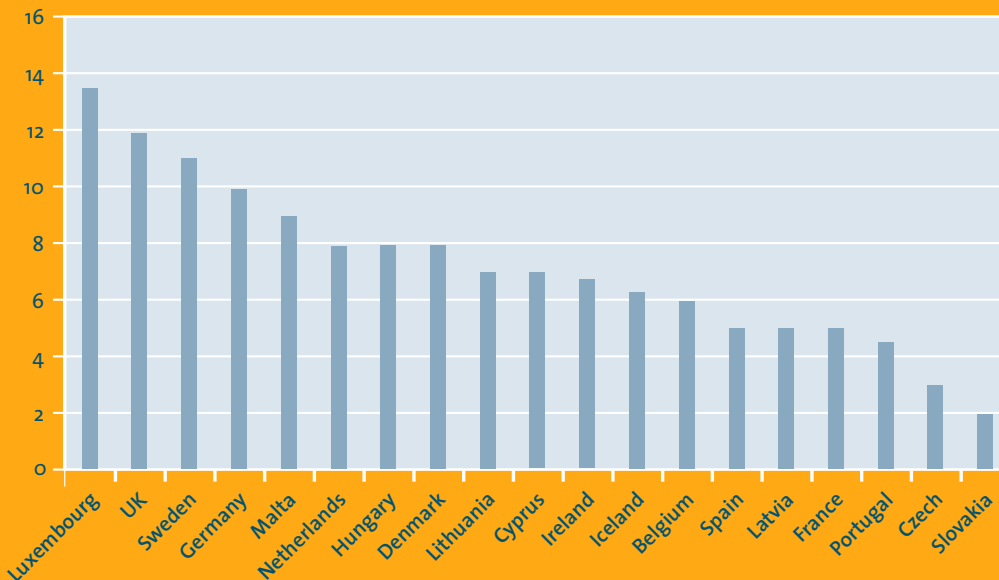
### United Kingdom

- 3.45 ● In England, the Office of the Deputy Prime Minister’s Social Exclusion Unit (2004) produced a report, *Mental Health and Social Exclusion*, which focused on reducing social exclusion for those experiencing mental ill-health and which has been useful to the work of the Project Team. With a clear timetable and action plan, a National Social Programme was established under the National Institute for Mental Health (NIMHE) to implement its recommendations. As of December 2006, 58% of the action points from the report were completed with a further 38% underway.
- 3.46 ● In Scotland, The National Programme for Improving Mental Health and Well-being has four key aims: raising awareness and promoting mental health and well-being; eliminating stigma and discrimination; preventing suicide; and promoting and supporting recovery<sup>12</sup>. With high profile media campaigns, discrete agencies and strategies, such as Choose Life, The Recovery Network, See Me and Breathing Space, a wide range of activities to promote mental health and address discrimination, suicide and recovery, and massive investment, Scotland is seeing a change in public attitudes to mental health and a small reduction in suicide rates among young men. A key element of the success in Scotland has been ensuring that suicide prevention work is undertaken within a wider framework of policy objectives and initiatives that share the overarching goals of population mental health improvement (Scottish Executive Social Research, 2006).
- 3.47 ● In this regard, while Ireland has developed a comprehensive policy document for the development of future mental health services, in the UK and the EU there has been more targeted policy development in relation to social inclusion.

### Expenditure

**3.48** ● Ireland’s reported expenditure on mental health services has dropped from 13% in 1984 to now just 7.34% of the national health budget, as compared with 12% in the UK and 10% in Germany (Mental Health Economics European Network, 2004; see Figure 3.2). This is complicated by the shifting definitions of mental health expenditure which now exclude addiction-related expenditure and intellectual disabilities, for example. Nevertheless, *A Vision for Change* includes recommendations for increased expenditure to 8.24%, based on 2005 figures. It further notes that 90% of public mental health services are provided at primary care level (p.179) but there is limited information available on the cost and effectiveness of these services. Even less is known on the expenditure on the housing, employment and training and educational aspects of mental health recovery. In the UK, between 60-80% of all costs associated with mental health problems occur outside the healthcare system (McDaid, 2004).

**Figure 3.2** Expenditure across the EU on Mental Health Services (% Total Health Expenditure)



Source: Mental Health Economics European Network (2004).

- 3.49 ● The increase of 11% in the numbers of people receiving disability payments over the last three years has prompted the Minister for Social and Family Affairs to initiate an examination by his Department on the reasons for this. However, Ireland was bottom of a table of 22 countries in terms of relative spending on disability in 2002 (Eurostat, cited in Wynne *et al*, 2006).
- 3.50 ● It is difficult to know what percentage of claimants would have mental health issues. In 2006, a total of 24,000 claims for Disability Benefit (DB) or Occupational Injuries Benefit (OIB) were made by those with incapacities that could be classified as mental or psychiatric illness, resulting in total expenditure in that year of €41.8m. This represents 8.3% of all of the total claims in that year and 6.4% of expenditure. One must also attach a note of caution to these numbers however as persons with mental illness may also be classified under other illness categories (figures supplied by the Department of Social Welfare, 2007)<sup>13</sup>.

### Wider Costs of Mental Ill-health

- 3.51 ● In recent years across the UK and more recently the EU and WHO, the policy focus has been directed at the economic and social costs of mental ill-health and outlining the business case for more effective policies (WHO, 2006). There is evidence to suggest that mental ill-health is costing governments significant sums in terms of benefits, loss of tax revenues and lower rates of employment and economic activity. The global burden of mental ill-health is increasing (WHO, 2005b) and work-related stress alone costs the EU at least €20 billion a year in lost time and health bills (European Commission, 2000).
- 3.52 ● Little is known about the economic impact of mental ill-health in Ireland<sup>14</sup>. In England, the Sainsbury Centre for Mental Health (2003) argues that mental illness costs the country more than £77 billion annually through the costs of care, economic losses and premature death and this is calculated at higher than the total costs of crime. In Scotland during 2005, the total cost of mental health problems was £8.6 billion which includes the human costs, output losses and health and social care. This is more than the total amount spent in Scotland by the NHS on all health conditions combined, and is equivalent in monetary value to 9% of their Gross Domestic Product. This figure is equivalent to a cost of £1,690 per head of population; the corresponding figure in England is £1,720, a difference of less than 2% (Scottish Association for Mental Health, 2006). This is still likely to be an underestimate, as the European Commission (2004) point out, mental ill-health can often start at an early age contributing to people living for a long time with the effects of mental ill-health and the indirect costs are not fully taken into account.

<sup>13</sup> There are three key benefits that people may receive if they have a mental health disability in Ireland: Disability Benefit is a short-term, contribution based, payment, received by 61,845 people at a cost of €540,957 in 2005; Disability Allowance is a long-term, means tested, payment received by 79,253 individuals in 2005 at a cost of €630,728; Invalidity Pension is a long-term, contribution based payment received by 58,352 individuals as a cost of €548,224 in 2005. However, these include all forms of disability and only Disability Benefit is classified by type of disability.

<sup>14</sup> A forthcoming paper on the economic impact of mental illness, funded by the Mental Health Commission has been prepared by Kennelly and O'Shea from the National University of Ireland, but is not yet published.

- 3.53** ● Preventative interventions in the population are likely to be a cost-effective use of resources (WHO, 2002). Evidence demonstrates that prevention can lead to health, social and economic gain, increases in social inclusion and economic productivity, reductions in the risks for mental and behavioural disorders and decreased social welfare and health costs<sup>15</sup> (Jané-Llopis and Anderson, 2005).
- 3.54** ● 94.6% of all young people and adults with mental health or intellectual difficulties are not economically active (Conroy, 2005). People with mental or emotional disabilities have the lowest rate of work participation (National Disability Authority, 2005); CSO (2004) reported that only 13.7% of people with mental health or intellectual difficulties and of working age were in employment, compared with 37.1% of those with all types of disability. In broader terms this represents a fifth of the employment rate of the general adult population, which was 64% in 2004 (Conroy, 2005). This issue is explored more fully in later chapters on employment.
- 3.55** ● Mental health problems take a heavy toll on the workplace in the form of work absences and decreased productivity. Self-reported work-related stress, depression or anxiety account for an estimated 10.5 million reported lost working days per year in Britain (Health and Safety Executive, 2006). More generally, the incidence of stress in European society is on the increase and accounts for over 30% of all absence from work (Paoli, 1997).
- 3.56** ● The social costs are just as dramatic with social isolation being a key element in this. The impact on families is also severe with family members seeing dramatic changes in the individual as a result of the illness, but not necessarily knowing how to help. In England, carers themselves have been found to be twice as likely to have mental health problems if they provide substantial care (Office for National Statistics, 2002). Recent exploratory research by the Health Research Board (2006) on the needs and experiences of families with enduring mental illness suggests that family-tailored services are needed which should include family education and individual and family counselling. Brosnan (2006) in a research study of service users and carers in the West, *What Part of the Picture?* outlines the impact of stigma on the lives of service users and carers. She notes that many felt lonely and isolated, contributing to a feeling of bringing shame on their families, and suggests that people in the wider community should have contact with service users and this helps to change their perceptions and tackle stigma.
- 3.57** ● Submissions received by the Project Team emphasise the important preventative and supportive roles played by parents and carers of children and young people. For example: *“Within the family, parents need to be informed to help them identify potential risk factors that could increase their child’s vulnerability to mental health disorders while also being reassured that the health services are in place to provide the necessary treatments for their child.”*

## Conclusions

- 3.58** ● The policy framework for mental health services, *A Vision for Change*, set out a comprehensive strategy for community-based services. However, the pace of implementation has been slow to date. With relative expenditure on mental health services reportedly less than in other EU countries, there is scope for increased support, if the recommendations of *A Vision for Change* are to be delivered.
- 3.59** ● While existing legislation offers rights and protection to those involuntarily detained within mental health services, it falls short of legislation elsewhere, which would ensure greater action to promote mental health and well-being of those experiencing mental ill-health.
- 3.60** ● Internationally, there is increased policy focus on the recovery approach within the delivery of services, but also on a population health approach in the broadening out of mental health in terms of social inclusion, prevention and promotion. The forthcoming EU strategy on mental health will include a focus on prevention, health promotion, and protection of rights, the involvement of service users and improved information and research. Within *A Vision for Change*, there is also a welcome focus on non-health areas such as work, housing and education. It is clear from international research that this intersectoral approach, with an emphasis on prevention and recovery, is both timely and necessary if the global economic and social costs are to be tackled more effectively.

4

## Introduction

- 4.1 ● The previous chapter set out the policy context in relation to mental health and social inclusion and the key influences involved, both domestically and at international levels. This chapter firstly identifies the key barriers to social inclusion for everyone. Secondly, it examines the particular barriers for those experiencing mental ill-health and lastly, examines issues of concern for vulnerable groups. Strategies and initiatives to tackle these barriers are detailed in Section II of the report.

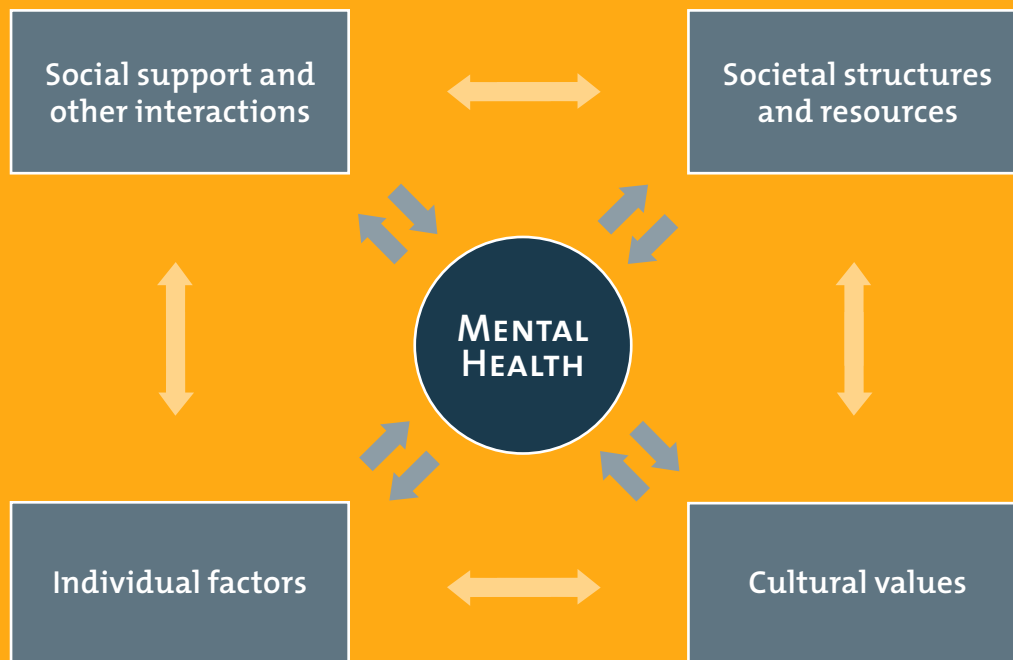
### (i) Mental Health for All

- 4.2 ● Positive mental health contributes to the social, human and economic capital of societies (Lehtinen *et al*, 2005) and society, social supports, individual factors and cultural values can have, in turn, an impact on mental health. Barriers to mental health exist for everyone, but are experienced most strongly by those who are most disadvantaged in our society. Figure 4.1 presents one structural model of mental health (overleaf). This model represents the inter-relationship between societal, social, cultural and individual aspects (WHO, 2005).

### Determinants of Mental Health and Well-being

- 4.3 ● Health promotion approaches to mental health examine the determinants of mental health to identify and target specific areas of everyday life. These determinants are the factors in the organisation of society and people's living conditions and lifestyles that contribute to health or ill-health (Swedish National Institute of Public Health, 2005). Factors that determine mental health fall into three broad areas, personal, social and community (Lehtinen *et al*, 1999). When these factors are minimal, there is increased likelihood of poor mental health:
- *Personal*: each person's ability to deal with thoughts and feelings, the management of life and emotional resilience;
  - *Social*: each person's ability to deal with the social world through skills like participating, tolerating diversity and mutual responsibility; and

Figure 4.1 The Structural Model of Mental Health



Source: WHO, 2005.

— *Community*: the development and maintenance of healthy communities which includes safe and secure environments and housing, positive educational experiences, employment, community validation, social support and positive role models.

- 4.4 ● Similarly, the Scottish programme for improving mental health (Parkinson, 2007) has identified a list of constructs (determinants, protective factors and consequences of mental health) for the indicators at the three levels of individual, community and structural/policy level. These provide a valuable overview of the factors which contribute to greater mental health (see Figure 4.2).



**Figure 4.2** Determinants and Protective Factors of Mental Health

Structural	Community	Individual
Social inclusion and equality	Participation	Emotional intelligence
Physical environment	Social networks	Spirituality
Working life	Social support	Learning and development
No stigma/discrimination	Trust	Healthy living
Financial security	Safety	Physical health
No violence		

Source: Adapted from Parkinson, 2007.

The following sections are structured under these headings of structural, community and individual factors.

### Structural

- 4.5** ● Increasing emphasis is being placed on the social and environmental contexts of poverty and exclusion (Evans, 2004). This approach was supported by many of the submissions received by the Project Team. One submission noted: *“Factors such as poverty, housing, employment, education, and safe neighbourhoods, cohesive and social just societies are all recognised as influencing people’s mental health potential. Creating a mentally-healthy society entails addressing the broader socio-environmental and political influences and working across diverse sectors in order to address the upstream determinants of mental health.”*
- 4.6** ● The impact of financial exclusion can be more far-reaching than the immediate effects on individuals and households and can impact on whole communities. It is concentrated among the most disadvantaged groups and communities, including people with disabilities (Combat Poverty Agency, 2006a). Across the world, poverty is experienced more frequently by women who are consistently poorer than men, due to their lower levels of education, lower rates of pay, doing more part-time and casual work (Women’s Health Council, 2005).
- 4.7** ● Mental health is inter-linked with most other aspects of contemporary life. It is affected by and affects physical health, social interactions and social networks, gender, family life, parenting, education and training, working life and work-life balance, housing, community life and social capital, addiction and prison among others.

- 4.8 ● Ireland has witnessed rapid population growth, inward migration and rapid social and economic improvements in the last decade. Yet, there remains significant inequality in the health and education systems, widening income disparities and growing social exclusion. A UN Development Index (United Nations Development Programme, 2006) reported that Ireland was 17th out of 18 selected high-income OECD countries in its human poverty index. While the relationship between social and economic changes and well-being is neither straightforward nor well evidenced, nevertheless, one view, as argued by Weehuizen (2006) is that what drives economic growth is not necessarily good for the mental health of people.
- 4.9 ● Changing social roles and economic conditions have led to greater numbers of women, especially those with children, in the workforce and this is expected to continue with unfilled demands for additional and affordable childcare. As the NESF Report on Early Childcare (NESF Report No. 31, 2005:17) argues, *“it is clear that it is now time for Ireland to put in place an effective and co-ordinated system of Early Childhood Care and Education, now regarded as essential for its national well-being, and to bring Ireland in line with its international obligations and best practice.”*
- 4.10 ● In recent years, work-life balance issues have become of increasing concern to Irish workers, with more time spent commuting and working long hours and less time for family. While flexible working options have become a feature of many Irish companies, CSO (2004) reported that the majority (68.6%) of Irish employees had a fixed start and finish time to their working day, with less than one sixth (16.5%) having the choice of flexitime.
- 4.11 ● The Institute of Public Health (2006) has found an association between poor mental health and lack of space within the home, as well as lack of social space for interaction inside and outside the home. Multi-occupation dwellings and flats, particularly high-rise flats, are the risk factors most strongly associated with poor mental health. Long commuting times can also impact on mental health, family life and social networks, with people having less time for civic engagement (NESF Report No. 28, 2003). One study suggests that Dubliners are less satisfied with life than people living in the country (Clinch *et al*, 2006) with overcrowding, congestion and the proximity to major transport routes being the main causes of unhappiness in the region.
- 4.12 ● The World Health Organisation (WHO, 2004) has identified risk factors for mental health which include the following:
- Poverty, socio-economic disadvantage;
  - Unemployment;
  - Social or cultural injustice and discrimination, including gender;
  - Violence and crime; peer rejection and anti-social behaviour;

- Isolation and alienation; poor social circumstances;
- Poor housing, recreational facilities and neighbourhoods;
- Lack of education;
- Work stress and lifestyle; and
- Poor nutrition.

### Community

- 4.13 ● Research has shown that, when communities disintegrate socially, there is a rise of mental disorders in that community (WHO, 2005). In broad terms, this is reflected in high rates of lonely people, divorces, and abandoned children, lack of social support, violence, crime, and drug and alcohol problems. Another aspect of community that can impact on mental health is inequality. A culture of inequality is damaging, leading to less cohesive communities and this, in turn, contributes to violence and mistrust (Wilkinson, 1996). This has implications for mental health policy and as WHO (2005:75) argue, *“from Wilkinson’s work, and the findings of others such as Putnam and Kawachi, a likely way to build social capital would be through improving income equality.”*
- 4.14 ● Without mutually satisfying and enduring relationships, mental health can suffer. WHO (2005) outlines how social relationships and networks can also act as protective factors against the onset or recurrence of mental ill-health and enhance recovery from mental disorders. Some authors regard the availability of social support as directly contributing to increased mental health, whereas others see its role mainly as a buffering one in face of stressful adversities or life events (WHO, 2005).
- 4.15 ● While there are no simple causal explanations between isolation and mental health, there is a strong relationship. The Institute of Public Health (2006) found that fewer social networks were associated with poorer mental ill-health. A cross-national study also found the level of social support predicted the state of positive mental health<sup>16</sup>. Chapter 9 further examines the role of community in shaping mental health.

### Organisations

- 4.16 ● Within communities, there is an organisational level which includes schools, the workplace, community housing and other settings, which can contribute to social exclusion in a variety of ways. Organisations that create cultures of mistrust and which lack a sense of belonging do not provide supports for positive mental health. In addition, organisations which lack clear health and well-being policies or work-life balance arrangements, in the case of the workplace, are more likely to contribute to poor mental health.

<sup>16</sup> <http://www.pubmedcentral.nih.gov>

## Individual

- 4.17** ● In personal terms, supporting emotional resilience in children and adults is a key factor in maintaining positive health and well-being. Resilience can be defined as *“a set of qualities that helps a person to withstand many of the negative effects of adversity”* (Gilligan, 2000). Difficulties arise when these skills are absent due to a lack of family support or education, and when exacerbated by challenging life experiences. A recent study of the mental health needs of children in Ballymun found two ways to improve psychological outcomes for children: (i) improving the physical, psychological, emotional and financial well-being of mothers; and (ii) supporting the mother-child relationship, especially parenting skills (McKeown and Haase, 2006). A growing body of research is also showing that fathers can play a positive role in improving health outcomes (Lamb, 2004). The *Da Project*, run by Barnardos in Cherry Orchard (Barnardos, 2006), aims to increase the participation of fathers in children’s lives through individual support, training, social activities and awareness-raising.
- 4.18** ● Lack of education can contribute to poor mental health (WHO, 2005). While this is particularly acute for children, its impact extends across the lifespan. There are barriers to education at all levels which can be caused by inequality, poverty, and a lack of support and encouragement for all to participate equally.
- 4.19** ● WHO (2005) argues that one intrinsic element of positive mental health is the spiritual dimension. This can impact on a sense of hopelessness, a symptom of depression, as well as forming part of the overall rating of quality of life.
- 4.20** ● While the interdependence of physical and mental health is often argued, what is less obvious is the impact on those with mental ill-health. Rethink<sup>17</sup>, the UK anti-stigma organisation, argues that people with severe mental illness die 10 years younger than other people because of poor physical health.

## (ii) Social Exclusion of People with Mental Ill-Health

- 4.21** ● As well as the personal, social and community factors that contribute to positive mental health, as outlined above, there are particular barriers facing those with experience of mental ill-health which contribute further to their social exclusion. The Social Exclusion Unit (2004) in England identified five main reasons (listed in Table 4.1) as to why mental ill-health often leads to and reinforces social exclusion. They then identified particular sub-groups that face additional barriers: ethnic minorities; young men; lone parents; and adults with complex needs. These factors are examined in turn in the following paragraphs.

---

<sup>17</sup> <http://www.rethink.org>

**Table 4.1** Contributory Factors to Social Exclusion

---

Lack of ongoing support to enable service users to work

---

Lack of clear responsibility for promoting vocational and social outcomes

---

Low expectations of service staff

---

Barriers to engaging service users in the community

---

Stigma and discrimination

---

Source: The Social Exclusion Unit, 2004.

### Enabling People to Work

- 4.22** ● Employment is increasingly important as a route to social inclusion (Conroy, 2005). However, only 22% of people with mental health problems in Ireland are employed (CSO, 2002). This is similar to the English figure (Morris, 2006). However, this is in marked contrast to survey results which suggest that 90% of people with mental disorders wish to be in employment (Constantopoulos, 2006). Many are highly skilled but are deterred from applying for fear of unfair treatment (Morris, 2006). Wynne and McAnaney (2004) report that the longer someone is off-work, the more likely they are to become socially excluded.
- 4.23** ● In a report, *A Strategy for Engagement*, for the National Disability Authority, WRC (2006) reported that in the twenty-month period between the two special surveys on disability conducted by the CSO in 2002 and 2004, the employment rate for people with a disability fell from 40.1% to 37.1% despite overall employment growth of 5.6% over the period. Gannon and Nolan (2007), in their study of disability and social inclusion, as recorded in the Living in Ireland Surveys (1995-2001), found that those with a disability on an ongoing basis over the whole period of the surveys had a pronounced reduction (by 42%) in likelihood of being in employment, and lower household income. They also found that the onset of disability for adults of working age was associated with a decline (of approximately 20 percentage points) in the probability of being in employment. It also was associated with a decline in household income, by an average of 15%. Social participation was also affected with significantly lower levels reported for those with a severe disability.

- 4.24 ● Some people with mental health problems face additional barriers to employment. For example, lone parents with mental health problems are over three times less likely to be employed. Young people can also face particular challenges and, if they develop mental health problems while still in education, stand to miss out on gaining necessary skills and qualifications for work.

#### Lack of Responsibility for Vocational and Social Outcomes

- 4.25 ● One of the central barriers to social inclusion for those with mental ill-health is a lack of responsibility by official bodies and agencies for non-health outcomes (Social Exclusion Unit, 2004). From a recovery approach, responses to furthering social inclusion must include broader social and vocational aspects, not just health services. In Ireland, there is no overarching agency responsible for ensuring the full implementation of recommendations from *A Vision for Change* that fall outside the domain of health.

#### Income Maintenance

- 4.26 ● The Institute of Public Health (2006) found that difficulty in meeting mortgage repayments may negatively impact upon health, particularly mental health. Limited financial resources and options to choose or change place of residence have also been linked to depression and anxiety.
- 4.27 ● The loss or feared loss of welfare benefits is a powerful barrier to employment for those with mental ill-health (McQuilken *et al*, 2003). The combined value of direct and indirect benefits can make staying out of employment, for those with mental health disabilities, more attractive financially (Conroy, 2005). Under the *Disability Strategy Sectoral Plan* of the Department of Health and Children, there will be increased focus on the removal of disincentives across schemes. However, barriers to accessing even basic entitlements are experienced by vulnerable groups such as homeless people without an address. Furthermore, that young people who drop out of school are still able to claim Disability Allowance from 16 years of age, needs to be examined. The Project Team supports the recommendation made by the National Disability Authority's *A Strategy of Engagement* (WRC, 2006) that this allowance be introduced incrementally subject to assessment and guidance.

#### Low Expectations of Service Staff

- 4.28 ● The attitudes of staff can impact on the recovery process. A narrow view of what service users are capable of can restrict their potential. The Social Exclusion Unit (2004) outlined how employment was not viewed as a key objective by health and social care professionals. Dunne (2006) reports the views of Irish service users on their experiences in psychiatric care: "*some participants felt that the service disempowered them rather than actively promoting their recovery. They [medical personnel] don't hand the power over to you, like. They take it all away from you*" (Dunne, 2006:149). The discussion paper on recovery by the Mental Health Commission (2005b)

recalls how staff attitudes and the environment are important in supporting people in developing and implementing their own individual plans for recovery and allowing the person to take some 'risks' in moving forward.

### Barriers to Engaging Service Users in the Community

- 4.29 ● Evidence from England indicates that people with severe mental ill-health feel isolated, report a lack of support and show low levels of community involvement (Social Exclusion Unit, 2004). Young people, ethnic minorities and people in rural communities were likely to be the most isolated. Research cited suggests that adults with severe mental health problems are five times as likely to report a perceived severe lack of support as those with no mental health problems (Social Exclusion Unit, 2004). In addition, 84% of those with mental health problems in one survey felt isolated, as compared with 29% of the general population (MIND, 2004). In Ireland, 82% of those with a mental disability live alone (Conroy, 2005). The NDA (2004) *Survey on Social Participation and Disability* found that disabled people's social lives (this includes physical and mental disabilities) are more concentrated in their own home, and significantly fewer get out socially compared to non-disabled people. 28% of disabled people did not get out socially at all in the previous week, as compared to 12% of non-disabled.
- 4.30 ● A more recent study by the Health Research Board (2007), *Happy Living Here... A Survey and Evaluation of Community Residential Mental Health Services in Ireland*, found that while the majority of the residents went out on their own and reported that they were happy with their level of participation in the community, few used social amenities in the community. Further discussion of social supports can be found in Chapters 5 and 9.

### Stigma and Discrimination

- 4.31 ● Stigma and discrimination have been identified as the greatest barrier to social inclusion, quality of life and recovery for people with mental ill-health (Social Exclusion Unit, 2004). Mental Health Ireland (2005) reported that 57% of people surveyed, who had experienced depression personally, believed there was at least some social stigma attached to having the condition. Negative attitudes were more prevalent among males than females, among older people (over 65) and younger people (under 25, especially men) and among lower socio-economic groups. In a previous survey, a significant minority of 31% held the view that people who have had a mental illness will never be quite their old selves again and 30% felt that there is something about people with mental illness that makes it easy to tell them 'from normal people' (Mental Health Ireland, 2003). The National Office for Suicide Prevention (2007) found that 6 in 10 adults would not want others to know if they had a mental health problem.

- 4.32 ● It is also important to recognise that stigma has a detrimental effect on a person's recovery, ability to access services and the type of treatment they receive (WHO, 2001). As previously mentioned, people with mental ill-health in Ireland have more stigma attached to them, than those with other forms of disability (NDA, 2002) and the general public still feel that the provision of mental health services in the local community may pose a threat to their safety (Mental Health Ireland, 2003).
- 4.33 ● Lansdowne Market Research (2006) found that 75% of people believe there was a lot/some social stigma attached to particular forms of mental illness such as depression (60%) and anxiety (42%), as compared to cancer (18%) or asthma (9%). One cross-national study provides comparative attitudes across EU states, placing Ireland, in general, towards the more tolerant end. For example, 25% of a sample of Irish people considered that people with mental ill-health were a danger to others, considerably lower than the EU average of 37%. In addition, while 21% of the EU sample agreed that people with psychological or emotional problems never recover, only 10% of the Irish sample agreed (European Commission, Special EuroBarometer, 2006)<sup>18</sup>.
- 4.34 ● NIMHE, The National Programme for Improving Mental Health and Well-being in England, is conducting 'From here to equality', a 5-year anti-stigma and discrimination programme (NIMHE, 2004), responding to the Social Exclusion Unit's report on mental health, which found that over 80% of respondents in the research identified stigma as the biggest barrier affecting people with mental health problems.
- 4.35 ● One of the submissions commented on the use of the term 'stigma,' specifically: *"One of the main problems with practically tackling stigma is that the word itself is stigmatising. Stigma means that the person is marked in some way negative, like a brand ..."*
- 4.36 ● Submissions noted the role of the media in raising awareness. *"The use of language and imagery associated with mental health needs to be re-evaluated ... The role the media plays in perpetuating a negative stereotype of those with mental ill-health needs to be challenged and relegated. This can be achieved by media portrayal of mental health problems in a more inclusive and accepting manner through broadcasting and dissemination of more positive images of mental health."*
- 4.37 ● NDA Disabilities Survey (2002) found that only 55% of respondents felt that people with mental ill-health should have the right to the same fulfilment through relationships and sexuality, compared to 83% in the area of physical disability. Most people (81-84%) were comfortable with people with physical, sensory or learning disabilities living in their neighbourhoods, but only half would be very comfortable with people

---

<sup>18</sup> <http://ec.europa.eu>



with mental ill-health living there (NDA 2002). It seems that people with mental ill-health may be subject to more negative attitudes than people with other forms of disability (NDA, 2002).

- 4.38 ● Stigma is also a barrier to employment. When respondents in an NDA survey were asked whether people with disabilities should have the same access to employment as everyone else, only 55% thought that people with mental ill-health should have this right, compared to 82% in the area of physical disability. 33% of respondents thought that they should not have the same opportunities as everyone else (NDA, 2002).
- 4.39 ● One of the submissions argued, *“mental health service users tell us that one of the biggest problems they face is prejudice.... Of particular concern, the negative public attitudes experienced by many participants lead a number of them to be cautious about participating in any type of public advocacy. This suggests that people with a diagnosis of mental illness are disadvantaged in their opportunities to advocate for their civil, social and economic rights.”*

### (iii) Barriers for Vulnerable Groups and Individuals

- 4.40 ● Certain groups in society are more vulnerable to experiencing mental ill-health and discrimination. These include women, refugees and asylum seekers, ethnic minorities, Travellers, disadvantaged children and young people, as well as some vulnerable older people, lone parents, isolated rural groups, gay, lesbian and bisexual young people, those with multiple disabilities, people with intellectual disabilities, the deaf, people with physical disabilities, prisoners, homeless people and those with complex needs. Combined with a marginalised position in society, the risk of mental ill-health and increased social disadvantage contribute to and are affected by higher levels of discrimination (WHO, 2005a). However, there is a lack of data and research on the needs of and provision of services for many of these groups (Amnesty International, 2003a/b/c) and particularly those with co-morbidity including addiction. Some of these groups are examined below, but others will be discussed later in the report in relation to particular initiatives or areas of good practice.

#### Across the Life Cycle

- 4.41 ● There are vulnerable points in the lifecycle for both men and women in relation to mental health. Young people are especially vulnerable. According to the Youth Council of Ireland and Barnardos, in making their presentations to the Project Team, 20% of children have a mental disorder at any one time and 4% have a severe disorder. This is coupled with a high youth suicide rate and self-harm rate and lengthy waiting lists for assessments. Fitzgerald (2007: 1) notes that *“rates of suicide among young people have increased and at the same time there has been an increase in the proportion of suicides diagnosed as having suffered from depressive disorders.”* Suicide accounts for 30% of deaths in the 15 to 24 year age

group and a variety of psychosocial disorders tend to rise or peak during the teenage years (Fitzgerald, 2007). Adolescents are under the most pressure and the suicide rate particularly among males is an indicator of high stress levels (The Irish Times, 2007).

- 4.42 ● However, some older people face particular challenges as well. It was noted by one submission that ageist attitudes towards older people and the stigma related to mental ill-health will need to be addressed in order to *“encourage community action for older people with mental ill-health.”* Another submission commented: *“... mental illness is often perceived as a sign of weakness and ... mental illness is often perceived as a sign of weakness and ... this stigma inhibits sufferers from seeking help. Furthermore, this may be compounded by a misunderstanding of the nature of older age on the part of the health and social care professionals. Many perceive mental disorders as a natural part of growing older and, as a result, they may be unwilling to initiate a comprehensive treatment package.”*

## Gender

- 4.43 ● Gender *“runs like a fault line, interconnecting with and deepening the disparities associated with other important socio-economic determinants such as income, employment and social position”* (WHO, 2001:2). The Women’s Health Council (2005:15) argues that *“women are more likely to be affected by stressful events and traumas, especially in relation to physical and sexual abuse which can cause serious physical and mental health repercussions.”* Gender-based violence is a risk factor for mental ill-health that disproportionately affects women. Anecdotal evidence in Ireland suggests that women may be referred to mental health services and/or prescribed medication without receiving support for the cause of their depression or anxiety, the violence they continue to live with or have experienced<sup>19</sup>.
- 4.44 ● However, there are particular difficulties for men as well as they tend to be more reluctant to seek help and support for their health problems, including mental health problems (McKeown and Clarke, 2004). Men are much more likely to abuse tobacco, alcohol or drugs. Alcohol-related health problems are a major cause of illness and death in young men. There are also difficulties faced by older isolated men in rural areas as outlined by the Outreach Worker of the Mevagh Men’s Education Initiative (Bradley, 2006). He notes the importance of strengthening community as a way of countering loneliness and depression.

---

<sup>19</sup> Information supplied in a submission from Amnesty International (Irish Section).

### Gays, Lesbians and Bisexual People

- 4.45 ● A report by Dillon and Collins for GAYHIV Strategies and the Northern Area Health Board in 2004 concluded from an overview of research that lesbians and gay men show an increased risk of psychological stress and negative mental health associated with prejudice, discrimination and isolation. Young men and women of same-sex orientation have been identified as one of a number of high-risk groups for youth suicide – they are six times more likely to engage in suicidal behaviour than their heterosexual peers (Ferguson *et al*, 1999). Young gays, lesbians and bisexuals can experience social isolation, discrimination and social exclusion. Rural isolation was identified as being particularly problematic. One submission noted the following: “... *some young LGB [lesbian, gay and bisexual] people are rejected by their families when they come out, and this can cause serious social isolation. For others, because they live in rural or even remote areas of the north east, they can be very isolated ... This can fuel the cycle of depression, anxiety, alcohol-dependence and low self-esteem.*”

### Travellers

- 4.46 ● There has been increased focus on the mental health needs of Travellers. At the HSE West Conference on *Addressing the Mental Health Needs of Minority Ethnic Groups and Asylum Seekers in Ireland*, a key issue which emerged was accommodation and its effect on mental health, particularly the lack of access to the wider community of many halting sites. The lack of trust between Travellers and health care workers was noted as a barrier as was the stigma attached to accessing mental health services (HSE West, 2006). The Traveller Health Unit Eastern Region has recently established a Mental Health Sub-Group to examine the key issues including access to services, barriers to mental health and the apparent rise in suicide rates. In addition, the forthcoming All-Ireland Traveller Health Study has been commissioned by the Department of Health and Children in conjunction with Northern Ireland’s Department of Health, Social Service and Public Safety.

### Prisoners

- 4.47 ● While the incidence of mental ill-health in prisons has already been briefly mentioned in Chapter 2, the difficulties experienced by ex-prisoners with mental health needs are often unmet (NESF Report No. 22, 2002). Their needs were singled out by one of the submissions received. It noted that: “*[There is a] lack of continuity of care for people leaving prison who may have had access to limited psychiatric services while in prison but there tends to be no link in with community psychiatric services prior to release and no follow-up upon release — that tends to be left to agencies such as PACE.*”

## Migrants, Asylum Seekers and Refugees

- 4.48 ● One of the most unknown of these groups is emerging ethnic communities (Moran, 2005). In England, despite similar prevalence levels of mental health problems to the wider population, “*people from ethnic communities are six times more likely to be detained under the Mental Health Act than white people*” (Social Exclusion Unit, 2004). CAIRDE, a voluntary organisation working to reduce health inequalities of ethnic minorities in Ireland, has recently produced a report (2006) outlining participative work with ethnic minority groups in inner city North Dublin. It revealed a low engagement with mental health services, despite over a third (38%) expressing feelings of stress, depression and anxiety. The HSE’s *National Intercultural Health Strategy* (HSE, forthcoming 2007) aims to ensure that provision of health services is equal, accessible, and culturally sensitive and appropriate to meeting the needs of minority ethnic communities. A number of mental health issues emerged during the consultations which informed development of the strategy, with asylum seekers, refugees and Travellers reporting a range of mental health needs and concerns around their particular situations. At the same time, the mental health needs of many migrant workers — often living in isolated, vulnerable circumstances — appear to be an emerging issue<sup>20</sup>.
- 4.49 ● The Women’s Health Council (2006) argue that many ethnic minority women find themselves in situations of isolation, poverty and exploitation which leads them to experience high levels of stress, anxiety and depression.

---

20 Information supplied by the HSE.

## Conclusions

- 4.50 ● This chapter outlined some of the main general barriers to social inclusion for the entire population and then identified those barriers most experienced by people with mental ill-health and vulnerable individuals and groups. From a population health perspective, there are broad determinants of mental health which are found at personal, social and community levels. We can diminish our risk of experiencing mental ill-health by strengthening individual, community and societal supports.
- 4.51 ● One central conclusion is that mental health for individuals is promoted by equipping them with the emotional resources and skills to cope. These can be developed and supported from an early age, and across the lifespan in continuing education programmes, focusing on self-development and life skills.
- 4.52 ● In social terms, relationships are central to positive mental health, from early family attachment through to broader social networks. Building friendships and intimate relationships is something that can be supported through community groups and activities, volunteering, and online social network sites. The recent *Report from the Taskforce on Active Citizenship* (2007) outlined ways of increasing community involvement and these are welcomed and supported by the Project Team. In addition, key barriers at this level are inequality and discrimination which can act as a deterrent to social cohesion. The Project Team welcomes the ongoing work of the Equality Authority in tackling inequality.
- 4.53 ● The local community is also central to positive mental health, not only in terms of safety, being free from violence, good housing, work and living conditions, but also in terms of extending social networks to community attachment and belonging. Everyone has basic living needs, but a healthy and fulfilling life embraces mental health and in turn, our positive mental health embraces our community. Further details on community initiatives which are effective in fostering mental health can be found in Chapter 9.
- 4.54 ● Barriers to inclusion are particularly strong for those with experience of mental ill-health. These include stigma and discrimination and lack of access to employment and adequate income. Some of the most vulnerable groups at risk of greater social exclusion through mental ill-health are prisoners, homeless people, ethnic minorities, Travellers, young people and those in isolated rural areas. There is also a need to focus particularly on those with complex needs who experience a revolving door to exclusion; for example, from psychiatric care or prisons to homelessness; and those with dual diagnoses, such as addiction and mental ill-health.

- 4.55** ● One of most critical of these barriers is employment as this has been shown to be a key gateway to inclusion for all adults of working age. This is of particular significance for those with a mental disability as research shows that the vast majority of them are not working. In addition, the longer they are off-work, the more likely they are to become socially excluded. Chapters 6 and 7 examine strategies in relation to training, work and meaningful occupation.

SECTION II

# Strategies and Initiatives

5



## Introduction

- 5.1 ● The previous chapter set out the main barriers to social inclusion that people with mental ill-health face and the impact this can have on the wider society. This chapter outlines the key strategies needed to foster positive mental health and social inclusion at the individual, social, organisational and societal levels. It cites evidence-based initiatives which can be effective for these purposes and later chapters will examine some of the key areas in greater detail.
- 5.2 ● From the evidence presented, mental health is not rooted solely within the person but is a dynamic concept that places them within a wider social and cultural life. This involves supportive relationships, involvement in community and group activity; and civic engagement. Chapter 9 will examine more fully the relationship between community and mental health and the value of community development approaches in this area.

## Strategies for Social Inclusion

- 5.3 ● The Victorian Health Foundation (VicHealth) argues that there is strong evidence supporting the effectiveness of interventions and activities in a wide range of areas which can be successful in the promotion of mental health (VicHealth, 2006). Many of the strategies outlined will impact on all four levels outlined below.
- 5.4 ● In essence, effective strategies need to be directed at four levels:
- **Strengthening society** through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful work, housing, services and support for those who are vulnerable (*A Vision for Change*; WHO, 2005; VicHealth, 2005). For a preventive focus to be effective, all public services must play a role in addressing mental health issues;
  - **Strengthening organisations** through initiatives and policies which foster positive organisational cultures that value diversity in workplaces, schools and other settings;

- **Strengthening communities** increasing social inclusion and participation, improving neighbourhood environments, developing health and social services that support mental health, such as anti-bullying strategies at school, workplace health, community safety, and childcare and self-help networks; and
- **Strengthening individuals** increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship, parenting skills and access to resources (work, education, housing etc.).

Some key supports are presented in Table 5.1 opposite, and structured under the four levels outlined above.

Each of the levels, society, organisational, community and individual are further examined in the paragraphs that follow.

## Society

- 5.5 ● While actions across all levels will impact on the positive mental health and well-being of everyone, there is a strategic societal level of intervention, where policies, legislation and co-ordinated campaigns and programmes can have a significant impact. But as VicHealth (2006) recalls, these levels of action need to be integrated, sustained and supportive in the development of increased social inclusion for those with mental ill-health.
- 5.6 ● According to WHO (2005:230), *“the application of positive mental health promotion principles across the whole mental health sector, and as part of the whole operation and thinking of governments with regard to the well-being of their populations, could usher in a new era of enlightened thinking. When a government puts the positive quality of life of their citizens first, then the nation is sure to prosper.”*
- 5.7 ● There are international examples of strategic policy-making in health promotion that impacts on mental health directly. Sweden’s public health policy sets objectives for the improvement of mental and physical health. By identifying key determinants of health, and turning them into objectives, they can be measured and assessed over time. Their 2003 policy argues that *“using health determinants as a basis means the vast majority of public health work must take place outside the medical care service”* (Swedish National Institute of Public Health, 2003). In terms of mental health, the objectives include participation and influence in society, economic and social security, secure and favourable conditions during childhood and adolescence, healthier working life, healthy and safe environments, products and good eating habits and food as well as increased physical activity and others relating more to physical health.

**Table 5.1** Examples of Strategies to Increase Social Inclusion and Mental Health

Society	Organisational	Community	Individual
Health promotion	Setting-based policies and strategies	Quality housing and environment	Early intervention
Intersectoral approaches		Physical and psychological security	
Health impact assessments/ Health in all policies	Workplace policies, health promotion and staff involvement	Strengthening social capital	Recovery and empowerment
		Participation and access to supportive social networks	
Integrated mental health services	Integrated, intersectoral resources and activities	Supportive family and social and community environments	Service user involvement
Continuing awareness-raising	School-based programs for mental health and well-being	Community development and engagement	Life skills
Mental health literacy		Volunteering	Increased physical health
Media campaigns		Access to a variety of activities	Access to meaningful employment income and education
Valuing diversity and no discrimination		Having a valued social position	
Less violence and crime		Increased sense of belonging	Programs tailored for at-risk and vulnerable groups

Source: Daly and Walsh, 2006. Sources: WHO (2000; 2005), Social Exclusion Unit (2004); European Commission (2005); VicHealth (2006) and Barry and Jenkins (2007).

### Health Impact Assessment

- 5.8** ● In a recent paper in the Bulletin of the World Health Organisation, Scott-Samuel and O’Keefe (2007:212) argue that the main purpose of undertaking Health Impact Assessments (HIAs) is “to move towards healthier societies through the development of healthy public policy.” HIA is a “combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the

*population*” (European Centre for Health Policy, 1999:4). The main purpose of undertaking HIA is to move towards healthier societies through the development of ‘healthy public policy’ — in other words, the development of policies, programmes and projects that take account of their likely or actual impacts on health. The Institute of Public Health in Ireland (2006) outlines the aims of HIAs as reducing health inequalities by informing policy makers of the potential health impacts of a policy proposal on different population groups and, where appropriate, recommending changes to enable a more equitable distribution of impacts. “*Health Impact Assessment is not straightforward, but such quantitative estimates, however debatable and tentative, can play a key part in ensuring that health concerns are taken into account in economic and social policy*” (Pearce, 2002: 889).

- 5.9 ● Although introduced as part of health policy in *Quality and Fairness* (Department of Health and Children, 2001), HIAs have not been implemented widely. Neither has mental health featured strongly in any assessments. However, the Project Team supports the further development of HIAs embrace health and well-being holistically, including indicators of mental health. The impact of policy on health and well-being should also be evaluated as part of a monitoring process, after the introduction of major policies.
- 5.10 ● A recent toolkit, *Mental Well-being Impact Assessment*<sup>21</sup> (MWIA), was developed in the UK by the Care Services Improvement Partnership — North West Development Centre (CSIP, 2007) to help identify how a proposed policy, programme or project will impact on mental well-being and what can be done to ensure it has the most positive impact. This monitors mental health impact across four key well-being protective factors: enhancing control, increasing resilience and community assets, facilitating participation, and promoting inclusion. It then sets out indicators for each factor which are measurable.

### Intersectoral Approaches

- 5.11 ● *A Vision for Change* has been widely welcomed as including the principles of inclusion, empowerment and recovery that contemporary mental health policies embrace. But, policies need adequate resources to be effective, and a policy on mental health, without integrated cross-departmental co-ordination, will not impact as positively on social inclusion. A strategic integrated approach to positive mental health should include non-health aspects such as access to meaningful employment, education, income and housing (WHO, 2005). This system, to be fully effective, would need to include medical care in the community with interlinked services to support recovery.

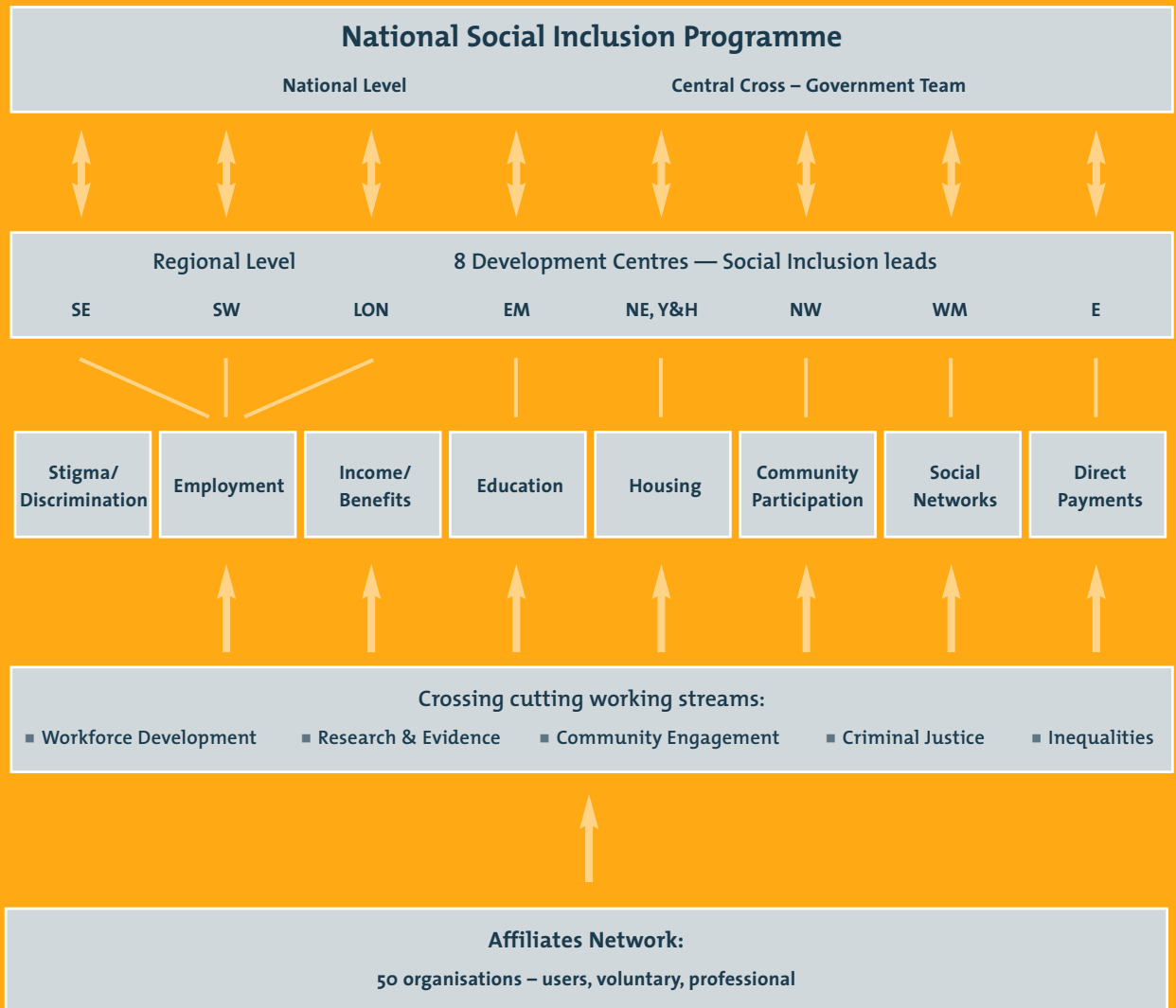
21 <http://www.northwest.csip.org.uk>

- 5.12 ● Policies and practice for all aspects of mental health prevention and promotion can be more effective when developed as part of an integrated strategy. Mental health crosses many aspects of social policy and therefore inter-ministerial cooperation is needed in order to truly safeguard mental health (The Women's Health Council, 2005; World Health Ministers, 2001). The National Inclusion Programme for Mental Health in England (NIMHE) is implementing a strategy for greater social inclusion that emerged from the Social Exclusion Unit's (2004) report. Presented at the NESF Seminar on Mental Health and Social Inclusion by David Morris, the implementation framework in Figure 5.1 overleaf shows the strategic planning necessary to bring in all sectors to respond to the needs of those experiencing mental health difficulties and social exclusion. The strategy is focused at a regional level as well as having cross-cutting 'work streams.' The subsequent 2006 Action Plan is founded on guiding principles: early intervention; identification of what works and securing the evidence; better co-ordination of services; personal rights and responsibilities; and intolerance of poor performance.
- 5.13 ● Effective strategies have to be over-arching. In Scotland, the National Programme for Improving Mental Health and Well-being provides such a framework with distinct components which is effective. WHO (2005) note the lack of evidence of the effectiveness of upstream policy interventions such as housing, welfare, education and employment but that this was more to do with a lack of mental health impact assessment methods, than to an absence of impact.

### Tackling Stigma: Awareness and Education

- 5.14 ● One effective way to counter stigma in society is to improve the quality of information and its ease of access, and to raise awareness of the realities of mental ill-health. Much of the basis of stigma is fear and a lack of knowledge, with myths of mental ill-health underpinning some of the media coverage in this area. Providing information in an accessible way is critical in developing mental health literacy, which is the knowledge and understanding of mental health, including knowledge about types of mental ill-health. Life skills education is a model of health promotion that seeks to teach adolescents how to deal effectively with the demands and challenges of everyday life (WHO, 1997). Moreover, as the international evidence increases, linking mental ill-health to physical illness such as heart disease, stroke and diabetes, may help to further reduce stigma.
- 5.15 ● There are benefits to taking a broad approach to mental health awareness. Rosenfield *et al* (2000) identify the value of services for young people, focusing on wellness and life skills as a way of avoiding the stigma of mental health care and support (cited in the submission made to the Project Team by Headstrong).

Figure 5.1 English National Inclusion Programme for Mental Health



Source: NIMHE, 2005.

- 5.16 ● Mental First Aid training was developed in Australia by Anthony Jorm and Betty Kitchener, and more recently in Scotland. The principles mirror those of the First Aid which are to preserve life, prevent deterioration, promote healing and provide comfort. Such first aid skills equip people to respond to situations where mental health issues are a concern, for example, how to talk to someone who is feeling suicidal. By providing knowledge and developing skills, it can be an effective tool to improve both mental health literacy and reduce the stigma around mental ill-health.

### Examples of Good Practice: Access to Information

Mental Health Shop is a UK-based information ‘one-stop-shop’; making it easier for people to find high-quality publications and products quickly and easily<sup>22</sup>. It is an online resource for mental health publications and was founded in 2006 by Mental Health Media and Rethink.

*Well* is a bi-annual magazine from Improving Mental Health and Well-being in Scotland (IMHW), which includes health promotion articles, and interviews with local writers and musicians about mental health issues. It is distributed with the Big Issue, and widely across Scotland.

### Education

- 5.17 ● Access to education is central to developing positive mental health and support for those with experience of mental ill-health. One strategy is that all learning institutions should have practical and user-friendly mental health policies, along with a holistic approach towards mental health. In addition, staff in these institutions should receive training and education to raise awareness about the needs of those with mental health problems, and confidence in working with this group. In addition, appropriate bridging programmes should be established to enable easier access to third-level education for service users with poor academic results.
- 5.18 ● In the submissions received by the Project Team, there were repeated calls for more appropriate levels of mental health education at individual, community and national levels to address prejudice and discrimination against people with mental health problems. In the case of older people, for example, it was argued that a comprehensive “*Public Education Programme, be undertaken by the Health Services Executive in conjunction with the Department of Health and Children and other relevant agencies on the nature of mental disorders in older age.*” An equivalent programme for care professionals, including GPs, social workers, psychiatric nurses and occupational therapists, was also recommended.

22 <http://www.mentalhealth.org.uk>

- 5.19 ● The submissions outlined specific components of this role as *“education, awareness raising, health promotion and myth busting.”* According to one submission *“... there needs to be much greater understanding and awareness among the public of the concept of positive mental health, how poor mental health can manifest itself, and what can be done by those directly affected and by others, to aid the recovery process.”* The submissions also included reference to increased national awareness of mental health issues. One submission emphasised its importance in schools. *“One of the best ways to address the issue of stigmatisation and social inclusion is to educate people from a very young age as to what mental health issues are and to remove some of the preconceived notions that exist. By targeting younger age groups this will eventually enable the issues to be addressed in a more positive way.”*
- 5.20 ● Significant positive improvements in knowledge of and attitudes towards mental health (particularly reducing stigma) have been found in UK, US and Norwegian evaluations of media campaigns (Jané-Llopis and Anderson, 2005). In an international review by the Australian Centre for Health Program Evaluation (2002), there was evidence that mass media campaigns designed to reach the general public can achieve positive outcomes in terms of mental health literacy. However, evaluations of previous communication campaigns suggest many failures and unrealistic expectations about possible outcomes. One factor which seems to make a difference in shifting attitudes is direct contact with individuals with experience of mental ill-health.
- 5.21 ● In the UK, Shift has been established to improve media reporting of mental ill-health and fight stigma in public and private organisations, among young people and the media. It is a co-ordinated strategy funded by the National Institute for Mental Health in England and will run over five years. A strategy which is a long-term and co-ordinated would seem to be central to changing attitudes and tackling stigma. An example of this, Moving People, is a partnership of mental health charities led by Mental Health Media, Mind, Rethink, and the Institute of Psychiatry at King’s College London, which has been recently awarded £18 million Lottery funds to change the culture of mental health through media campaigns, community projects, mass participation events, website and training and education programmes<sup>23</sup>.
- 5.22 ● Here, the National Office for Suicide Prevention is working with the HSE in developing a national mental health awareness campaign, following on from a recommendation in *Reach Out*. This will be launched before the end of 2007 after a period of consultation and research (National Office for Suicide Prevention, 2007).

---

<sup>23</sup> <http://www.mind.org.uk>



- 5.23 ● Headline, the National Media Monitoring Programme, was established by the National Office for Suicide Prevention in 2006 to monitor the media and develop good practice guidelines. It aims to encourage responsible reporting of suicide and mental health. Their website contains guides to the appropriate portrayal of suicide and schizophrenia<sup>24</sup>.

### Organisational

- 5.24 ● In broad terms, public and private organisations such as companies, schools, community centres and public service providers can be positive working environments and offer critical supports in mental health recovery. Key elements include developing an inclusive, responsive, safe, supportive and sustainable organisational climate (VicHealth, 2006). Other elements of inclusive practice include working in partnerships across sectors and implementing evidence-based approaches to their work. Chapter 8 examines the elements of an integrated approach to mental health, in which partnership and working alliances are fundamental.
- 5.25 ● Public service organisations of all sizes that employ, educate, care for, support or house people should develop policies and initiatives to better support the health and well-being of their staff and clients. This need not be an elaborate set of documents, rather an awareness of the key role that organisations play in the everyday supports for enhanced well-being for all. Many organisations already adopt policies which place respect for clients at their heart.

### Schools

- 5.26 ● Policies and direct interventions in schools tend to be more effective when they occur across the entire school, run for long periods, and are linked to outreach and community services (Hayes and Morgan, 2005). The development of the European Network of Health Promoting Schools movement has highlighted the important role of schools. Some interventions in Irish schools include Mental Health Matters, developed by Mental Health Ireland for 14-18 year olds; Beating the Blues, developed by Aware for older young people, and Life-Skills for the same age-group. These initiatives are welcome, but a more co-ordinated approach to school mental health education is needed.
- 5.27 ● In Irish schools, health, including mental and emotional aspects, is part of the curriculum for Social, Personal and Health Education (SPHE) which is compulsory for all students up to Junior Cert. The Project Team welcomes the development of the new framework for senior cycle SPHE, which includes mental and emotional health and hopes that all schools are adequately supported in its implementation. The Team would also support regular monitoring and evaluation of this programme to ensure it meets the requirements of effective mental health promotion.

---

24 <http://www.headline.ie>

- 5.28 ● As outlined by WHO (2001) and *A Vision for Change*, schools have a further role in early identification and referral of mental health difficulties experienced by children and adolescents, as parents can often find it hard to distinguish between the normal ups and downs of adolescent mood behaviour and mental ill-health. Training for school personnel in mental health literacy would be an important step towards early intervention.
- 5.29 ● The National Council for Special Education (2006) argue that, with 8% of Irish children having a special education need arising from mental ill-health, greater supports are needed for children to remain engaged in the educational system as a first step to break the cycle of social exclusion. Increased liaison between schools and mental health services is essential. This could include greater institutional supports for schools on inclusive education provision, structured educational planning for children with special educational needs, and a greater emphasis on outcomes.

### Communities

- 5.30 ● The role that the community plays in social inclusion is multiple and complex. In day-to-day terms, living and working conditions that are safe, supportive, sustainable and inclusive as outlined by VicHealth (2006) provide the basis for social inclusion. This includes housing, local recreational facilities and public spaces, transport links and the quality of the local environment. In addition, having a valued social position in the community has been found to be important in recovery and social inclusion (WHO, 2005).

### Quality Housing and Environment

- 5.31 ● Housing has been shown to be important for mental health. In one study, the degree of improvement in mental health was directly related to the extent of housing improvement (Thomson *et al*, 2003).
- 5.32 ● Improving the social environment in schools, the workplace and the community will help people feel supported and will contribute to their mental health as well as designing facilities to encourage meetings and social interaction in communities (WHO, 2003).
- 5.33 ● Community building and regeneration programmes should have increasing social inclusion as one of their aims. In doing so, they can enhance mental health and well-being (VicHealth, 2006). VicHealth (2006) outlines the key ingredients which include: sustainability through the building of communities, not just the infrastructure and physical capital (housing, open space, transport); multi-agency partnerships as the primary mechanism for area regeneration; local government playing a lead role; and addressing issues of diversity, through citizenship and social connectedness.

### Example of Good Practice: Regeneration

The Beacon Project, an English regeneration project, identified dramatic health improvements. Led by two primary health care visitors, it aimed to tackle the rapidly declining health and social needs of a poor community in Cornwall, southwest England. This project used community development approaches to bring about a range of social and environmental improvements. Significant improvements in conditions and a general sense of well-being on the estate, together with the improvements in social outcomes, were observed over a period of four years. These have included an 80% decrease in post-natal depression, a 60% reduction in child protection notifications, a 50% reduction in child accident rates and a 50% decrease in the crime rate. There is anecdotal evidence to suggest this approach has also benefited people who are socially excluded (VicHealth 2006).

### Individual

- 5.34 ● Research on resilience has shown that mental health depends on an individual's ability to mentally cope with, transform, and find meaningful lessons from stressors and life's challenges (Ryff and Singer, 2003).
- 5.35 ● There is explicit acknowledgement of the importance of early intervention and reintegration (Wynne and McAnaney, 2004) and increasing evidence of the personal, social, service and economic impact early intervention can have. Studies on severe and enduring mental illness show that early detection and treatment can reduce the likelihood of re-admittance (Goldberg *et al*, 2006). Furthermore, McCrone *et al* (2006) have shown that early intervention for certain mental disorders can make substantial cost savings.
- 5.36 ● Early intervention is also critical in relation to suicide prevention. One large study has shown that of those who committed suicide in Ireland, 33% had been referred to mental health services at some point, of whom less than half had been diagnosed as suffering from depression. Post-suicide psychological autopsies, however, report that between 65% and 95% of those who die by suicide had some form of mental illness (Joint Committee on Health and Children, 2006). There is, therefore, a further potential benefit in the promotion of positive mental health in terms of suicide prevention.
- 5.37 ● Although clinical treatment is not examined in this report, Chapter 8 examines strategies for effective integration of non-health services such as employment, housing and health services.

### Focus on Recovery

- 5.38** ● Empowerment and choice are critical to both the recovery of those experiencing mental ill-health and their social inclusion. The recovery model emphasises that responsibility for and control of the recovery process must be given in large part to the person who has the condition (Frese *et al*, 2001). Individuals who feel empowered to choose the direction of their lives and make decisions relating to their own recovery are more likely to stay well. Choice and autonomy are fundamental to our sense of well-being and positive mental health, as are opportunities for self-determinism and having control of one's life. Other psychological aspects of positive mental health are feelings of physical and psychological security which can be elusive to people in vulnerable settings such as prisons and on the streets. A Recovery Map is a personalised schematic of a service user's recovery journey and is a valuable tool in this regard (a copy of a Recovery Map can be found in Annex 3).
- 5.39** ● One of the challenges of implementing recovery-oriented initiatives is measuring the outcome. Jacobson and Curtis (2000) outline on-going work to develop recovery indicators, first through specifying the dimensions of recovery and then finding ways to operationalise and measure them reliably and validly across time. One such inventory is the *Recovery-Oriented Practices Index (ROPI)* (Mancini *et al*, 2006). This inventory places the focus on employment, education, feeling valued, having control and a varied list of qualities of life. These, if scored positively, indicate positive steps towards recovery.

### Service User Involvement

- 5.40** ● Service-user involvement should be a central part of mental health policy. The Project Team welcomes the planned establishment of the National Service User Executive to involve service users in the planning and delivery of mental health services. An NESF Report (No. 28, 2003) outlined the value of participation in healthcare and suggested that a common theme from research in this area is that participation is not just about achieving an outcome. It is about a meaningful and real process of engaging and informing communities of health practitioners and users. Tokenism has to be guarded against, and such participation if it is to be effective will require supports for service users and re-balanced structures to ensure their full involvement (McDaid, 2006).
- 5.41** ● The Project Team supports a rights-based approach to mental health, which emphasises individual choice, autonomy and entitlement. Some of the submissions supported this approach. Suggestions made included: adopting clear equality policies in line with the equality legislation; ensuring that those with mental ill-health have the opportunity to participate in the development of equality policies, to become self-advocates and to influence real change. Advocacy services are noted here as an essential part of any strategy to improve the rights of people who may be reluctant to access essential information and services, or to complain or seek redress.

### Examples of Good Practice: Stories Project

England's Eastern Region Development Centre recently launched a 'Stories Project' inviting people to share their experiences and to help challenge the myths and stigma surrounding many health and social care issues. People submit stories in writing, on tape or video, as a poem, motto or artwork. The stories support the ongoing work and have been integral in developing a logo, 'My Life,' with publicity materials used in campaigns and at events that support the ongoing collection of people's own stories and aim to raise awareness within the wider community (*STORIES PROJECT* taken from NIMHE, 2006)<sup>25</sup>

Schizophrenia Ireland run [www.recover.ie](http://www.recover.ie), a schizophrenia information resource where people can post their own recovery stories.

GROW has also produced two volumes of personal testimonies, *Soul Survivors* (GROW, 2003; 1996).

### Securing Basic Entitlements

- 5.42 ● In order to be able to participate more fully in society, people need sufficient income to be able to go out socially or use public services such as transport and access to community facilities. However as most people with severe and enduring mental illness are not in employment, they are either surviving on State benefits or through family support. It is important to secure adequate basic entitlements so that individuals can regain a sense of autonomy. However, employment is still the best route to inclusion, as its benefits are wider than income provision alone, in terms of self-esteem and independence.
- 5.43 ● Moreover, benefits need to be responsive to the fluctuating nature of mental health problems and fit in with part-time work. The Institute for Public Policy Research (2005) recommends an earnings replacement allowance, replacing income rather than being a payment for disability, developed from evidence that helping people with mental health problems to increase their hours gradually can improve their employment prospects. 'Permitted work' aims to bridge the gap between benefits and full-time work by enabling people to work for up to 16 hours per week and remain on benefits (Social Exclusion Unit, 2004). In Ireland, permitted work is allowed under the Disability Allowance while earning up to €120 per week, approved on a case-by-case basis by the Department of Social and Family Affairs.

<sup>25</sup> <http://www.socialinclusion.org.uk>

- 5.44 ● Mental Health Europe (2007) recently completed a survey on the situation of the ‘personal budget’ that is allocated to people with a disability. This is money for particular services, transport and other needs arising from their disabilities. It found that there is generally no legal framework for the provision of a personal budget and it is not used in Ireland. However France, Sweden and the UK, among others, have adopted it in various forms. In the UK, direct payments are managed by clients or their guardians and are paid directly to them once assessed as requiring services, including people with mental health difficulties (European Anti-Poverty Network Ireland, Flash No 179, 2007).
- 5.45 ● Childcare is critical to support women with mental ill-health needs to allow them to avail of training and employment opportunities and to access social and community supports as part of their recovery process. OPEN, in their submission to the Project Team outlined the importance of childcare to lone parents with experience of mental ill-health and called for *“increasing the supply of affordable, flexible, quality childcare, especially during after-school and holiday periods.”*

### Supportive Social Networks

- 5.46 ● There is a strong association between mental health and social support (Lehtinen *et al*, 2005). Extensive social networks have been found to protect against dementia (Fratiglioni *et al*, 2000). The Social Exclusion Unit (2004) in England makes a strong case for the role of social networks in developing social inclusion. They show that high levels of social support reduce the likelihood of a first occurrence of mental health problems and can increase quality of life for people with severe and enduring mental health problems. Conversely, low social support has been shown to reduce the likelihood of recovery.
- 5.47 ● Social isolation can be tackled through a combination of strategies including accessible and affordable transport and contact with other service users. Effective strategies to boost social support and social networks include: volunteering; peer support groups; faith and religious groups.
- 5.48 ● Social connectedness is important to the quality of life of older people with a disability in Ireland. The National Council on Ageing and Older People conducted a study of people with a disability and their quality of life. It recommends that a care needs assessment tool should include a section on social connectedness indicators to focus on the proximity of family and friends: whether or not they live alone, their involvement in clubs and organisations, and their connectedness to their local community (National Council on Ageing and Older People, 2007).

### Examples of Good Practice: Mind Blogging

Mind Blogging is a website with blogs/personal accounts, which gives a space to people with mental ill-health to share their experiences and express their views<sup>26</sup>.

The Youth Orchard Programme, a new initiative in North Kildare, offers social skills training, social support and activities for young service users and their families, and is staffed by community mental health nurses with a multidisciplinary support team.

### Suicide Prevention

- 5.49 ● Ireland has the fifth highest rate of youth suicides in the EU. Initiatives and strategies on suicide prevention are being developed by the National Office for Suicide Prevention to implement current policy as outlined in *Reach Out*. These include awareness raising, research and information provision. But these need to be more adequately resourced. Recent research, discussed in Chapter 2, examined mental health awareness and attitudes around mental health issues in Ireland.

### Example of Good Practice: Choose Life

Choose Life, a suicide prevention organisation and strategy, forms one element of the Scottish Executive's National Programme for Improving Mental Health and Well-being, which was established as a key driver of the commitment to improve health, tackle health inequalities and achieve social justice in Scotland. Some of their training initiatives include: Applied Suicide Intervention Skills Training (ASIST), which develops the skills necessary for suicide first aid; Skills-based Training On Risk Management (STORM), a suicide prevention training package for all healthcare, social care, criminal justice staff and volunteers; Mental Health First Aid (MHFA), the help given to someone experiencing a mental health problem before professional help is obtained; and SuicideTALK, a short exploration and awareness session.

<sup>26</sup> <http://www.mindblogging.org.uk>.

## Work and Employment

- 5.50 ● Work is important for income generation and to provide opportunities to engage in the civil, economic and social life of a community (Pavis *et al*, 2002). It is a fundamental component of how we define and perceive ourselves in the social world (Galloway, 1991). As Perkins and Repper (1996) point out, it is ironic that work is generally seen as falling outside the health remit, yet not necessarily within the remit of social services. However, the combined value of direct and indirect benefits can mean staying out of employment is increasingly attractive financially to those with mental health disabilities (Conroy, 2005).
- 5.51 ● Work provides five categories of psychological experience that promote mental well-being: (i) time structure (an absence of this can be a major psychological burden); (ii) social contact; (iii) collective effort and purpose (employment offers a social context outside the family); (iv) social identity (employment is an important element in defining oneself); and (v) regular activity (organising one's daily life) (WHO, 2000). The positive impact that employment has on mental health was highlighted in the submissions, with one stating that *“every effort should be made to help people suffering from mental health problems to retain or re-enter employment.”*
- 5.52 ● This issue was also a strong theme in other submissions received by the Project Team. *“There is a need to increase public awareness that people who experience mental health problems can work and that work can contribute to positive mental health”* (from a submission made to the Project Team). Chapters 6 and 7 examine existing opportunities for employment and attitudes to mental health in the workplace and good practice examples and effective strategies are detailed there.

## Protecting Vulnerable Groups and Individuals

- 5.53 ● The key factors to facilitate greater social inclusion have been covered under the four levels of action that were outlined earlier in this chapter. Particular strategies raised in the submissions are outlined here. These include:
- Developing inclusive communities and reducing stigma;
  - Early intervention in health difficulties;
  - Greater empowerment and choice for those experiencing ill-health;
  - A focus on employment;
  - Promoting broader social participation, volunteering and enhanced social networks;
  - Securing basic entitlements so that there is a basic income;
  - Acknowledging people's social networks and family relationships and supporting carers and friends and family;



- Building confidence and trust within an individual and in the community; and

- Support for advocacy services.

**5.54** ● Recommendations presented for lesbian, gay and bisexual (LGB) people in submissions to the Project Team, included:

- Provide ongoing training to mental health professionals to ensure that they are sufficiently competent to meet LGB people's needs;

- Ensure that the specific mental health issues of LGB people are taken into account in all future health and social policies and that LGB people are clearly identified as a target population of these strategies; and

- Undertake a positive awareness raising campaign targeted at mental health and other health and social care services to challenge negative perceptions of LGB people.

**5.55** ● Some of the points made in submissions to the Project Team focus on other specific groups but many of these concluding points are applicable to all vulnerable individuals and groups. The following issues were identified as crucial for older people:

- Initiatives that lead to a better understanding of ageing and older people among the population as a whole;

- A structured programme for regular liaison and consultation with older people at a local level to ensure that their needs are identified and included in the planning and delivery of any service designed to meet their needs; and

- The adoption by older people's interest groups of community development approaches.

**5.56** ● Recommendations presented in the submissions for prisoners included:

- Making additional resources available for psychiatric services to ensure that prisoners are diagnosed and treated appropriately while in prison;

- Enhancing the level and availability of one-to-one supports for ex-prisoners with mental ill-health; and

- Addressing the lack of long-term accommodation options for ex-prisoners.

**5.55** ● The recommendations outlined from the HSE West Conference Report (2006) are worth noting and are supported here in relation to Travellers, asylum seekers and refugees. In relation to Travellers, that report makes recommendations including that:

- Training for GPs on multi-cultural health;

- Travellers to be involved in the design of services and training as health care workers; and
  - Clear user-friendly information on mental health to be available for Travellers.
- 5.58** ● In relation to asylum seekers and refugees, the HSE report highlights the need to:
- Improve integration and community networks; encourage people to join local community activities and work in partnership with minority ethnic groups;
  - Provide training to service providers in cultural competencies and offer training to asylum seekers and refugees in the Irish system;
  - Appoint cultural diversity officers; and
  - Ensure the available of psychological support to these groups and to those working with them (HSE West, 2006).
- 5.59** ● There are other vulnerable groups who warrant specific initiatives to support their mental health needs and these should be developed in conjunction with the groups concerned. For example, in 2006, an All-Ireland Mental Health and Deafness Service was initiated to support the deaf community with mental health problems on both sides of the border. This work is provided by a psychiatrist and deaf peer support workers.

## Conclusions

- 5.60** ● This chapter identified four strategic levels for effective interventions to increase social inclusion for those with mental ill-health with respect to society, organisations, the community and the individual. International evidence suggests that strategies have to focus on all these levels to succeed. Many of these strategies have been examined in greater detail elsewhere (for example, VicHealth, 2006; WHO, 2000; and Social Exclusion Unit, 2004). However, the most critical interventions are in relation to employment, social and community supports and a framework for the delivery of integrated public services. These will be examined more fully in the chapters that follow.
- 5.61** ● There are some key conclusions from this chapter. At a societal level, there is a need for intersectoral strategies that cross key policy areas and Government Departments. The Project Team strongly emphasises that a comprehensive, intersectoral implementation strategy on mental health is necessary to support the implementation of *A Vision for Change*, the need for which has also been raised by the Independent Monitoring Group (2007) on *A Vision for Change* and the recent Health Research Board research on community residences (Health Research Board, 2007).

- 5.62 ● As the promotion of mental health is broader than mental health policy, the Project Team also supports the inclusion of health dimensions in reviews and evaluations of all key policies; and the more effective use of Health Impact Assessments, entailing a holistic approach to health and well-being in all policy development.
- 5.63 ● Another key conclusion is that effective strategies are needed to reduce stigma. These should include targeted advertising campaigns and website developments, for example, directed at young people as well as the wider community. These should be supplemented by local initiatives to close the gap in understanding between those experiencing mental ill-health and the community, through regular community meetings and activities and local media awareness campaigns. Initiatives in this area are being led at present by the National Office for Suicide Prevention and the HSE and are very much supported by the Project Team.
- 5.64 ● Inappropriate language and imagery associated with mental ill-health needs to be challenged and particularly so in the media. The work of *Headline* and other media watchdogs in this area is commended by the Project Team.
- 5.65 ● The Project Team concluded that the role of recovery in mental health is not well understood in the health sector and especially also by the general public. Creative approaches to raising awareness of this should be encouraged and undertaken, for example, a National art or writing competition centrally-funded by the HSE to focus specifically on the recovery journey and experience.
- 5.66 ● Another important conclusion is that there is poor general awareness of mental health issues among children and adults alike. Holistic health education from the cradle to the grave should be made available to all schools and integrated into the school curriculum, with particular projects for every level. For example, transition year students could complete a project or module relating to mental ill-health. For adults, these programmes could be offered as part of adult education programmes nationally. The training in Mental Health First Aid used in Scotland, is considered effective by the Project Team.
- 5.67 ● Vulnerable groups need targeted action to cater more effectively for their particular needs, such as young people, women, gays and lesbians, those with disabilities including severe deafness, Travellers and particular groups such as homeless people and prisoners. The report has examined some of the strategies which could be effective in this regard and which should be implemented.
- 5.68 ● The work of the National Office for Suicide Prevention is strongly supported by the Project Team and it fully supports the urgent implementation of the recommendations from *Reach Out*.

- 5.69** ● Finally, the Project Team has highlighted how specific and targeted programmes are needed to build and strengthen social networks of those in recovery through befriending schemes, peer advocacy, community development activities. To maintain adequate income levels, people with disabling mental ill-health should receive a personal budget to cover the costs of their support needs, in the form of a Disability Payment. *The Programme for Government 2007 – 2012* includes a commitment by the Government to publish a review of the cost of such a Disability Payment.
- 5.70** ● The following chapter examines the workplace and outlines particular strategies to increase mental health for all and provide positive supports for those who need them. It also presents the findings of commissioned research on attitudes of Irish employers and employees towards mental health.



6

## Introduction

- 6.1** ● This chapter focuses specifically on the workplace and the issues facing employees with mental ill-health and their employers. It sets out potential strategies and examples of good practice to tackle barriers to inclusion and more broadly to foster healthier workplaces for both employers and employees.
- 6.2** ● One of the central questions for the Project Team as set out in the Terms of Reference was “what more can be done to support those with mental ill-health in the workplace?” This chapter draws from new research commissioned by the Project Team and conducted by Millward Brown IMS<sup>27</sup>.
- 6.3** ● The *Mental Health in the Workplace* research comprised:
- Two telephone surveys with employers<sup>28</sup> and a sample of adults who were either employed or retired (referred to in this chapter as the Surveys) and ‘Employees’; and
  - Four focus groups with employers and employees (the *Focus Groups*).
- 6.4** ● The issues concerning the workplace and mental health are wide-ranging from workplace health promotion to specialist supports for those returning to work after an episode of ill-health. This chapter examines two broad areas which affect both those employed and their employers: (i) mental health and well-being in the workplace including positive mental health, promotion, prevention and supports; and (ii) mental ill-health in the workplace including, incidence, legal and policy context, challenges of disclosure and returning to work.

---

<sup>27</sup> A separate report of this research is being published by the NESF.

<sup>28</sup> 306 employers (MDs, CEOs, HR Managers, Senior Directors); 686 adults aged over 15 years either employees or retired. The surveys were broadly similar, using both open questions and attitudinal scales with which respondents agreed or disagreed.

## (i) Mental Health and Well-being in the Workplace

### Policy and Legal Context

- 6.5 ● From an overview of legislation in this area, it is possible to conclude that in relation to people with disabilities in employment, the issue of mental health is not treated any differently from any other disability. However, there has been relatively little case law on it to date. What is clear from the *Employment Equality Acts, 1998-2004*, is that employers must not discriminate against those with mental health issues in relation to any aspect of their employment. However, while employers are not obliged to employ or retain an individual who is not capable of undertaking the employment, they do have a legal obligation to provide *reasonable accommodation* for those with disabilities, subject to it not imposing a *disproportionate burden* on them. Employers also have a legal obligation to ensure equality in practice between employees in the workplace. The equality legislation contains provisions allowing for ‘positive action’, that is, measures to remove existing inequalities that affect opportunities in access to employment, training, promotion and working conditions. These points are presented more fully in the paragraphs that follow.
- 6.6 ● Employers are legally obligated to protect the health and safety of their staff. *The Safety, Health and Welfare at Work Acts, 1989 and 2005* require them to put in place systems of work which protect employees from hazards which could lead to mental or physical ill-health. Employers have to draw up a written risk assessment of all known hazards, including psychosocial hazards, which might lead to stress. Eardly (2002) outlines the potential hazards linked to work related stress, including occupational culture, change in the workplace, role and work schedules. However in broad terms, occupational health and safety provisions do not extend beyond risk prevention (Wynne and McAnaney, 2004).
- 6.7 ● Under the *EU Framework Health and Safety Directive and the EU Framework Agreement on Work Related Stress*, employers must develop a coherent overall prevention policy. The *Safety Health and Welfare at Work Act 2005* provides that “every employer shall ensure as is reasonably practicable, the safety, health and welfare at work of his or her employees” (Government of Ireland, 2005). There are also obligations on employers and employees in terms of a duty of care to protect others from avoidable harm.
- 6.8 ● According to the Health and Safety Authority (HSA), while risk assessments are compulsory and do include health, no statistics are kept on ill-health or stress. As yet the HSA has not taken any court case on a mental health issue. Only one psychologist offers guidance on best practice on developing safe organisational cultures.



- 6.9 ● There is also a legal obligation on employers to make reasonable accommodation for their employees with mental ill-health under disability and equality legislation. While the *Disability Act 2005* supports the provision of specific services to people with disabilities, the *Equal Status Acts 2000 to 2004* and *Employment Equality Acts 1998* and 2004 prohibit discrimination on nine grounds, one of which is disability (Government of Ireland, 1998; 2000; 2004; 2004a). This is broadly defined as including people with all physical, sensory and intellectual disabilities and mental health issues. Under this legislation, employers have to make reasonable accommodation for employees with mental ill-health.
- 6.10 ● The nature of ‘reasonable accommodation’ is only emerging slowly from cases brought to Equality and Employment Tribunals. The Workway initiative (see Chapter 7) developed a *Guide to Disability in the Workplace in 2004* which outlines the core categories of reasonable accommodation as being: (i) changes to a job application process enabling a qualified applicant with a disability to be considered for a position; (ii) changes to the work environment, or to the way a job is usually done; and (iii) changes that enable an employee with a disability to enjoy the same benefits and privileges of employment (such as access to training) as other employees.
- 6.11 ● There is evidence of reluctance by employers to hire people with mental ill-health as less than 40% of UK employers said they would recruit people with mental health problems (Morris, 2006). 68% were unsure or disagreeing as to whether employers would be understanding or supportive of depression in the workplace. A third of employers, in an attitude survey commissioned by the NDA in 2002, stated that their employment criteria would be different for people with mental health difficulties, as compared to people with a disability generally.

### The Business Argument

- 6.12 ● The World Health Organisation argues that employers need to recognise mental health issues as a legitimate workplace concern (WHO, 2000). They make the case that good health equals good business. Certainly the challenge to retain experienced staff in a competitive economic climate is added pressure on employers to adopt an inclusive approach. Such an approach can:
- Reduce absence;
  - Create better work relations;
  - Enhance productivity and motivation;
  - Make the workplace more efficient;
  - Foster acceptance and diversity;
  - Employ the best person for the job; and
  - Gain and retain important skills (WHO, 2005b).

**6.13** ● Richard Layard argues that depression, anxiety and other forms of mental illness have taken over from unemployment as the greatest social problem in the UK (Layard, 2004; 2006). He points out that there are “*more mentally ill people drawing incapacity benefits than there are unemployed people*” (2004: 2). In the United States, the Partnership for Workplace Mental Health (2006) produced *A Mentally Healthy Workforce: It’s Good for Business*, a focused report outlining the business case for employers to help them move towards having mentally healthy workforces. They argue that investing in action early on can lower total medical costs, increase productivity, lower absenteeism and decrease disability costs. The key points include:

- The high incidence of mental ill-health in the workplace and that more workers are absent from work because of stress and anxiety than because of physical illness or injury;
- The cost to employers of \$80 - 100 billion in indirect costs related to mental ill-health and substance abuse annually;
- Treatment for ‘mental disorders’ is highly effective, with 80% of individuals with depression recovering fully;
- Ignoring mental ill-health is costly as untreated mental ill-health costs more; and
- Adopting a proactive approach, linking with health services and in the community and spreading the word i.e. being open about policies and innovations.

**6.14** ● *Impact on Business*

*The Surveys* asked employers to think of any problems that might arise at work from mental ill-health among employees: **39%** thought it increased absenteeism; **26%** thought that relationships with other employees suffer and **25%** thought it reduced work capacity.

**6.15** ● There are other less obvious costs involved with mental ill-health in the workplace. Mentality (2003) outlines the following:

- Poor performance;
- Staff illness and shortages that can threaten quality of service or product supplied;
- Reduced morale;
- High staff turnover;
- Early retirement;
- Management time to deal with issues associated;

- Providing temporary cover;
- Complaints and litigation associated with problems; and
- Costs to government of health care and rehab.

### Mental Health Policies

- 6.16 ● In the UK, in a Confederation of British Industry (CBI) survey of over 800 companies, 98% of respondents recognised the importance of mental health to their employees and acknowledged that there should be a mental health policy for staff. Yet the analysis points out that most companies do not have an official policy on mental health (ILO, 2000).
- 6.17 ● Without policies in place, it is unlikely that companies will be able to support staff in caring for their mental health. Wynne and McAnaney (2004) argue that workplaces should adopt more proactive and interventionist approaches to managing sickness absences.
- 6.18 ● The benefits of developing policies can be multiple. According to WHO (2005b), organisations adopting healthy guidelines and programmes have experienced major improvements in their human and business conditions.

### 6.19 ● *Mental Health Policies in Irish Workplaces*

*The Surveys* found that **only one in five companies have a written policy on mental health** (see Figure 6.1 below).

Only **41%** of employers had guidelines for dealing with mental health in the workplace.

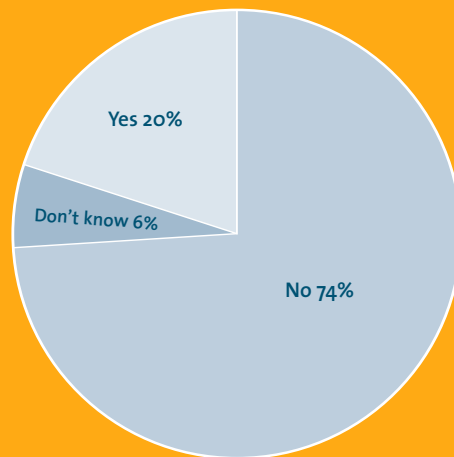
**75%** of employers agreed<sup>29</sup> they did not know enough about the law regarding mental health in the workplace.

Just over half (**55%**) agreed that *“the managers in your organisation have a good understanding of mental health issues.”*

<sup>29</sup> The term “agreed” is used here to refer to those who either “strongly agreed” or “agreed” with the statement provided and “disagreed” refers to the combined percentage of respondents who “disagreed” or “strongly disagreed”.

**Figure 6.1** Workplace and Mental Health Policies

Companies with mental health policy



- 6.20** ● That only 20% of employers had mental health policies in place, (see Figure 6.1) is very similar to results from a Scottish survey in 2006. In that survey, some of the same statements were also used so a direct comparison is possible. 80% of Scottish employers did not have a mental health policy and 70% did not know enough about the law in relation to mental ill-health (The Shaw Trust, 2006). This contrasts with a recent study on bullying in the workplace by the ESRI (2007) which found that approximately half of all organisations reported having a formal policy on workplace bullying.
- 6.21** ● The lack of policies in place was also noted in the *Focus Groups*. One employee commented, “*they have guidance on the wall, what to do if someone breaks their arm, but nothing for depression. What do you say to somebody like...?*” There was also an awareness of the limits of employers’ capability to respond to mental health issues. One employee said, “*you can’t expect the company to be going round asking everybody how are you doing, how are you keeping, how is the auld head there?*”
- 6.22** ● A recent EU seminar on mental health and well-being concluded it is more effective to consider mental health and stress in the workplace in terms of preventative activity, rather than as the response to mental health problems (SUPPORT, 2006). The following paragraphs set out some international and Irish projects and initiatives which have been successful in health promotion and mental ill-health prevention.

- 6.23 ● However, it is not always clear what a mental health policy should contain or how it should be developed. The International Labour Organisation (ILO) (2000) outlines the key stages (see Figure 6.2).

### Figure 6.2 Key Stages in the Development of a Mental Health Policy

1. **AUDIT:** Gather information on existing levels of stress and mental ill-health (for larger companies).
2. **DEVELOPMENT:** Establish working group from all levels of the company.
3. **POLICY DOCUMENT** could contain:
  - An introduction: outlining the impact of mental ill-health; aims and objectives (to promote mental well-being, reduce stigma and promote assistance to employees); health, safety and welfare policy.
  - Human resources policies, e.g. on mental health and recruitment, sickness absence, disclosure, rehabilitation, and alcohol use.
  - Organisational philosophy on health promotion and mental ill-health prevention.
  - Draft strategies for stress prevention and management, based on identification of mental health needs via the process of audit.
  - Details of staff training programs, including stress management courses; health education of the workforce.
  - Descriptions of the roles and responsibilities of employees to promote mental health.
  - Details of the processes of auditing, monitoring, and evaluation.
  - Estimated costs and time schedule for implementation.
4. **IMPLEMENTATION:** Convert the policy into practice throughout the organisation. This is reinforced by regular monitoring and evaluation against performance indicators, such as reductions in sickness absence and improvements in job satisfaction. Revise the policy in line with review findings.

### Example of Good Practice: Putting a Policy in Place

In the United Kingdom, the Health and Safety Executive recommends that a mental health policy should be an integral part of any organisation's health and safety policy. Some large companies, such as Marks and Spencer, Astra, Zeneca, and The Boots Company, have developed policies which have addressed mental health issues in the workplace. The most fundamental step for organisations is to recognise and accept that mental health is an important issue<sup>30</sup>.

- 6.24 ● In addition to companies putting policies in place, governments also have a role in promoting positive mental health in workplaces. The Dutch Government has taken pro-active steps in tackling workplace stress.

### Example of Good Practice: Government Policy and Legislation

Over the years, the Dutch government has pursued an active policy towards job stress and its prevention. This not only relates to reforming legislation but also to its implementation through positive incentives and facilitating initiatives rather than through penalising measures. The Netherlands have a policy which places an obligation on employers to cover 70% of an employee's wages in the first year of sickness absence as well as making them enter a contract with a health and safety service<sup>31</sup>.

#### 6.25 ● *Training and Support Needs*

Any workplace strategy has to include training and support for employers. *The Surveys* revealed that this would be welcomed by the vast majority of employers.

The Surveys found that over 90% of employers would welcome:

- Training for themselves;
- Good practice guidelines for managers;
- The ability to refer employees to support programmes;
- Well-being information and activities for employees; and
- Access to experienced advisors who can support the retention of staff.

- 6.26 ● Without training and support, companies may not feel equipped to cope effectively with a diverse workforce. *The Focus Groups* revealed that for some employers, the difficulties of dealing with a challenging employee due to ill-health, bullying or poor performance were too much to cope with. As one employer said, "it's becoming cheap for you as a private company to go and fire somebody and go up and pay the €40,000

30 <http://www.ilo.org>

31 <http://hesa.etui-rehs.org/uk/newsletter/files/2002-19p31-38.pdf>

*when you go to unfair dismissals. It's actually cheaper for you to do that."* This suggests that employers, particularly from small or medium-sized companies, need support in responding to the needs of all their employees.

**Workplace Stress, Bullying and Work-life Balance**

**6.27** ● WHO (2000) states that stress is one of the most common work-related health problems in EU countries. In an Irish study, women were found to experience higher levels of work stress than men, even though their level of work pressure was lower (O’Connell *et al*, 2004). They found that over half of all employees experienced some measure of work pressure, with 65% finding work stressful. Those with least control experienced more stress. In a TUC survey (2006) in England, 61% of the health and safety representatives surveyed cited stress as being their most pressing concern at work. The biggest causes of stress were cuts in staffing levels (57%); rapid change (53%); long working hours (34%); and bullying (33%). Women may experience greater work stress as they often have greater responsibility for caring and domestic work, as well as less control and discretion in the workplace due to the kind of positions and types of sectors in which they are primarily employed (O’Connell *et al*, 2004). Employees, who perceive they have little control over their work, have low support from colleagues and high stress in the workplace, experience poor mental health and high sickness absence (Marmot and Wilkinson, 1999).

**6.28** ● Workplace bullying has been estimated to affect up to 50% of the United Kingdom’s workforce at some time in their working lives, with annual prevalence of up to 38%, and is becoming increasingly identified as a major occupational stressor (McAvoy and Murtagh, 2003). O’Connell and Williams (2001) report from an ESRI survey, that 7% of those in the workplace experienced bullying in the 6 months preceding the survey. Women were more likely to report that they have been the victims of bullying than men: 9.5% of all women reported that they had experienced bullying, compared to 5.3% of men. This study was repeated in 2006 and the results show a slight increase to 7.9% of the sample having experienced bullying (ESRI, 2007). This study found a greater increase in the incidence of bullying as experienced by women (see Table 6.1).

**Table 6.1** Incidence of Bullying by Gender

	2007 %	2001 %
<b>Men</b>	5.8	5.3
<b>Women</b>	10.7	9.5
<b>All</b>	7.9	7.0

Source: ESRI (2007).

- 6.29** ● Employers also reported bullying in a separate survey and found it is more likely to be perceived as a problem in larger rather than smaller organisations. While about 10% of organisations (with less than 10 employees) perceive bullying to be a moderate or major problem, the comparable figure for large organisations (with 250 or more staff) is nearly 30% (ESRI, 2007).
- 6.30** ● In an economy that is close to full employment, Irish employers are paying increasing attention to the management of the work-life balance in responses to recruitment and retention difficulties (Dobbins, 2000). Although wide-ranging and lacking a single focus, work-life balance has become a catch-all term to include parental commitments as well as work-related stress and mental ill-health<sup>32</sup>. It contrasts with mental health as a concept in that most people view it as being framed in the workplace rather than at an individual level.

**6.31** ● *Work Life Balance*

*The Surveys* found that **63%** of employees felt that workplace stress interfered with their family life to some extent. (This was higher for women than for men). However, this did not seem to affect their work-life balance as **66%** were somewhat or very satisfied with the balance between their working and non-working lives, with a fifth, **19%**, dissatisfied overall.

**79%** of employers agreed that their organisation offers flexible working conditions while fewer (**60%**) employees agreed.

- 6.32** ● Women have the lion's share of housework and caring responsibilities as well as increasingly joining the labour market, with greater reported levels of stress across many studies, including the *Surveys* outlined here. *The National Women's Strategy (2007-2015)* includes a focus on increasing women's role in the labour market. It is important, therefore, that family friendly policies and flexible working arrangements are also supported as they can make a key difference in combating women's workplace stress (The Women's Health Council, 2005).

The results of a pilot EQUAL Work-Life Balance Project showed that flexible working arrangements facilitate employment and work-life balance of people with mental ill-health (Fine-Davis *et al*, 2005). They found that the most important policies for those with mental ill-health would include: supportive attitudes at work; flexible hours; and an open environment where one could disclose mental health problems.



## Healthy Workplaces

- 6.33 ● Positive mental health at work includes having satisfying workplace relationships and dealing with difficulties quickly and efficiently (WHO, 2005b). Examples of being mentally healthy at work include:
- Communicating and relating, being able to express one's feelings, understanding others and maintaining good relationships;
  - Balances between work and home;
  - Informal mentoring, mediating and counseling roles;
  - Taking responsibility and initiative; and
  - The company providing a good working environment.
- 6.34 ● The US Department of Health and Social Services have developed a comprehensive guide on mental health in the workplace, *Businesses Materials for a Mental Health-Friendly Workplace* (Substance Abuse and Mental Health Services Administration, 2004). One useful aspect of this guide is the *Mental Health Friendly Workplace Circle*, which portrays the potential elements of a healthy workplace across the life of an individual's employment in a given organisation. It shows what an employee (at the heart of the circle) can expect from a Mental Health-Friendly Workplace from the time of recruitment through times of working in health or, in times of distress or disability and return to work. Each area of the circle has examples of policies and strategies that can be effective, including workplace wellness or health promotion programmes for those who are working. Although this is US-based, it could be adapted for the Irish workplace. It includes five key areas: Recruitment/orientation; Working: wellness; Working: distress; Away: sick leave or disability; and Return to work (see Figure 6.3).

## Workplace Stress Interventions

- 6.35 ● Evidence suggests that a range of stress management interventions can have a beneficial and practical impact on employees (British Occupational Health Research Foundation, 2005). McKeon and Burke (2006) recommend the introduction of a 'stress policy' for employers in order to help improve this situation. *Understanding Depression in the workplace: How can you help?* from Aware, aims to encourage workers to be more open and accepting of illness and to support those who are unwell.
- 6.36 ● One submission noted that employee assistance programmes (EAPs) provide access to professional support and can be extremely beneficial. These are company-sponsored and designed to alleviate and assist in eliminating problems experienced in the workplace. The programmes typically provide supportive, diagnostic, referral and counselling treatment services (WHO, 2000).

**Figure 6.3** The Mental Health-Friendly Workplace Circle



Source: Adapted from Substance Abuse and Mental Health Services Administration (2004).

- 6.37** ● One strategy is to target individuals within the workplace who might need special support. It is argued that individual rather than organisational approaches are more effective for those deemed to be at risk of developing common mental health problems (British Occupational Health Research Foundation, 2005). Cost effective intervention is brief (up to 8 weeks) Cognitive Behaviour Therapy (CBT).
- 6.38** ● There are also guidelines available on responding to workplace bullying, *Bullying and Stress in the Workplace: Employers and Employees-A Guide*, by Irish barrister John Eardly. In addition, since 2002, a code of practice on bullying in the workplace has been in place and although not binding on the courts, is admissible as evidence in any legal proceedings (Eardly, 2002).
- 6.39** ● A new code of practice on prevention and resolution of bullying at work was recently produced by the Health and Safety Authority (2007) in response to the ESRI study which found 8% of workers were affected. The code defines bullying in the workplace as “repeated inappropriate behaviour, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others at the place of work and/or in the course of employment which could be reasonably

regarded as undermining the individual's right to dignity at work" (p.5). The Health and Safety Authority (2002) also produced *Work-related Stress: A Guide for Employers*. However, as yet, there is no guide available on mental health issues.

## (ii) Mental Ill-health in the Workplace

### The Challenge: Incidence of Mental ill-health at Work

**6.40** ● As previously mentioned, mental health problems take their toll on the workplace in the form of work absences, lower productivity and morale. The link between workplace conditions and levels of mental ill-health is complex, but clearly workplace stress can be a factor. The Social Exclusion Unit (2004) reported that two thirds of people with mental health problems believe that unrealistic workloads, long hours and bad management caused or exacerbated their problems. A study by Maguire and O'Connell (2007) in the Civil Service Occupational Health Department examined teacher retirements due to ill-health and found that 46% retired due to 'mental disorders' with depression, anxiety and chronic fatigue the most common.

#### **6.41** ● *Incidence of Mental Ill-health*

*The Surveys* found that more than one in six of employees (16%) said they had experienced mental ill-health in the last two years. This was higher among females (19%) and 25–34 year olds (23%).

Of those who said they had experienced difficulties, 57% said it was stress related illness, 31% depression and 15% anxiety related illness.

46% of employers reported at least one person with mental ill-health in the workplace in the last two years, as did 43% of employees.

This level of mental ill-health, 16%, is higher than the 10% found by the National Office for Suicide Prevention (2007) and Mental Health Ireland (2005). However, this may be due to the focus on the workplace and the inclusion of stress as an aspect of mental ill-health.

### Perception of Ability and Liability

**6.42** ● An aspect of stigma is the negative perceptions of the abilities of employees with mental ill-health. Studies by the *US National Alliance for the Mentally Ill* (1999) show that there are no differences in productivity for those with mental ill-health and other employees. Employers who have hired individuals with mental ill-health report that they are higher than average in attendance and punctuality and as good as or better than other employees in motivation, quality of work, and job tenure. Long-term studies have shown that the majority of people with mental ill-health show genuine improvement over time and lead stable, productive lives (WHO, 2000). Despite this, perceptions may not be as positive among some employers.

### Attitudes: Taking a Risk?

**6.43** ● As mentioned in Chapter 4, there are negative attitudes and stigma towards mental ill-health in Ireland. This is also the case in relation to employment. A survey by the National Disability Authority (2002) found that only 55% of the general population thought that people with mental ill-health should have the ‘right to work,’ as compared to 82% of those with physical disability. 33% of respondents thought that those with mental ill-health should not have the same opportunities as everyone else (NDA, 2002).

#### **6.44** ● *Attitudes Towards Employees with Mental Ill-health*

**91%** of employers agreed that employees with mental ill-health have valuable skills and experience that employers do not want to lose. (This is the same percentage (**90%**) who agreed with a similar statement used in a survey by Fine-Davis *et al*, 2005).

**87%** agreed that “*employers should make a special effort to accommodate the particular needs of employees with mental ill-health in the workplace.*” However, when it comes to hiring someone with a history of mental ill-health, just over half (**56%**) agreed they would.

The Surveys found that nearly three quarters (**73%**) of employers and **69%** of employees, think full recovery from a mental health difficulty is likely. However, **54%** of employers think that organisations take a significant risk when employing people with mental ill-health.

Furthermore, over a third (**34%**) of employers thinks that people with mental ill-health are less reliable, and **39%** of employees agreed.

In Scotland, fewer employers, **45%**, felt that organisations were taking a significant risk when employing people; but the same, **35%** thought they were less reliable (The Shaw Trust, 2006).

**6.45** ● In the *Focus Groups*, some employees and employers argued that information and attitude change had to happen outside of the workplace on a larger scale. One employee said, “*I mean really everybody’s mindset has to be changed on it because companies are just reflecting what everybody else thinks. It’s like the way they changed drinking and driving, became antisocial... I mean it’s really an education thing, it needs to be for everybody.*” Another employee commented, “*we need a change in national attitude. I think we need a campaign of awareness and education. It should be even something school leavers are taught.*”

### To Tell or Not to Tell: The Risks of Disclosure

**6.46** ● Research suggests that the way managers approach their staff and their well-being are considered important by employees and may reduce their stress levels (Affinity Health at Work<sup>33</sup>). This is particularly evident in relation to disclosure. There are risks and benefits to disclosing a mental health difficulty. Employees can feel they may be viewed less positively in the workplace, be the subject of gossip or negative attitudes, and ultimately may jeopardise their future career. One employee from the *Focus Groups* said: *“I think if they could talk to a person they could trust and it wasn’t going to go any further than the proper channels, because I know in our place if you said something in confidence by the time you got down the stairs everybody knows.”*

#### **6.47** ● *Double Standards: Disclosure in the Workplace*

**80%** of employers said they would feel comfortable talking about a mental health difficulty with an employee. The Scottish Survey found this was the case for **85%** of employers (The Shaw Trust, 2006).

However, the *Surveys* found a double standard in that **95%** of employers would like their employees to tell them if they had mental ill-health, but only **69%** would tell their own employer.

In the *Focus Groups*, one employer said, *“I don’t want on my medical cert that I’m suffering some sort of mental illness. That’d be a death knell to my career.”*

**31%** of employees said they would not tell their employer. Figure 6.4 below outlines the reasons given. However, employees were more likely to tell their employer (**58%**) than their colleagues (**43%**).

**Figure 6.4** Reasons for not Disclosing Mental Ill-health among Employees

Statement	All %	Male	Female
Afraid it would have negative impact on my job/prospects	53	50	57
Would not want employer to know personal stuff about me	24	27	21
Would not feel comfortable talking to my employer	20	25	13
Fear of being talked about	15	18	9
Fear of stigma/discrimination	6	5	6
They might not understand	3	3	4
None of their business/too personal	3	0	9
Have nothing to gain by telling them	3	3	3
Other	2	2	2
Don't know	2	3	2

**6.48** ● It is not known how many people do actually tell their employers. However, a recent study with people who had experienced depression by McKeon and Burke (2006) found that the vast majority said they would not tell a prospective employer. Indeed, the number who would tell rose from 14% in 1995 to 19% in 2006. According to the earlier study, where employers knew about depression, they were reported to be understanding in almost 84% of cases. However, by 2006, this figure had fallen to 73%, and McKeon and Burke (2006) conclude that this suggests employers are less understanding of mental illness today than they were 11 years ago. Fine-Davis *et al* (2005) reported a similar number, 62.7% of a sample of those with mental ill-health, had not told their employers about their illness.

**6.49** ● *Risks of Disclosure*

*The Surveys* found that with disclosure, came added risks for employees, with nearly two thirds of employers (62%) in agreement that if they knew that an employee had a mental health difficulty, they would be likely to reduce the level of responsibility given.

Only a third, 35% overall of employers said they would be likely to consider those with mental ill-health for promotion, with over a quarter of employers, 27%, saying it would be unlikely.

- 6.50 ● The lack of clear guidance does little to reassure employees about the consequences of disclosure. One employee from the *Focus Groups* said, *“if you broke your leg you’d be fairly confident that your company would stick by you and you’d still have your job to walk into when you’d be better again. If you’re off with depression, because there’s that whole ‘is he mental?’ thing about it, ‘is he a liability?’... that you would fear what your company will do when you get back..”*

### Disclosure: What the Employer is Really Thinking

- 6.51 ● A key aspect of disclosure is the effectiveness and skills of the line manager, human resource manager or director that an employee tells about their difficulties. In the *Focus Groups*, employers felt that most employers would be sympathetic to employees with mental ill-health. One employer said, *“I think every employer would have a certain amount of sympathy once they know what the problem is, to try and overcome that problem.”* However, further discussion in the *Focus Groups* revealed that neither employees nor employers would feel comfortable talking over mental ill-health with their employer. Employees felt that they would be viewed negatively by the employer. In a fictional scenario, presented with a disclosure scene between an employer and employee, they imagined employers were thinking things like: *“I am not qualified to deal with this; “Oh no! Please let the phone ring now!”; “This one’s a nut!”; “What will I do; what will I say?”; “Who do you think I am- a shrink?”* There was some similarity with the imagined thoughts of employers in the same situation: *“I haven’t the time for this!”; “Here we go again. Basket case!”; “It must be serious, she has taken the time to tell me”; “Is it work related?”*, but they also had some positive thoughts about how to respond, such as *“How can I help?”*
- 6.52 ● Employers have an obligation to consider the welfare of their employees and their customers. *The Focus Groups* found that some employers found it difficult to decide if someone with mental ill-health should remain in direct contact with customers. As one employer commented about a situation they’d experienced, *“we were scared because this person was based in the field dealing with customers and the last thing we want in the world is somebody who basically wants to end their life out on a customer’s site.”*

## Strategies and Issues for Employers

### Reasonable Accommodation

**6.53** ● Under equality and disability legislation, employers have to make reasonable accommodation in the employment of people with mental health disabilities. *Just Ask! Guidelines* produced by E.V.E. Limited (Eastern Vocational Enterprises Limited), outlines common accommodations which can be made for an employee with mental ill-health (or any personal difficulties which impact on work). Accommodations may include:

- Adjusting work schedules, flexible rostering etc;
- Restructuring the job;
- Modifying the work station;
- Formalising mentoring and supervision; and
- Allowing time for training and re-training.

### The Challenge for Small and Medium-Sized Companies

**6.54** ● There are particular challenges and benefits to managing mental ill-health in the workplace for SMEs (Small and Medium Enterprises). While larger companies have more employees to support, they also usually reap the benefit of a dedicated human resource department and a larger workforce to cover any absences. However, their workforce can be more anonymous to employers.

#### **6.55** ● *Impact on Smaller Companies*

*The Surveys* found that employers from smaller organisations reported a lower incidence of mental ill-health and more thought that their managers had a good understanding of the issues. However, more felt they would be taking a risk hiring someone with mental ill-health. Employers felt they didn't understand enough about the law in relation to mental health at work. This was highest among employers in smaller companies. *The Focus Groups* found that the impact of absenteeism and sick leave was particularly disruptive for those small companies running a service business. As one of the employers from a small company in the *Focus Groups* commented, "we don't have that luxury of carrying somebody."



## Strategies and Issues for Employees

### Experience of Those with Mental Health Difficulties

- 6.56** ● 16% of the sample of adults had experience of mental health difficulties in the previous two years. This group had a more negative experience of the workplace when their responses are examined and compared directly with responses for the sample as a whole. Broadly 10% more of those with experience of mental health difficulties feel uncomfortable talking with employers than the overall sample and are less likely to disclose to their employers (by 7%). 20% more of this group think that the organisation is not sensitive to mental health issues.
- 6.57** ● Furthermore, this group felt a greater impact of workplace stress on family life, 17% higher than the overall sample and higher dissatisfaction of worklife balance, by 15%. In broad terms, experience of mental ill-health paints a darker experience of the workplace for this small group.

### Accurate Information

- 6.58** ● One successful strategy has been to increase mental health literacy in the workplace through targeted campaigns, information and guidance material and general awareness-raising. The Social Exclusion Unit (2004) argues that reducing the stigma around mental health (in the workplace) requires the dissemination of accurate information and the provision of targeted support. As one submission outlined, “*employers possess a lack of knowledge about mental health problems and about the types of accommodations that may lead to successful outcomes for their organisation as well as the individual.*”
- 6.59** ● There are guidelines available for employers in relation to disabilities but these do not specifically refer to mental ill-health. However they do include useful material which could be circulated more widely. *Guidelines on Employment of People with Disabilities* includes a section on reasonable accommodation<sup>34</sup>. However the examples included only refer to physical disabilities (Workway, 2004). ILO (2001) also developed a *Code of Practice on Managing Disability in the Workplace*<sup>35</sup>. The NDA has also produced guidance on disclosure for people with disabilities.
- 6.60** ● The Workway (2005) training pack, *Ability in the Workplace*, includes guidelines of what to include when writing up a code of practice in relation to the employment of people with disabilities. Some of the issues that are raised on the needs of people with mental ill-health in the workplace include:
- Avoid any preconceptions about their ability;
  - Responsibility should be clearly defined;
  - Evaluate the effectiveness of accommodations;

<sup>34</sup> <http://www.workway.ie>

<sup>35</sup> <http://www.ilo.org>

- Allow additional time to learn new tasks, if needed;
- Consider allowing for a job-coach;
- Dividing tasks may make an assignment more manageable;
- Counselling and employee assistance programmes should be available;
- Time off for scheduled medical visits should be allowed; and
- A flexible approach to leave may help an employee to remain in their job after hospitalisation.

**6.61** ● *Just Ask!* (EVE Limited, 2004) is an Irish handbook for employers and employees for dealing with mental ill-health, endorsed by IBEC and available in all FÁS offices. E.V.E. Limited identify some of the questions that an employee should ask before disclosing:

- Is my disclosure necessary?;
- Does my mental health difficulty affect my ability to do the job?;
- Is my disclosure likely to lead to the provision of accommodations and supports in the workplace?;
- Will telling my employer reduce the pressure to keep ‘my secret’? ; and
- If an employee is going to disclose, they should ask themselves, when should I tell? What will I say? And how much do I need to tell?

**6.62** ● There are also good practice examples internationally. In England, Line Managers’ Resource packs for employers have been developed by Mindout for Mental Health<sup>36</sup>. WHO (2005b) produced another guidance package, *Mental Health Policies and Programmes in the Workplace*, showing how to introduce work-based policies. In Canada, the non-for-profit organisation, Mental Health Works, helps organisations to manage their duty to accommodate employees experiencing mental disabilities such as depression or anxiety in the workplace through an innovative website and guidelines for employers and employees. They have a range of speakers available to run manager workshops and provide an interactive training course on CD Rom.

### Example of Good Practice: Partnership Approach

In the United States, the Partnership for Workplace Mental Health advances effective employer approaches to mental health by combining the knowledge and experience of the American Psychiatric Association and employer partners. The partnership delivers educational materials and provides a forum to explore mental health issues and share innovative solutions. It promotes the business case for quality mental health care, including early recognition, access to care and effective treatment<sup>37</sup>.

<sup>36</sup> <http://www.mindfulemployer.net>

<sup>37</sup> <http://www.workplacementalhealth.org/>

## Charters and Incentives

- 6.63 ● A new commendation award, *Mental Health and Well-being*, is awarded to employers by the Scottish Centre for Health Working Lives. Another example, *Working Minds*, in the Department of Health Mind Out Campaign (England), actively seeks out partners in the business sector who publicly sign up to and support the campaign to change attitudes in the workplace.
- 6.64 ● Part of Rehab, Access Ability, is a consultancy for employers relating to the employment and retention of people with disabilities. It operates the O2 Ability Awards which recognise best practice in the employment of people with disabilities. The Project Team welcomes these awards and would encourage a specific focus on mental and emotional disabilities.

### Example of Good Practice: Charter for Employers

The Charter for Employers who are Positive about Mental Health is part of the MINDFUL EMPLOYER initiative from Devon Partnership NHS Trust. This is a voluntary agreement seeking to support employers in working within the spirit of its positive approach<sup>38</sup>.

### Early Intervention

- 6.65 ● Wynne and McAnaney (2004) produced a report for the European Foundation for the Improvement of Living and Working Conditions, *Employment and Disability: Back to Work Strategies*. The Project Team's support for early intervention incorporates a number of action principles drawn from this report:
- It is not inevitable that a health condition, regardless of its impact on function or activity, results in exit from employment;
  - It is better to prevent individuals from losing their job than invest in attempting to return them to work after they become unemployed or inactive;
  - Early intervention is the most effective way to achieve job retention and reintegration and can only be effective if responsibility for action is located in the workplace;
  - Co-ordinated delivery of appropriate services and supports is essential for effective return to work; and
  - Disability management provides a useful template for effective policy and measures to support job retention and reintegration.

<sup>38</sup> <http://www.mindfulemployer>

### The Challenge: Returning to the Workplace

- 6.66** ● Wynne and McAnaney (2004) argue that generally speaking, the longer a person is away from a job, the less likely it is that he or she will ever return to a productive working life. The probability of returning to work for those absent between three and six months is reduced to less than 50% and, for those who are absent more than 12 months, is 20%. They argue that role of the employer in early intervention, job retention and reintegration is often poorly specified and in some cases not effectively communicated. As the employer is usually the first to become aware of the problem, it is essential to integrate that role into policy and system measures. In their view, return-to-work policies do not often exist; awareness of the possibilities for return to work may be low; and the requisite skills may be absent. However, where policies and skills are present, success rates appear to be high (Wynne and McAnaney, 2004).
- 6.67** ● Layard (2004) argues there is a vicious circle between work and treatment which can only be broken by action at both ends. On one side, the world of work has to become easier to re-enter and be supported by effective return to work programmes. On the other side, doctors have to stop the automatic signing of sick-notes, and to understand that work can often improve the quality of a patient's life.
- 6.68** ● WHO (2000) suggest the following return-to-work steps can be applied for any company size:
- Visit the employee as soon as possible to demonstrate concern and to encourage an early return to work;
  - Always try to return the worker to his or her old job, even if an accommodation or flexible work time is required;
  - Local community support groups and services may aid in a successful return to work with minimal or no expense to the business; and
  - Make a special effort to inform the employee's doctor on the requirements of the job and possible changes and accommodations.
- 6.69** ● Effective Strategies
- Flexible working, modifications to the job, working environment or workplace policy, together with human and technological assistance and additional supervision have emerged as important for those with mental ill-health in the workplace (Secker and Membrey, 2003). This can include parental leave, homeworking and flexible working time.
  - There is evidence that helping people with mental health problems to increase the hours they work gradually can improve their mental health problems (Social Exclusion Unit, 2004). One submission recommended, *“staggered return to work after period of illness; flexible working arrangements; provision of a range of incentives for employers,*

*including tax breaks; contributions to wage payments from Social Welfare/FÁS to encourage employers to provide jobs to people with mental health disabilities; and support and advice around issue of disclosure of mental health illness to prospective employers.”*

- There are support guides available for employers on this particular issue such as that by Wynne *et al* (2006) and Wynne and McAnaney (2004). In England, recognising the particular needs of SMEs, *Workplace Health Connect* is being piloted by the Health and Safety Executive (HSE) to deliver advice on occupational health, safety and return to work for these companies (Disability Rights Alliance, 2006).

## Conclusions

- 6.70 ● This chapter has cited examples of good practice and effective strategies to tackle barriers at work. *The Surveys* and *Focus Groups*, commissioned for this project, have clearly underlined the need for mental health policies in Irish workplaces. This is reinforced by the finding that only 1 in 5 companies have a written policy on mental health, yet nearly all employers in the surveys would welcome information and guidance in this area.
- 6.71 ● Irish companies are not sufficiently promoting positive mental health across the workforce. Training and guidance for employers is not widely promoted or sufficiently specific on mental ill-health. Our research also found that there are negative attitudes among employers, resulting in risks for employees in disclosing any mental health difficulty. Many employers consider it a risk to employ them and would be less likely to promote them, and likely to reduce their level of responsibility. The Project Team concludes that all companies should have mental health policies in place.
- 6.72 ● It is clear that most employers would welcome guidance and information in this area. There are many positive examples of good practice and policy initiatives which could help engage them such as charters, incentive schemes and encouraging action as part of corporate social responsibility. Key conclusions are that mental health policies are needed in the workplace; employers need further guidance, support and information; greater leadership is needed at a strategic level to give incentives and policy guidance in this area; occupational health services and training could be developed further; and anti-stigma at work campaigns would also be of value.
- 6.73 ● Furthermore, the role of the Health and Safety Authority (HSA) could be strengthened in this area. The Project Team considers that health and safety statements should include policies and procedures to tackle workplace stress, bullying and mental ill-health. The HSA could produce a code of practice on mental health, similar to their recent code on bullying

in the workplace, to highlight the obligations and duties of care outlined in the *Health and Welfare at Work Act, 2005* (Government of Ireland, 2005). This should include guidance on the identification of hazards, and risk assessment for people with mental ill-health.

- 6.74** ● There is a growing business case for health promotion at work and also to support and retain experienced staff. It is clear that mental health problems impact on the workplace, economically, socially and personally. Examples of good practice outlined in this report should be circulated to show how companies can take preventative and positive action to support the health and well-being of their employees as well as providing benefits to themselves also in the process. However, there are still many challenges ahead. The *Surveys* reveal an attitude among employers that there is a risk in recruiting someone with mental ill-health, and that once they have disclosed, a belief they should not resume normal responsibilities or be promoted. The risks of disclosure are real for both employers and employees. There is fear of being talked about, of risking their future career and of revealing personal information at work. However, employers are also expressing the need for support and guidelines in this area, to know what to say in such a situation and what steps to follow.
- 6.75** ● Our research also shows that those with mental health experience found the workplace more challenging and reported more negative attitudes about employers and the supports that might be available. The Project Team concludes that their experiences, while taken cautiously, could indicate a bleaker picture of Irish workplaces which needs urgent action.
- 6.76** ● Employers could be incentivised to develop policies by the use of a Health and Well-being Company Charter which would actively disseminate and promote good models of practices to Irish companies and offer chartership to those companies operating effectively in this area. This could be adopted as part of the O2 Access Ability Awards with a specific category for mental health.
- 6.77** ● There is considerable value in work-life balance initiatives and flexible working options to support everyone at work, but in particular, those with caring needs and those experiencing stress and mental ill-health. This could also be extended to older people with the introduction of gradual and flexible retirement to accommodate older people's diverse preferences for employment and retirement. *The Surveys* found that more women than men reported that workplace stress interfered with their family life to some extent. Greater awareness and training among companies in relation to mental health and gender would help to counter this.
- 6.77** ● The following chapter examines the barriers to employment and meaningful occupation for those in recovery from mental ill-health.



7



## Introduction

- 7.1 ● For those recovering from mental ill-health not currently in employment, there are a variety of meaningful occupation, vocational training and return to work schemes available. This chapter sets out the programmes and schemes available as well as presenting some of the key barriers to accessing and maintaining employment. Secondly, it examines the current rehabilitation and supported workshops for people with mental ill-health which are not directed at the labour market. Finally, effective strategies and examples of good practice are provided to demonstrate the potential for policy development in this area.

### The Value of Work

- 7.2 ● As previously mentioned, maintaining employment can be critical for those experiencing mental ill-health (Fine-Davis *et al*, 2005; Wynne and McAnaney, 2004). The importance of work as an income generator as well as a gateway to the civil and economic life of a community has been well documented (Pavis *et al*, 2002). As Chapter 5 has outlined, work is key to social inclusion for those with mental ill-health. While income is important, having a job (regardless of the type or its quality) can provide latent benefits, including: a time structure for the waking day; regular contact with people outside the nuclear family; involvement in shared goals; and a sense of identity and enforced activity (Jahoda, 1982).
- 7.3 ● There has now been a paradigm shift internationally in the placement of those with severe and enduring mental ill-health directly in jobs with supports, rather than on prevocational training as was the case previously (Evans and Repper, 2000). It is argued that, “*it is precisely this move away from service-based initiatives towards the provision of support in ‘becoming part of the community’ that will increase users’ chance of genuine social inclusion*” (Evans and Repper, 2000:17). This will be discussed further under Supported Employment.

## A Continuum from Meaningful Activity to Full-time Employment

- 7.4 ● People in recovery are not always ready for full-time employment. There needs to be, therefore, a continuum of support for activities which are productive and of value, through to supports to actively participate in the labour market proper. There are many paths towards recovery. What really matters is some form of meaningful activity: something to do and someone to do it with (Rankin and Regan, 2004). The spectrum should be from full-time work to being meaningfully occupied. The Project Team recognises that participation in meaningful activity is important for good mental health and well-being in later life as well and older people often also face barriers to participation in public and private life. For those of working age, the evidence suggests that most people recover, want to work and are able to contribute well to the labour market. Employment should become a fundamental part of every service user's care plan (Evans and Repper, 2000).
- 7.5 ● 'Work' can be defined as the *"undertaking of organised tasks which may attract some forms of organised remuneration, but which is not covered by employment protection legislation or pay-related social insurance."* 'Employment' is described as *"work which complies with statutory requirements in regard to employment protection legislation, pay related social insurance and income tax liability"* (NACTE, 1997). 'Sheltered work' is described by the Committee as work *"undertaken by people with disabilities in workshops specifically established for that purpose"* (cited in Tom Martin and Associates, 2001).

### Types of Schemes, Programmes and Initiatives

- 7.6 ● There are two broad categories considered here: (i) Employment and training programmes and schemes which maintain and support entrance to the labour market; and (ii) Those programmes and services for people with mental ill-health which are not linked to formal employment and are focused on rehabilitation. Although the focus is on public provision, there is also now a growing occupational service in the private sector, with innovative models of training, support and employment good practice.

#### (i) Employment Schemes and Programmes

- 7.7 ● Responsibility for rehabilitative training, personal development and sheltered work currently falls within the policy remit of the Department of Health and Children. Their *Sectoral Plan* under the Disability Act, 2005, specifies that *"the two departments (Health and Children and Enterprise, Trade and Employment) will plan and develop a joint bridging programme between health-funded rehabilitative training services and vocational training services to ensure progression and vocational advancement for users who have the ability, skills, aptitudes, interest and potential to progress from rehabilitative to vocational training"*, (Government of

Ireland, 2005a). This programme change will form part of the ‘*comprehensive employment strategy for people with disabilities*’ referred to in the recently concluded *Partnership Agreement Towards 2016*”<sup>39</sup>.

**7.8** ● The Department of Enterprise, Trade and Employment is responsible for all other training and employment schemes linked to the labour force. These are delivered by FÁS and, for the most part, are not exclusively for people with disabilities but are open to long-term unemployed and all disadvantaged groups, such as the Community Employment Scheme. While this means they may be less stigmatised than tailor-made schemes for those with mental ill-health, their lack of direct focus on the issues and challenges of mental disabilities and ill-health may, however, reduce their effectiveness in this area. The relevant schemes are outlined in Table 7.1 . Other schemes include those targeted at private sector employers to help retain employees with disabilities in the workplace. While some schemes can be of benefit to those with mental ill-health, schemes seem to have been developed pragmatically over the years and there is now a need for greater coherence and rationalisation in the schemes provided.

**Table 7.1** Relevant FÁS Schemes and Programmes

Schemes	Details	Accessed By:
Community Employment Scheme	Can work up to 19.5 hours per week	Individuals
Wage Subsidy Scheme	Incentives to employ disabled people who work more than 20 hours per week.	Private Sector Employers
Employee Retention Grant Scheme	To help retain employees who become disabled through illness or injury.	Private Sector Employers
Supported Employment Programme	Worth up to €12k. To assist in obtaining and retain a job with use of Job coach.	Individuals with disabilities and impairments.

**7.9** ● The Employee Retention Grant Scheme is one such scheme, but is largely under-utilised by employers. The Supported Employment Programme includes support for individuals with disabilities with the use of a job coach and on the job support. An evaluation of an earlier supported employment pilot programme showed a 17% subsequent employment rate for clients with mental ill-health (as compared to 40% overall) (Martin and Associates, 2003).

<sup>38</sup> <http://www.dohc.ie>

- 7.10** ● FÁS reports that in 2006, 2.3% (983) of those who commenced training were people claiming disability-related benefits and allowances. 22% of participants who commenced on FÁS Employment Programmes (Community Employment and Jobs Initiative) were in receipt of disability-related allowances in 2006. Relative to throughputs, those that completed these Programmes, the number is significantly higher (around 30%). However, FÁS recognise that these figures may under represent the actual figure significantly as participants with disabilities may be claiming other social welfare allowances<sup>40</sup>. In addition, these figures do not indicate how many participants have mental health difficulties.
- 7.11** ● A new Social and Economic Participation Programme is to be introduced by the Department of Social and Family Affairs, as set out in the *NAPinclusion (2007–2016)*. This will see the Department taking a more active role in fostering employment by those on social welfare benefits and will be strengthened with personal development and counselling supports for marginalised groups. Under the *Sectoral Plan* of the Department of Enterprise, Trade and Employment, as part of the Disability Strategy outlined in Chapter 3, FÁS will increase its targeted training and supports to people with disabilities, informed by the principles of equality, maximising participation and enabling independence and choice, which have been adopted by the Commission for the Status of People with Disabilities.
- 7.12** ● *A Strategy of Engagement* (WRC, 2006) presents a comprehensive strategy to address the labour market integration of people with disabilities, with a view to achieving fundamental change. One of its recommendations is that participation by people with disabilities in Community Employment Schemes should be more closely linked with the employment and career aspirations of people with disabilities, and access to education and training designed to enhance the labour market skills of people with disabilities should be integrated into the operation of the programme.
- 7.13** ● Another initiative, Workway, ran from 2001-2004 under the Programme for Prosperity and Fairness (PPF), involving IBEC in close association with Disabilities Ireland. This aimed to raise awareness and maximise employment opportunities for people with disabilities in the private sector for 3 years. Workway (Phase II), outlined in the *Sectoral Plans* of the Department of Enterprise, Trade and Employment, aims to continue the focus on disability by developing a template for action at the pre-employment stage and develop IBEC/ICTU guidelines in relation to employment and disability. In 2005, Workway II developed a training pack, 'Ability in the Workplace.' This kind of initiative should be fully supported on a long-term basis to build greater working links between employers and those working to support people with disabilities.

- 7.14** ● Some of the submissions to the Project Team detailed other smaller and localised initiatives around the country. Some of these are listed below.
- The PINEL Programme (Programme for Integration, Normalisation, Education and Learning<sup>41</sup>), which offers a 20-week training course for people with mental ill-health in Dublin 12, intended to help them to access progression opportunities, including education, training and employment. The programme has been running since 2004 and has encouraged integrated approaches to service provision.
  - EQUAL Operational Programme/ESF-funded projects combating discrimination and inequalities in the labour market. One project funded is Access Ability which is a Disability Management Consultancy, set up in May 2002; it assists organisations to recruit and work effectively with employees who have a disability.
  - PACE Training for Employment Project in Santry is an education and training project dealing with up to 24 ex-offenders at any one time. This project aims to provide an opportunity for individuals to acquire vocational skills and the soft skills necessary to sustain employment, to improve their literacy and numeracy skills and to be in a better position to secure employment.

## (ii) Rehabilitative Training and Workshops

- 7.15** ● The Department of Health and Children has responsibility at present for rehabilitative training (training that is not linked to the labour force) and sheltered work. Responsibility for the delivery of these services rests with the Health Service Executive (HSE) and these are provided largely in accredited training centres that are run by the HSE or by service providers contracted by the HSE.
- 7.16** ● There is no publicly available information on the extent and quality of service provision for people with mental ill-health; for example no figures exist on the number of sheltered workshops which include people with mental ill-health. There is little accurate information either on the number of people in FÁS training programmes, partly due to a lack of disclosure. Strategic planning and integrated services are, of course, essential to develop the provision of appropriate support and training programmes. An audit of existing rehabilitative and training services would be extremely valuable. This was supported in submissions received.
- 7.17** ● The Project Team is, therefore, pleased to note that the Mental Health Employment and Training Consultative Forum which includes the Irish Advocacy Network, E.V.E. Limited, Schizophrenia Ireland, Mental Health Ireland, National Learning Network, Cluain Mhuire Services, the HSE and FÁS has undertaken a review of current provision in the area of

---

<sup>41</sup> This Programme is managed by the Kimmage Walkinstown Crumlin Drimmagh Partnership (KWCDP).

rehabilitative and vocational provision. Their report is due in 2007, *A Framework for the Training and Employment of People with Mental ill-health*. This document will set out recommendations for the development of training and employment schemes nationally and the Project Team looks forward to its publication. The HSE is currently reviewing provision nationally and drawing up a numerical overview which brings together broader disability and mental ill-health workshops and service providers.

- 7.18** ● The HSE describes the rehabilitative training they offer as training which focuses on the development of an individual's life skills, social skills and basic work skills with the objective of enhancing the trainee's quality of life and general work capacity. Sheltered workshops give people with disabilities the opportunity to take part in daily work in a sheltered setting where they receive personal support services. While recent figures are not available, there were approximately 7,900 people with disabilities working in an estimated 215 sheltered workshops across Ireland (NACTE, 1997) but it is not known how many of these will experience mental ill-health. Trainees in foundation training and sheltered workshops retain their social welfare payments, usually the Disability Allowance, and also receive a training allowance of 31.80 euro a week<sup>42</sup>. There is an emerging debate on the appropriate payment for work in sheltered employment services, but as yet no clear policy has emerged.
- 7.19** ● The National Learning Network, part of the Rehab Group, is the largest non-Government training organisation with more than 50 purpose-built training and employment facilities catering for around 4,500 students each year<sup>43</sup>. They identified 890 service users in 2007 with mental health difficulties. Another part of the Group, Rehab Enterprises Ltd, formerly Gandon Enterprises, provides social employment opportunities for workers with disabilities across four businesses: Rehab Recycle, Gandon Logistics, Gandon Managed Services, and Access Ability. They currently have 375 employees, 216 of whom have disabilities and out of that number, 42 have mental health disabilities (11% of the workforce). More broadly, Rehab Care operates a wide variety of health and social care programmes in Ireland and currently reports 215 service users with mental health difficulties.
- 7.20** ● Another provider of training programmes and occupational services is Eastern Vocational Enterprises Limited (E.V.E. Limited) a subsidiary of the Health Service Executive (HSE)<sup>44</sup>. E.V.E. Limited provides 24 person-centred community services in Dublin, Wicklow and Kildare on behalf of the Local Health Offices. They also operate four Clubhouses in Ireland.
- 7.21** ● The Clubhouse Model offers *“an innovative, member-run and centred service with clients gaining self-confidence by participating in a work oriented programme. It offers members a supportive environment where they can work alongside staff in planning and operating the Clubhouse”*<sup>45</sup>. The Clubhouse Model (Beard *et al*, 1982) was pioneered in Ireland by

---

<sup>42</sup> This information was downloaded from <http://www.citizensinformation.ie>

---

<sup>43</sup> Information provided by Rehab.

---

<sup>44</sup> This information was provided by E.V.E. Limited in their submission to the Project Team.

---

<sup>45</sup> Speech by Minister Tim O'Malley, 5/4/06.

E.V.E. Limited in the late 1990s. One of the Clubhouses in Ireland, Platinum Clubhouse in Kildare, provides a Transitional Employment Placement<sup>46</sup>.

- 7.22 ● There are also many examples of locally-based initiatives run by the voluntary and community sector. The Mental Health Commission (2005b) cites one, in particular, which reflects the recovery model in ethos and service: Cluain Enterprises in Clonmel, developed with support from Mental Health Ireland, it provides individually-tailored training opportunities for people with mental ill-health.

### Example of Good Practice: Gateway

The Gateway Project is a community-based initiative in Dublin whose aim is to maximise opportunities for people with mental ill-health to integrate into the social cultural, education and commercial/working life of the community. It has a drop-in facility twice a week and provides an informal opportunity to meet others. The project began in 2004 as a partnership initiative between the Rathmines Community Partnership and HSE East Coast.

- 7.23 ● The voluntary and community sector also has many other examples of innovative practices such as Clubhouses, peer support and advocacy run by Schizophrenia Ireland, Mental Health Ireland and the Irish Advocacy Network, among others.

### Skills, Beliefs and Attitudes

- 7.24 ● The attitudes and beliefs of both service staff and service users are fundamental to recovery and there is evidence to suggest that beliefs have an impact on recovery. Negative assumptions about service users' capabilities for full recovery and potential employability need to be challenged. As one submission argued, "*there is a need to increase public awareness that people who experience mental health problems can work and that work can contribute to positive mental health.*" Those who participated in Assertive Community Treatment programmes (ACT), in one study, and who later obtained employment, had different beliefs from those who did not. They tended to see their illness as just one part of who they were and not define themselves in terms of their illness (Cunningham *et al*, 2000).
- 7.25 ● Furthermore, having a positive attitude towards work is an effective part of any employment strategy. In general, those who are actively seeking work are more likely to achieve work in the future than those who are not and having 'a positive attitude to work' was particularly predictive of employment by participants of an ACT programme (Mowbray *et al* 1995).

- 7.26 ● In terms of getting employment, it is not just the skills needed for a particular job which are important but also wider social and employability skills. While previous work experience is an important factor in gaining and maintaining satisfying employment (Rusinova *et al*, 2002), it is also the case that work-adjustment-skills, defined as the ability to get along with people at work, to do the job and being dependable, are as important (Anthony *et al*, 1984).

#### Example of Good Practice: Rathmines Community Partnership

Rathmines Community Partnership has developed a Learning for Life programme with support from the Gateway Project. This programme aims to support unemployed people with a history of mental ill-health to develop improved life skills, to be aware of supports and options available to them, to develop personal training /career plans, and to progress into appropriate education, training, employment, supported employment or voluntary work. Training can be completed part-time, and is accredited to FETAC Level 3 where possible.

#### Bridging Programmes

- 7.27 ● Programmes which link the rehabilitative workshops and training for those with severe and enduring mental ill-health with mainstream employment have been shown to be effective. One submission stated *“we would like to emphasise the importance of providing bridging programmes to facilitate the transition from initial recovery from mental ill-health to full participation in ‘normal’ life including employment or further education. We recommend that the importance of tailoring pre-entry course to the needs of this group be recognised (women with depression).”*
- 7.28 ● One training intervention to promote re-employment and improve mental health, the JOBS Programme (Caplan *et al*, 1997) was adopted by Margaret Barry at NUI, Galway and colleagues as the *Winning New Jobs Programme*. This was piloted in the border region and led to improved psychological and employment outcomes for young people. Also, the *Trinity Horizon Project* demonstrated that a tailor-made programme of training, counselling and support for women with depression doubled employment levels compared to a control group (Fine-Davis and McCarthy, 1998). Fine-Davis *et al* (2005) conducted a further project and a survey of 133 who had experienced mental ill-health. It examined respondents’ mental health history; own attitudes as well as their perceptions of the attitudes of others in the workplace; and attitudes of the general public. The study found that their mental health problems were perceived as a major barrier to employment. But 70.2% currently not employed wanted to return to work.



- 7.29 ● Another submission made it clear that *“all too often those with mental health problems become trapped in the cycle of training courses, attending many courses and yet ending up with no job-specific skills...There needs to be a more readily available ‘step down’ service to facilitate employment opportunities after completing a training course.”*

### Examples of Good Practice: Bridging Programmes

In Ireland, the JOBS programme was piloted as part of the Cross-Border Rural Mental Health Project (Barry, 2003, 2005; Reynolds, Byrne and Barry, 2004), an action research project concerned with promoting positive mental health and well-being in rural communities. Twenty-four workshops (12 in Northern Ireland and 12 in the Republic of Ireland) were held over a period of 18 months with unemployed participants, some with mental ill-health. The findings indicate that the programme produced positive benefits for participants in terms of improved confidence in job seeking skills at four months post-intervention and improved re-employment, and reduced economic hardship for the intervention group up to 12 months afterwards.

*The Transition to Employment Options Programme:*<sup>47</sup>

Began in parts of rural Cork, Kerry and Limerick, is to develop a model of enhanced delivery of education, training and employment services to people in rural areas which has the potential to be replicated and mainstreamed.

The programme involves collaboration between the statutory sector, the voluntary sector, and 3 partnership organisations: Ballyhoura Development, Avondhu Development and IRD Duhallow; and disability organisations.

The programme’s objectives include:

- Developing pre-employment training, to prepare people with mental ill-health to engage with statutory provision in education, training and employment services;
- Working with State agencies, particularly FÁS, to adapt existing programmes to better meet the needs of people with mental ill-health; and
- Innovative outreach strategies targeting people with mental ill-health, particularly in isolated rural areas, including those not accessing mental health services.

<sup>47</sup> This is taken from a submission to the Project Team made by Pobal.

## Supported Employment

- 7.30** ● Supported employment (the ‘place and train’ model) refers to both a type of employment status (competitive work) and to a type of employment programme (help with finding and keeping jobs) (Bond, 2004). This refers to placement in competitive employment while offering on-the-job support. Supported employment is most effective when provided through an employment specialist integrated in a mental health team rather than through a separate service (Drake *et al*, 2003). Interventions with a strong focus on job search, self-efficacy, social and emotional coping skills and building social support are effective (Price *et al*, 1992; 2002). Since 2000, FÁS has operated an open labour-market supported employment programme which aims to assist people with disabilities, who are considered to be job ready and have who have difficulty getting into paid employment, through providing services of a job coach to both employer and job-seeker.
- 7.31** ● There are different types of supported employment. The most researched and supported by evidence is the Individual Placement and Support model (IPS) (Becker and Drake, 1993). This includes integration with mental health services, a focus on competitive employment, rapid job search, attention to service user preferences and unlimited support. Supportive employment is well documented as being effective in helping service users to obtain and retain employment. Between 40% and 60% of people enrolled in supportive employment obtain competitive employment, where less than 20% do so when not enrolled in supported employment (Bond, 2004). It would seem to be more effective than prevocational training at helping people with severe mental illness to obtain competitive employment (Crowther *et al*, 2001). Unlike other vocational approaches, supported employment programs do not screen people for work-readiness but place all who want to work, providing ongoing support once the client is employed (Bond *et al*, 2001).
- 7.32** ● Other organisations offering supported employment schemes include Enable Ireland and Rehab Enterprise Ltd. This type of supported employment is not new and has been operating here for over twenty years, starting with an early project, Open Road, run by St Michael’s House, supporting people with intellectual disabilities with the support of job coaches and co-workers. However, it has been less often used with people with mental ill-health. Enable Ireland was founded as Cerebral Palsy Ireland in 1948 and is now a national provider of services for 3,000 people with disabilities and their families across 14 regional centres. Their supported employment service provides assistance such as job coaches, transportation, assistive technology, specialised job training and individually-tailored supervision.

### Example of Good Practice: Rehab Enterprise

Rehab Enterprises (formerly Gandon Enterprises), provide integrated social employment in commercially viable settings where employees with disabilities work alongside able-bodied people in an equal working environment. They report positive feedback from employees (previously in sheltered workshops or unemployed) with the level and types of supports available. *“Equally important is the impact of these supports beyond work which include a greater feeling of worth and self-esteem, a sense of well-being and increased independence<sup>48</sup>.”*

- 7.33 ● The development of supported employment schemes was strongly supported in submissions received by the Project Team. One of these argued *“there is a need to investigate ways to increase the number of people with mental health problems in employment through supported structures within the workplace e.g. adapted or flexible work schemes and schedules.”* This was supported by another submission which said that *“Individual Placement and Support programmes have demonstrated the most effective outcomes in helping people return to work successfully. There is a need to encourage and provide the resources to pilot this type of programme and to evaluate its effectiveness in an Irish context. The first step to facilitating this could be through establishing a working group with members from the leading specialist vocational rehabilitation services, FÁS, DOHC, service users and local employment services.”*

### Training Supports

- 7.34 ● Other training organisations include Irish Social Firms Initiative (ISFI), who specialise in enabling people who have experienced a setback in life due to mental health or disability difficulties to move forward with their lives. They offer vocational skills programmes which lead to nationally recognised qualifications in catering, retail, graphic design or business administration and IT.

### Social Enterprise

- 7.34 ● A social enterprise is a business venture created specifically to provide employment and career opportunities for people who are unemployed, disabled, or otherwise disadvantaged. Social enterprises create benefits-plus part-time work in more commercial and ‘real’ circumstances, but do not generate revenue to pay wages and may not have a mixed workforce (O’Flynn, 2001).

48 <http://www.rehab.ie>

- 7.35 ● In a review of social enterprise schemes in Ireland, O’Shaughnessy (2005) points out that social enterprises have been generally established and managed by voluntary and non-profit organisations. O’Hara (2001) outlines different forms of social enterprise, including ‘work integration social enterprise’, which aims to create employment and facilitate labour market integration for people with physical and social disabilities. Generally established and managed by voluntary and non-profit organisations, they are commercially oriented but have tended to also avail of public subsidies. The use of voluntary organisations for the provision of services to people with disabilities has been described as a unique feature of Irish health policy (Quin and Redmond, 1999).
- 7.36 ● There are examples of effective services which combine social enterprise, training and rehabilitation services.

### Example of Good Practice: Momentum

Momentum which is one of Scotland’s leading providers of rehabilitation and training services, empowering disabled and excluded people to gain the skills they need to live independently and to gain access to employment. Established in 1990, the organisation now operates from 25 locations across the country, assisting around 1,500 people each year. Momentum also provides employment for disabled and excluded people through its social enterprise firm, Haven Products, which operates from three sites across Scotland.

### Challenges

- 7.37 ● Personal barriers to achieving and sustaining open employment can result from functional difficulties associated with severe and long-standing mental health problems: fear of failure, lack of self-confidence, limited attention span, maintaining stamina throughout the work day and managing time pressure and deadlines (*A Vision for Change*). One challenge for employers is to accommodate occasional episodes of “*erratic attendance, attention deficits and social problems*” among people with severe and enduring mental ill-health (Evans and Repper, 2000:19). However, these problems are not insurmountable. The use of a ‘virtual ramp’ (Hooper, 1996) can assist people in overcoming obstacles they may experience in the workplace, just as physical adaptations are made for other types of disability. This could include supports on working hours, location and job type within the company. However, people with serious mental ill-health can have a heightened susceptibility to stress which needs to be considered in the workplace (Evans and Repper, 2000). A further barrier to access is a lack of appropriate and affordable childcare.

- 7.38 ● Young adults with disabilities, including mental and emotional disabilities, are significantly less likely than their disabled peers to have paid employment and often have much lower aspirations for employment (Taylor *et al*, 2004). Vulnerable young adults need particular supports to obtain and maintain employment. Vocational Opportunities in Training for Employment (VOTE) is one Northern Ireland pilot scheme which provided training and supports for young people with disabilities including mental ill-health. An evaluation of the project found that supported employment is more effective than prevocational training alone (Taylor *et al*, 2004).

### Strategic Development

- 7.39 ● A *Vision for Change* (p.111) recommends “the development of formal co-ordination structures between health service employment agencies should be a priority if the delivery of seamless service is to be facilitated” and “to facilitate the service users in re-establishing meaningful employment, development of accessible mainstream training support services and co-ordination between the rehabilitation services and training and vocational agencies is required.” However it is not clear who will take the lead on this development (see the recommendation on the establishment of a cross-departmental team in chapter 10).
- 7.40 ● This lack of strategic development was also noted in the submissions. As one outlined, “the provision of training and employment services for people with mental ill-health has been largely based on local initiatives and does not reflect a strategic needs-led approach” and “any future strategy must ensure that a co-ordination process is put in place to bring all providers together to ensure that service development and delivery occurs in the overall context of agreed identified needs and aspirations within the local health area. The process of needs identification should include a dialogue with the sector teams, the individual themselves as service user and their families.”
- 7.41 ● One way forward is the *National Disability Strategy* which is targeting employment. The *Sectoral Plan*, from the Department of Enterprise, Trade and Employment, outlines the establishment of a new Consultative Forum on the Employment Strategy which should improve collaboration. Mental health disabilities should be given particular attention within this strategy due to the particular barriers and low employment rates already outlined. Finally, the above *Sectoral Plan* includes an emphasis on raising awareness regarding the employment of people with disabilities and identifies the suite of materials developed under the Workway initiative to inform future policy and best practice in this area.

## Conclusions

- 7.42** ● Most people with severe and enduring mental ill-health are not in employment and are at risk of greater social exclusion. This is despite work being long regarded as an important facet to mental health. The provision of training, rehabilitation and employment services has tended to be locally driven and has not developed strategically at national level. Moreover, useful information is lacking on the availability of rehabilitative, training and employment opportunities for people with mental ill-health. While there are rehabilitative programmes and supported employment schemes, little is known about their effectiveness, quality or suitability. The Project Team concludes that the Supported Employment, Place and Train model has the strongest evidence base for success in assisting those with mental health problems to gain and retain employment and this model should be implemented in all mental health services.
- 7.43** ● While there are many examples of innovative practice to respond to the employment and training needs for people with mental ill-health, there is a lack of coherence and of strategic development in this area. Furthermore, duplication should be avoided and there should be more effective co-ordination between all rehabilitative services and vocational programmes run by both the statutory and voluntary and community sectors. More bridging programmes and supported employment schemes are needed, particularly those which are integrated within Community Mental Health Teams. Clubhouse is another successful model which should be developed further. A key conclusion is the need for a comprehensive audit and mapping exercise to be undertaken to establish the current level of provision of rehabilitative, training and employment services for people with mental ill-health. Service user involvement is essential in the further development of these services.
- 7.44** ● The recommendations of the National Disability Authority's *A Strategy of Engagement* to support those with disabilities to gain and maintain employment are supported by the Project Team. These include *"that all employer organisations be engaged with their membership in respect of the employment of people with disabilities and to identify from among their members a pool of employers stating a willingness to provide employment placements for people with disabilities, thereby facilitating the interaction of employment services with employers in this regard"* (WRC, 2006:22).
- 7.45** ● As mentioned in *A Vision for Change*, formal co-ordination is needed to create and maintain bridges between accessible mainstream training support services and co-ordination between the rehabilitation services and training and vocational agencies. The Project Team very much supports this and considers development of an integrated strategic plan for the delivery of training, work and employment services for people with mental ill-health should now be given top priority by the cross-departmental team, which it recommends should be established as outlined in Chapter 10.



8



## Introduction

- 8.1 ● This chapter examines the relationship between health and non-health services. It outlines the current structure for primary care and mental health services and stresses how these should be further integrated with employment, housing, education and other services. Drawing from international evidence and models of good practice, it identifies the barriers to greater integration of services at the societal, community and individual level and outlines a model for the integration of services from early intervention right through to recovery.

### Why an Integrated Model is Needed

- 8.2 ● Creating a mentally-healthy society entails addressing the broader socio-economic and environmental influences and working across diverse sectors in order to address the upstream determinants of mental health (Barry, 2005). To be effective, an integrated approach has to tackle those determinants directly and in a co-ordinated way. In the submissions, there were repeated calls for a multi-disciplinary approach to mental health care provision since, as one submission put it, *“it is now accepted that the main determinants of mental health and mental health inequalities lie outside the health sector and that intersectoral collaboration is needed to effectively address them.”*
- 8.3 ● *A Vision for Change* (p.59) argues that *“a comprehensive mental health system exists when mental health activities — from community support groups, to voluntary groups, to primary care, to specialist mental health services — work in an integrated, co-ordinated fashion for the benefit of all people with mental ill-health.”* As part of this comprehensive system, it identifies the role of rehabilitative and vocational training, education and housing and makes recommendations in this regard. For example, it makes the point that *“vocational training and employment are not the responsibility of the mental health services, there is a need for rehabilitation and recovery services to liaise with the agencies that do have statutory responsibility in this regard, and ensure that whatever arrangements are offered, are in the best interest of the service user”* (p. 111).

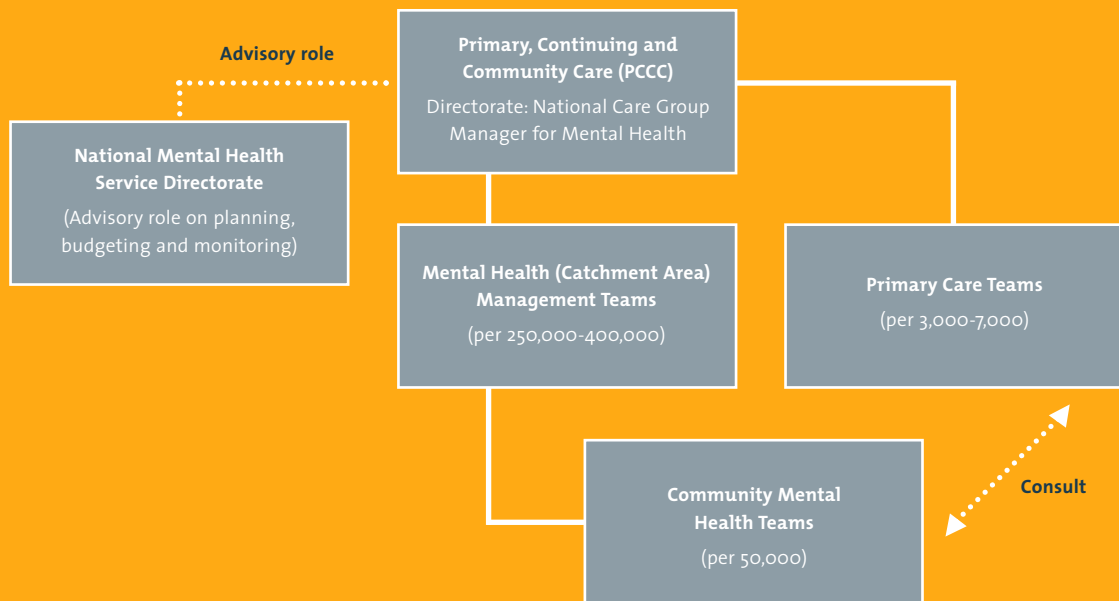
## Mapping the Service User

- 8.4** ● From the many accounts provided in the submissions and in other reports of service user experience, the lack of integrated services is readily apparent. One valuable approach in examining this is to map the service user's journey which can help to improve service design and foster innovation in service delivery. Its biggest potential, however, is in mapping the experiences of people who need a range of interrelated services, often provided by different agencies. The feedback from this can then be used to reduce complexity and clarify how inter-agency working at the local level can be improved (NESF Report No. 34, 2007).

## Public Health Services

- 8.5** ● Public health services are now administered by over 30 local health managers located within HSE West, HSE South, HSE Dublin Mid-Leinster and HSE Dublin North East. Each catchment area has a local health manager (LHM) who is responsible for all health services, including mental health. Mental health services are managed by senior management teams (SMTs) which consists in most cases of the clinical director, director of nursing and hospital manager.
- 8.6** ● Figure 8.1 presents a representation of the planned mental health services model as described in *A Vision for Change* (overleaf). The National Mental Health Service Directorate should be responsible for advising the National Care Group Manager for Mental Health. As discussed in Chapter 3, this Directorate has yet to be established.
- 8.7** ● *A Vision for Change* recommends that local multi-disciplinary CMHTs should provide a single point of access to primary care for advice, routine and crisis referral to all mental health services (community and hospital based). These CMHTs should offer multi-disciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families. Each team should include the core skills of psychiatry, nursing, social work, clinical psychology, occupational therapy. The composition and skill mix of each CMHT should be appropriate to the needs and social circumstances of the population. *A Vision for Change* recommends that Community Mental Health Teams and Primary Care Teams should establish standing committees to facilitate better integration of the services, and guide models of shared care.
- 8.8** ● *The Quality Framework for Mental Health Services in Ireland* was produced by the Mental Health Commission (2007) as a guide for all mental health services. It comprises 8 themes, 24 standards and 163 criteria and provides a framework for the provision of quality mental health services.

**Figure 8.1 A Vision for Change:  
Proposed Structure of HSE Mental Health Services**



Reinforcing *A Vision for Change*, the following key aspects of an integrated model are outlined in the *Quality Framework*:

- Focus on a recovery approach and the family/chosen advocate involvement;
- Planned entrance and exit from every part of a mental health service;
- The development of positive partnerships and active communication with key agencies in the community;
- Effective use of all community resources to maximise real integration; and
- The establishment of formal links with: mainstream health services; social welfare services; education services; housing authorities.

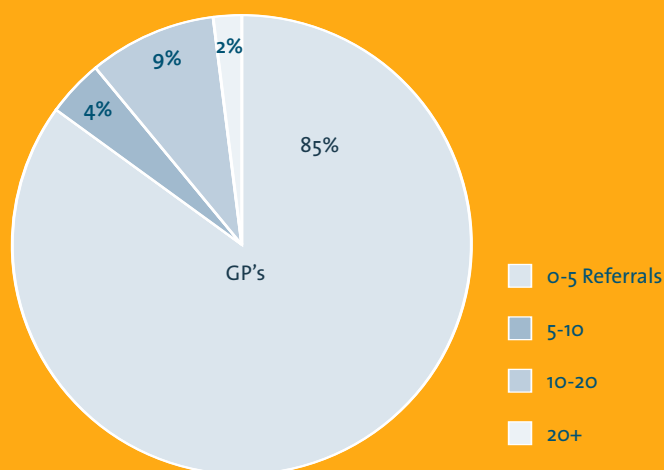
With a specific implementation plan outlined, these formal links should be put into operational effect now so as to ensure the development of an integrated national model and underpin service delivery at regional and local levels.

### Gateways to Services: Primary Care

- 8.9** ● Primary care “offers a non-stigmatising service with many possibilities for intersectoral collaboration with schools, workplaces, local agencies, voluntary organisations and community groups in the local setting” (Barry and Jenkins, 2007, p. 256). According to the European Observatory on Health Systems and Policies, most mental health problems will be first seen in primary care, where the detection and management of common mental health problems such as depression remain poor across the EU (McDaid and Thornicroft, 2005).
- 8.10** ● The HSE South Western Area (SWAHB) and Irish College of General Practitioners (2004) *Mental Health and Primary Care Report* found in a survey of GPs, consultants and service users, that anxiety, depression and emotional difficulties made up 73% of the mental health related contact with patients.

Figure 8.2 shows further results in relation to referrals. 85% of GPs referred fewer than 5% of their patients to mental health specialists.

**Figure 8.2** Percentage of GPs Referring Patients to Specialist Mental Health Services



Source: From SWAHB/ICGP (2004).

- 8.11 ● This is also supported by UK figures which show that 90% of people with significant mental ill-health are cared for entirely in primary care (Sainsbury Centre for Mental Health, 2003b). In a recent EU survey, Irish people were most likely (91%) to turn to a GP regarding a psychological or emotional problems (European Commission, 2006). The National Office for Suicide Prevention (2007) also found that 79% of Irish adults would consult their family doctor or GP if they thought they had a mental health problem.
- 8.12 ● More effective training for primary care practitioners requires a combination of strategies, including access to information and liaison with and feedback from other health care professionals (Gilbody *et al*, 2004). *A Vision for Change* recommends that the education and training of GPs in mental health should be reviewed and the National Primary Care Steering Group (Department of Health and Children, 2004b) *Progress Report* made recommendations on increased training for the professionals involved in primary care. Moreover, the Project Team considers that this training should be appropriate to the provision of mental health services described in this policy (i.e. community-based mental health services) and that service users should be involved in delivering the training.
- 8.13 ● In this regard, a welcome step is the reform underway at present in primary care with greater emphasis on integrated person-centred care. The term primary care, now encompasses a much broader range of health and social services and these are delivered by a variety of professionals, such as GPs, public health nurses, social workers, community welfare officers, welfare officers in places of employment, and many others. New multi-disciplinary Primary Care Teams will identify and prioritise each person's needs; service the majority of people's needs, at or close to home; access specialist services, at or close to home; and provide direct access to acute hospital services and guide health improvement for that person's care across the lifecycle<sup>49</sup>. There is a golden opportunity now to build on this as the basis for developing an integrated service.
- 8.14 ● Given that the vast majority of people are not referred to mental health services, and that depression and anxiety-related problems are the most frequent difficulties, what more can be done at a primary care level to respond to this? In this regard, Layard (2004) highlights how only 3% of people in the UK with mental ill-health (whether treated or not), have seen a psychiatrist in the last year. Even among people suffering from depression the proportions are very low – 8% have seen a psychiatrist and 3% a psychologist. Layard calls for the availability of evidence-based psychological therapy through training more psychological therapists and funding therapy. The availability of psychological or 'talking-therapies' was also emphasised in submissions made to the Project Team. One submission advocated the need for a frontline advisory/counselling service that could be accessed without the risk of stigma, "*this would ensure that people could avail of both emotional and practical help before problems*

---

49 Information provided in a presentation by Frank Mills, a member of the Project Team.

*become too big or entrenched. Organisations such as Comhairle could easily be expanded to incorporate this service through the Citizen's Information Centres that are located throughout the country."*

### Integrated Supports

- 8.15 ● Greater co-ordination, and designated vocational, housing and welfare advisors and advocacy services within and between existing and future Community Mental Health Teams and Primary Care Teams, are clearly called for. To ensure a continuum of care from early intervention to recovery, the links to non-health sectors should be included at every point. Moreover, for equity of access and seamless delivery, there also needs to be greater integration of primary care and mental health services. The Mental Health Commission (2006a) presents a useful model for multi-disciplinary team working which places the service user at the centre and works outwards to the community level. However the relationship between the wider community and primary care should be strengthened in order to support such an integrated model.

### Example of Good Practice: West Dublin Community Mental Health Team

West Dublin Community Mental Health Team has a home care team, psychiatric clinic, day hospital and a day centre, involving doctors, mental health nurses, psychologists, social workers and occupational therapists and less often, a dietician, alcohol counsellor and behaviour therapist. They are currently seeking a job coach to add to the team and this model could be replicated nationally (from a submission made to the Project Team).

The remaining part of this chapter seeks to highlight those aspects of integrated services which impact on individual and community levels.

## Individual level

### Recovery Approach

- 8.16 ● A recovery approach, as outlined in Chapter 2, has particular implications for mental health services. These were outlined by the Mental Health Commission (2005b) and include: training in recovery principles for all staff; individualised self-management plans; individualised treatment programmes; optimism about recovery; peer support; and use of community resources. For this purpose, the Project Team emphasises the need for tailored information such as *Going Home? Let GROW help you find your way*, aimed at those with mental ill-health being discharged from hospital. A Recovery Context Inventory or a tool to capture and validate recovery outcomes is required and this should be directed at those

areas and contexts where recovery is facilitated. The recent *Quality Framework for Mental Health Services* (Mental Health Commission, 2007) should help to put greater emphasis on recovery.

- 8.17 ● As the Department of Health (2001) in England argues, diagnosis is only one part of a person's life, so medical treatment is only one part of the support needed. The other support will come from family, friends, schools, employers, faith communities, neighbourhoods and from opportunities to enjoy the same range of services and facilities within the community as everyone else.
- 8.18 ● In a study of patients taking part in a psychosocial rehabilitation programme (REACH programme), there was a greater improvement in quality of life compared to those who received standard care. Furthermore, the beneficial effect was maintained for over two years after completion of the programme. The environmental focus of such programmes provides patients with the learning and skills necessary for societal integration (Whitty *et al*, 2006).
- 8.19 ● One element of health promotion at primary care level is social prescribing, in which patients are linked to non-medical sources of support such as exercise or arts-prescriptions and which have been used to achieve positive outcomes (Mentality, 2003). In this way, patients are offered links into the community directly from primary care, alongside medical interventions.

### Case Management Approach

- 8.20 ● A case management approach allocates a single case worker as advocate/liaison for all the client's needs in recovery. The Department of the Environment, Heritage and Local Government (2006) has outlined this model in relation to homelessness and more recently, the NESF (Report No. 34, 2007a) outlined its value to the development of quality public services. The Homeless Agency (2007a) and the HSE have recently developed a holistic needs assessment and care plan which has been piloted in Dublin. The assessments identify current needs of service users and begin to address those needs, while also identifying gaps in service provision and making recommendations for future service development. Currently training courses are underway with housing, drug service and mental health service providers (Homeless Agency, 2007).

### Gender Sensitive Approach

- 8.21 ● In placing the service user at the centre of the mental health system, there needs to be recognition of the different patterns of service use; and mental ill-health symptoms, treatment and outcomes (The Women's Health Council, 2005; WHO, 2001). In particular women are affected by depression at twice the rate of men (WHO, 2004), while men are twice as likely to be affected by alcohol or drug abuse (Women's Health Council, 2005; WHO, 2001). In service terms, internationally women have been found to be prescribed more psychotropic drugs than men and are less likely to be referred for specialist treatment (Women's Health Council, 2005). This

suggests that primary care may be treating a higher proportion of women's mental health problems than men's, which impacts on how these services are delivered and what supports are needed. Yet, little is known about gender patterns in mental health service use in Ireland.

- 8.22** ● However, if as the Women's Health Council argues, a gender approach to service provision is paramount, then one important factor is that women tend to prefer counselling services over medication (Morrow and Chappell, 1999). A study of women's mental health service needs found that women preferred a more proactive approach, so they could access counselling at an earlier stage before their mental health deteriorated (Batt and Nic Gabhainn, 2002). *The National Women's Strategy (2007 -2016)* outlines this as part of their objective "to improve the mental health status of women in Ireland" and calls for the provision of counselling services through primary care referrals (Department of Justice, Equality and Law Reform, 2007:76).
- 8.23** ● There are challenges to men accessing services as this tends to happen later and when a problem has become more chronic. This results in higher levels of referrals to specialist services as well as involuntary admissions to psychiatric hospitals. In particular, masculine gender roles can contribute to a lack of early intervention (Women's Health Council, 2005).
- 8.24** ● The Women's Health Council (2005) argues that a model of care for women needs to be:
- Woman-centered, taking into account women's health concerns and life priorities;
  - Holistic to social circumstances as well as physical health;
  - Community-based;
  - Person-driven; and
  - Supported by advocacy services.

### Cultural Sensitivity

- 8.25** ● The Project Team looks forward to the forthcoming *National Intercultural Health Strategy 2007-2012* and hopes it will be holistic in its approach to mental health. There is need to develop greater awareness of the particular needs of different cultures in relation to health care. This should facilitate greater cultural competency in mental health services. However, as The Women's Health Council (2006:10) in their submission to the National Intercultural Health Strategy argues, it is "crucial that developing cultural competency extends beyond providing simplistic information on the habits and beliefs of different cultures to produce an integrated system to promote tolerance and diversity at all levels." They call "for a 'whole system' framework of cultural competence to be developed and implemented in all HSE run and funded health care providers."



### Role of Service Users, Peer-support Groups and Self-help

- 8.26 ● Self-help movements and support organisations could play a stronger role in a recovery-based strategy. GROW, a voluntary organisation and approach which originally developed in Australia, has been evaluated over many years, and its programmes have shown consistently impressive results including higher rates of current employment, lower levels of psychopathology and higher levels of personal adjustment (Rappaport *et al*, 1985). As in AA, the GROW programme has 12 steps for recovery and personal growth. Like the recovery model of services, it stresses the resilience of the human being and the importance of mutual help, and of supporting others in addition to being helped oneself (Mental Health Commission, 2005b).
- 8.27 ● As McDaid (2006:62) argues (and in her submission to the Project Team) *“the appointment of a service user onto the Area Management Team of every local area, the establishment of a national Service User Executive and the presence of service users on the Mental Health Commission are profound steps toward greater equality in the mental health services. But service users’ experiences tell us that a simple equality of presence (the right to be present in decision making forums) will not ensure equal participation.”* The Project Team supports effective and tailored support mechanisms to encourage meaningful participation of service users in the planning, delivery and evaluation of mental health services. The NDA’s (2005) publication entitled *Strategic Partnership Guide, Good Practice in Working with People with Mental Health Difficulties*, to be promoted at national level, is a tool to assist in the organisational change process required to implement *A Vision for Change* and offers useful supports to facilitate service-user engagement.
- 8.28 ● Brosnan (2006), in her research of service users and carers in the West, recommends that strategic partnerships should be developed at local, regional and national levels of mental health services using the National Disability Authority strategic partnership guide. Furthermore, she recommends that the role of voluntary mental health organisations and support groups should be recognised and actively promoted by mental health service staff.

### Advocates

- 8.29 ● One of the standards set out in the *Quality Framework for Mental Health Services* by the Mental Health Commission (2007) is that peer support/advocacy should be available to service users. As part of the *National Disability Strategy*, the Department of Health and Children launched a development programme for the provision of regional peer advocates through the Irish Advocacy Network, a national network of mental health advocacy user groups. Advocacy organisations such as the Irish Advocacy Network and S.T.E.E.R. now offer peer advocacy to all inpatient facilities (Inspectorate of Mental Health Services 2007; Mental Health Commission, 2007). The national pilot of the Youth Advocacy Programme was launched in 2002 in the Northern Area Health Board. This has been designed to provide support to at-risk young people and

their families. It is based on a trust relationship between a skilled adult advocate from the locality and the young person. Mental health services should employ peer advocates to assist service users when addressing employment and housing difficulties.

## Community Level

### Community Care

- 8.30** ● The number of people living in community residences has risen from 900 20 years ago to over 3,000 in 2004 (Health Research Board, 2007), in line with the development of community-based services. *A Vision for Change* highlighted the community residential facilities needed for the relocation of long-stay patients from psychiatric hospitals. These are to have a therapeutic and rehabilitation function in that residents move from higher levels of dependency to lower levels of support and, where possible, to complete independence (Health Research Board, 2007). The HRB research found that there was a clear lack of multi-disciplinary and recovery teams for the provision of evidence-based rehabilitation programmes in community residential care. Only two sectors within the Health Service Executive (HSE) local areas had multi-disciplinary rehabilitation and recovery teams and these had yet to receive the full complement of staff. There was little involvement of residents in their own care and treatment. Individualised care planning that incorporated the residents' expectations and aspirations for the future was generally lacking. The Project Team strongly supports the report's recommendations that community residences adopt a recovery-oriented approach.
- 8.31** ● *A Vision for Change* recommends that rehabilitation and recovery mental health services should develop local connections through linking with local statutory and voluntary service providers. Networks for people with mental ill-health are also necessary to support community integration. However, this is not currently happening. The Health Research Board (2007) study shows that although the majority of residents went out into the community on their own, few availed of community facilities.

### Housing

- 8.32** ● The Health Research Board (2007) study also found that mainstream and employment needs were not being met, and there was a perception among community residents and staff that they had a limited opportunity of getting housing from the local authority. The report recommends that "*multi-agency groups involving, among others, local housing authorities and mental health service providers, should be set up as a matter of urgency to discuss partnership schemes in the provision of housing and care.*" It further recommends that "*the provision of low and medium support housing should be the responsibility of the local housing authorities*" (p.10). The Project Team fully supports these recommendations and, for these purposes, would encourage increased co-ordination among the providers concerned.

- 8.33 ● Step down services are needed to bridge psychiatric care with independent living. Dunne's (2006:98) report on the views of service users in Ireland concluded that *"short and long-stay hostels and other forms of 'step down' facilities, varying in the levels of support offered to residents, are required to aid service users' transition or to allow them to live safely and comfortable in the community. This aspect of the public mental health service seems to have been allowed to decline in many locations."* A particular challenge is how to ensure that sheltered housing does not re-institutionalise people.
- 8.34 ● It is clear that a more co-ordinated approach is needed if service users' needs for housing and support are to be properly met (The Sainsbury Centre for Mental Health, 2003). Housing provision for people in recovery is provided by the HSE (often contracted out) with capital funding from the Department of the Environment, Heritage and Local Government. Local authorities have a statutory obligation to provide accommodation but the HSE can pay rent supplements. A *Vision for Change* (p.112) recommends that *"opportunities for independent housing should be provided by appropriate authorities with flexible tenancy agreements being drawn up in accordance with each service user's needs. Arrangements that best enable service users to move from high support to low support and independent accommodation need to be considered."*
- 8.35 ● People in need of housing can often fall between the responsibility of the HSE and the local authorities. As *A Vision for Change* (p.39) mentions, *"mental health services have always been keen to support individuals using their services, and this has extended to providing housing in many cases. However, this has often had the unfortunate effect of reducing the chances of an individual with a mental health problem being housed by their local authority, a right they have under the Housing Act. This results not only in the exclusion of individuals with mental health problems, but also diverts mental health funds away from providing mental health treatment and care."* It, therefore, recommends that *"the provision of social housing is the responsibility of the local authority. Mental health services should work in liaison with local authorities to ensure housing is provided for people with mental health problems who require it."* However, the Project Team is concerned that this has not yet been fully implemented.

### Example of Good Practice: Partnership Approach

A partnership approach between mental health services, county councils and social housing agencies has led to sustained housing and supports for people who were homeless or in unsustainable living conditions. Dublin South City and Dublin South West Mental Health Services, a social housing agency, Dublin City Council and South Dublin County Council all agree on the supports needed for each individual housed; and the local authorities provide or source the appropriate accommodation. A Mental Health and Housing Group meet monthly and discuss potential tenants, review those who have been accommodated and identify potential accommodation availability. Those who have been accommodated using this process have sustained their tenancies<sup>50</sup>.

- 8.36** ● The Project Team welcomes the Department of Environment, Heritage and Local Government's (2006) commitment to inter-agency protocols for vulnerable groups, such as those experiencing mental ill-health, as outlined in *Delivering Homes, Sustaining Communities*. A further positive development is that the forthcoming *National Housing Strategy for People with Disabilities*, headed by the Department of the Environment, Heritage and Local Government, will include a focus on adults who experience mental ill-health.

### Employment and Training

- 8.37** ● In addition to housing provision, the development of formal co-ordination structures between health services and employment services should also be a priority if the delivery of seamless services is to be facilitated. For this purpose, the development of accessible mainstream training support services and coordination is required between the statutory, voluntary and community rehabilitation services; and training agencies such as FÁS and the National Learning Network. As *A Vision for Change* argues, there is urgent need for joint working between the rehabilitation team and the institutions responsible for these individuals such as the Departments of Health and Children, Enterprise Trade and Employment; and Social and Family Affairs. However, this is not happening on a national basis.
- 8.38** ● As Chapter 7 outlined, the type of supported employment which has found to be the most effective is that which is provided through an employment specialist integrated into a mental health team, rather than through a separate service (Drake *et al*, 2003). According to one submission from a Community Mental Health Team, combining vocational and clinical services within the same team produces higher rates (3-4 times) of employment than do non-integrated services .

<sup>50</sup> Information supplied by Frank Mills of the HSE, a member of the Project Team.

### Examples of Good Practice: Pathways to Work

As part of the Pathways to Work initiative in England, highly skilled, experienced employment advisors and condition management practitioners based in GP surgeries will offer advice about finding work, returning to work and job retention. Six pilots commenced in April 2006 and will be independently assessed<sup>51</sup>.

South Essex Partnership NHS Foundation Trust is using the Individual Placement and Support approach with four Community Mental Health Teams (CMHTs) and the Forensic Services Community Team. An Employment Specialist is based within the clinical team and co-works with Community Psychiatric Nurses (CPNs) and Social Workers (SWs) to achieve the aims of the individual's care plan for social inclusion through paid employment, vocational education and voluntary work. Any service user of the CMHT who expresses the desire to return to work is offered the support of the Employment Specialist. This support takes the form of initial discussion about work history, employment goals, skills and training, negative experiences at work to be avoided, whether job retention is required, and how many hours of work are desired. As soon as clear actions are identified, the job search begins — this is usually within a month of the first meeting (NIMHE, 2006).

## Particular Groups in Need of Integrated Support

### Homelessness

- 8.39** ● *A Key to the Door*, the Homeless Agency Partnership's Action Plan 2007-2019, argues that *"it is imperative that society's most vulnerable groups, such as people experiencing homelessness, are well and truly accounted for in any future service developments, including those related to community-based services in mental healthcare and drug and alcohol addictions"* (The Homeless Agency, 2007:16).
- 8.40** ● Homeless agencies are faced with particular challenges in supporting their clients with mental health needs who are trying to access services. These challenges can include claiming welfare benefits, getting assessed by a psychiatric team and finding appropriate accommodation. Anecdotal information from Focus Ireland indicates there are difficulties getting clients assessed by a psychiatric team (CMHT)<sup>52</sup> as they may not accept referrals from a client who already has a mental health service. Without a letter from a psychiatrist, bed and breakfast accommodation may not be available and some clients are barred from the available hostels. However, many homeless clients are by definition displaced and often are no longer

<sup>51</sup> <http://www.dwp.gov.uk>.

<sup>52</sup> This information was gathered during a meeting with Focus Ireland's staff.

linked into previous services. Even then, the use of bed and breakfast accommodation for people who are barred from hostels is problematic as there are no trained staff or supports there, and clients have to prove their mental ill-health with a medical letter before they will be placed there, leaving little or no option for those who have been barred from hostels but who are not linked into medical services.

- 8.41 ● However, according to *A Key in the Door* (The Homeless Agency, 2007), this will improve as the recommendations from *A Vision for Change*, relating to the homeless population are implemented. *A Key in the Door* (p.51) also states that “*the Health Service Executive will implement its plans to provide respite beds for people who are homeless to prevent inappropriate use of Accident and Emergency services as well as to support people to recuperate following acute hospital stay.*” These developments are welcomed by the Project Team. However, other areas of concern remain such as the suitability of emergency accommodation for those with mental ill-health and the lack of move-on accommodation with appropriate supports. The forthcoming Health Impact Assessment of the *Homelessness Strategy* is welcomed by the Project Team and might be helpful in this regard.
- 8.42 ● *Homelessness: An Integrated Strategy* of the Department of Environment, Heritage and Local Government (2006b) includes an assessment of needs and the use of a case management approach which should be applied to people with mental ill-health in need of social housing.

### Ethnic Minorities

- 8.43 ● *The NAPinclusion strategy* (2007-2016) mentions that the HSE will be developing a National Equality Framework in 2007 which will address the health needs of minority groups including Travellers, refugees and asylum seekers and ethnic minorities. Pierce (2003:42) concluded that “*minority ethnic people with disabilities face barriers to participating in many areas of Irish society on the basis of ethnicity and disability. In a similar way to people with disabilities in the wider community, they face disabling barriers to accessing health and disabilities services. Such experiences can lead to exclusion and disempowerment and need to be addressed by health and disability services.*”
- 8.44 ● The (forthcoming) HSE *National Intercultural Health Strategy 2007-2012* includes recommendations relating to mental health needs of service users are made within the context of *A Vision for Change* and include the provision of culturally sensitive services and training and support for community initiatives providing care and support for the mental health needs of people from diverse cultures.

**8.45** ● Better equipped mental health services should be provided which recognise:

- That culture profoundly influences an individual's health beliefs, practices, behaviour and the outcomes of health care;
- The need to respond respectfully and effectively to people of all cultures; and
- That the worth and dignity of individuals, families and communities are respected (Pierce, 2003).

#### **Prisoners and Ex-offenders**

**8.46** ● Another important issue is the incidence of mental ill-health among women prisoners as outlined in Chapter 4. As reported, 60% of these women have been found to have some form of mental ill-health (Kennedy *et al*, 2004). While the lack of appropriate services and the reasons for their detention need further action, in terms of mental health and social inclusion, any resettlement strategy for this group has to adopt a gendered approach to take into account these differences. A central issue of concern is the reliance on the Central Mental Hospital, a high security centre, as the only location for in-patient treatment for women prisoners. This needs to be tackled by amending legislation to alter the sentencing powers of courts so as to include treatment orders in more appropriate places. The Report of the *Committee into Current Care and Treatment Practices in the Central Mental Hospital* (2007) documents poor access to rehabilitation services for women.

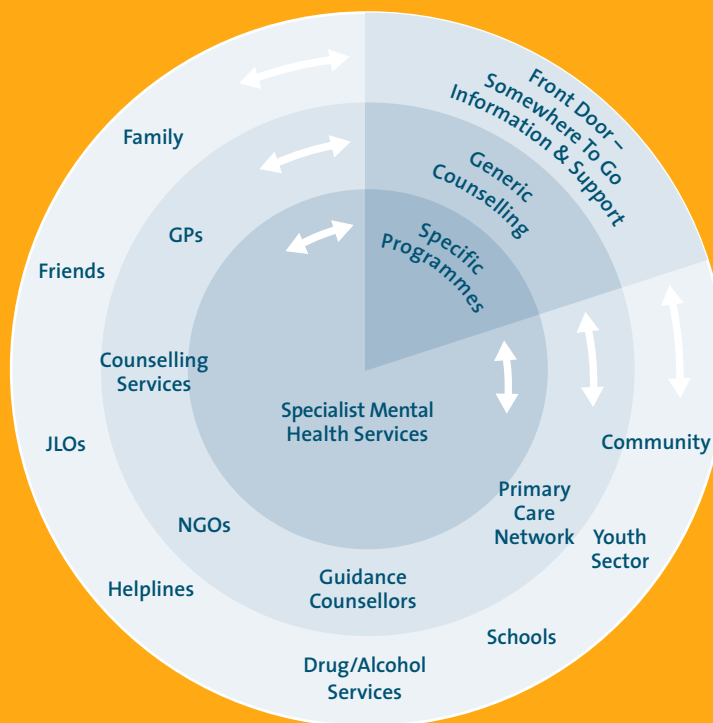
#### **Young People**

**8.47** ● The model for adults will not work effectively for young people as they do not access primary care services to the same extent. Research suggests they respond more effectively to non-stigmatised open access gateways such as 'one stop shop' and drop in centres (e.g. The Zone, Plymouth; Clockwork, Melbourne; The Corner, Dundee; The Gaf, Galway). The Gaf is a drug- and alcohol-free café in Galway, open 35 hours a week, that is run and operated by young people. Other Irish examples include the Loft in Letterkenny, C.R.I.B in Sligo and The Squashy Couch in Waterford.

**8.48** ● As outlined in the European Commission's (2006) *Green Paper on Mental Health* and in Irish mental health policies, the mental health of young people is of increasing concern. With high suicide rates and increasing abuse of alcohol and drugs, young people warrant particularly urgent action. Early intervention and support can have a significant impact. However, there are barriers to access of adult services for this group. One of the major issues of concern is the inadequate level of resources for youth organisations (Joint Presentation made to the Project Team by the National Youth Council of Ireland and Barnardos).

**8.49** ● Headstrong, the National Centre for Youth Mental Health, in their submission to the Project Team, outlined the Jigsaw model of integrated supports for young people, which links youth friendly services to a wide range of resources in the community (see Figure 8.3). They argue that young people are the most vulnerable in terms of the onset of mental ill-health and yet are the least supported in levels of service provision and types of services. One American study found that 75% of mental disorders were first experienced when patients were under 24 years (Kessler *et al*, 2005). Some studies suggest that early intervention in psychosis can make substantial cost savings (McCrone *et al*, 2006) and can be more effective than standard clinical care (McGorry, 2000). The one-stop centres in the Jigsaw Model show how opening a wide and friendly door early to young people can help support them in accessing specialist services they may need at a later date. This model also stresses the importance of early intervention for this age group.

**Figure 8.3** Jigsaw Model



Source: Courtesy of Headstrong, from their submission to the Project Team.



### Routes Out of Mental Health Services

- 8.50 ● It is important for services to draw up a recovery plan for patients, which identifies the steps from initial treatment to full recovery. A submission to the Project Team made reference to the Pathways Report (Brosnan *et al*, 2002) which noted: *“I dream of a service which has got clear exits, which show the way out of the system back into the real world.”*
- 8.51 ● The Department of the Environment, Heritage and Local Government’s (2006) *Homeless Strategy* wants all psychiatric hospitals to develop a formal and written discharge policy, communicated to all staff involved in the discharge of patients. The Strategy also calls for psychiatric teams to have a nominated professional to act as Discharge Officer and ensure that discharge policy is followed. However, this is not currently happening. As Focus Ireland reported, service users arrive on a regular basis to them, with Focus Ireland written on their discharge papers, rather than an appropriate accommodation.

### Attitudes and Expectations

- 8.52 ● Mental health and primary care services must take more positive steps to confront prejudice and present positive images of service users and to challenge staff and service users’ negative assumptions. High expectations have been shown to impact on outcomes (Social Exclusion Unit, 2004). Training needs to be ongoing and there are no off- the- shelf solutions for vocational rehabilitative provision (Evans and Repper, 2000), as strategies must be locally sensitive and relate to the particulars of that community.

## Societal level

### Incentives and Person-centred Approach

- 8.53 ● Policy development and leadership is needed to enhance integrated service provision. *As Improving the Delivery of Quality Public Services* (NESF Report No. 34, 2007a) outlines, putting the service user at the centre in the design and delivery of public services is central to the reform of public services. However, this needs to be strengthened by an intersectoral and co-ordinated approach with clear lead roles and responsibilities specified for non-health policies and outcomes.
- 8.54 ● While there are established links between community and voluntary sector, primary care teams, mental health services, vocational and housing services across the country, these are not developed strategically but often arise out of good local partnerships and personal contacts. Models of best practice for Community Mental Health and Primary Health Care Teams on intersectoral cooperation should be developed by the HSE to support this happening nationally. The use of incentives to promote and encourage multi-agency working was recommended in another submission, as follows: *“We believe that services should be incentivised to work around individuals as opposed to individuals working around the service. This*

*will allow for professionals to provide a co-ordinated and personalised response that is based on a full understanding of an individual's problems."*

- 8.55** ● Evaluation should be an integral part of this. According to WHO (2005:224), *"there has also been minimal evaluation of the impact of social and health policies on the mental health of the population. It is critical that any mental health promotion policy include evaluation strategies. This should not be limited to the evaluation of specific mental health promotion interventions but also include actions to assess the overall impact of the policy on the mental health of the community."*
- 8.56** ● Strategies for more effective community supports and community engagement are needed. Community development strategies have been shown to be effective in this area (see Chapter 9).

## Conclusions

- 8.57** ● Although there is a comprehensive policy for the reconfiguration of mental health policy in Ireland, and even if it is fully resourced, it will take an estimated 7-10 years before the policy is fully implemented, according to *A Vision for Change*. Community Mental Health Teams are being put in place, but these are not all fully multi-disciplinary nor are there enough of them in place to meet current needs. Other support services such as housing, employment, education and training were included in recommendations in *A Vision for Change*, but these have not yet been fully taken on board and implemented. An overarching intersectoral strategy supported by all the Ministers concerned is needed for all statutory and community and voluntary sectors to work more effectively together, as the basis of a fully integrated strategy. Within the current development of primary care, there is an obvious opportunity to integrate community mental health, community outreach services and primary care together at a strategic/ regional/local level.
- 8.58** ● One of the key requirements is for non-health services to play a fuller and more comprehensive role in recovery than has been the case up to now. To that end, working structures are needed on a national, regional and local basis between all service providers for integrated care. It is essential that clear protocols on training, work and community-based recovery-oriented services are embedded in the service continuum which commences with the mental health services. But full integrated services have to be resourced to be successfully implemented. The Inspectorate of Mental Health Services (2007) expressed concern about the lack of community resources and the poor staffing of multidisciplinary teams. It argued that community mental health cannot work without these resources.

- 8.59** ● Another key conclusion is that adopting a recovery approach is vital and if fully incorporated in the delivery of services would redirect attention to the service user's health and well-being, and not just to stabilise their medical care. Service users should have a key role in planning for their own recovery. The Inspectorate of Mental Health Services (2007) concluded that there is now greater recognition that service user involvement is key to delivering any mental health outcomes across the country. Service users, families and advocacy groups should have a significant role in the development of policy.
- 8.60** ● Health services, like all public services, need to develop customer-centred services, adopting a case management approach where the user is mapped through mental health and primary care services. Prevention and early intervention services are critical and should be strengthened, for example through increased funding for early intervention programmes.
- 8.61** ● The Project Team concludes that the most effective care strategy would be to integrate primary care and mental health services. In this regard, it is salutary to read that the Inspectorate of Mental Health Services welcomes the development of increased linkages between primary care and mental health services, which will, it argues, facilitate the integration of care for service users (Inspectorate of Mental Health Services, 2007). This does not negate the need for specialist mental health services.
- 8.62** ● Another essential building block is improved training/awareness-raising for health professionals, including GPs, on mental health. This training should include gender, sexuality, ethnicity and equality awareness-raising as well as grounding in the recovery model.
- 8.63** ● Every service user, either at Primary Care Team or Community Mental Health levels, should have direct access to vocational and welfare support. Supported employment programmes work more effectively when integrated into mental health services and, in particular, when that support is provided by someone with mental health knowledge and experience.
- 8.64** ● Multi-disciplinary Primary Care Teams also need to include counselling support for common mental health problems and wider health-related concerns. This service should be located in the Primary Care Centre and be flexible, affordable and available to all without referral. However, the Project Team is concerned at the lack of a single recognised national register of counsellors in Ireland and supports further work in this area to provide an accredited service for wider accessibility and quality of service.

- 8.65** ● Services for young people are critical, and innovative projects such as the Jigsaw model outlined by Headstrong, which create gateways for young people to access services, should be developed and supported.
- 8.66** ● Another key and long-standing requirement is the provision of step-down services, by statutory bodies, including housing, training and social supports. In addition, the Department of Environment, Heritage and Local Government and local authorities need to ensure that people recovering from mental ill-health are appropriately housed.
- 8.67** ● The Project Team considers evaluation central to any effective integrated strategy and independent outsiders, with expertise in this area, should be employed to provide regular evaluations of the effectiveness of services from the perspective of service users, staff and friends, families and carers.
- 8.68** ● Finally, the Project Team notes there is a lack of national indicators for mental health and well-being improvement at national and at community level and considers these should be developed as a tool for service users, carers and professional staff to work together and identify steps to positive health and well-being. Such a tool is the *Recovery Oriented System Indicators (ROSI) Self-Report Survey Measure*<sup>55</sup>. These indicators would provide an invaluable tool for policy implementation and evaluation, as well as a benchmark to support the recovery process.



9

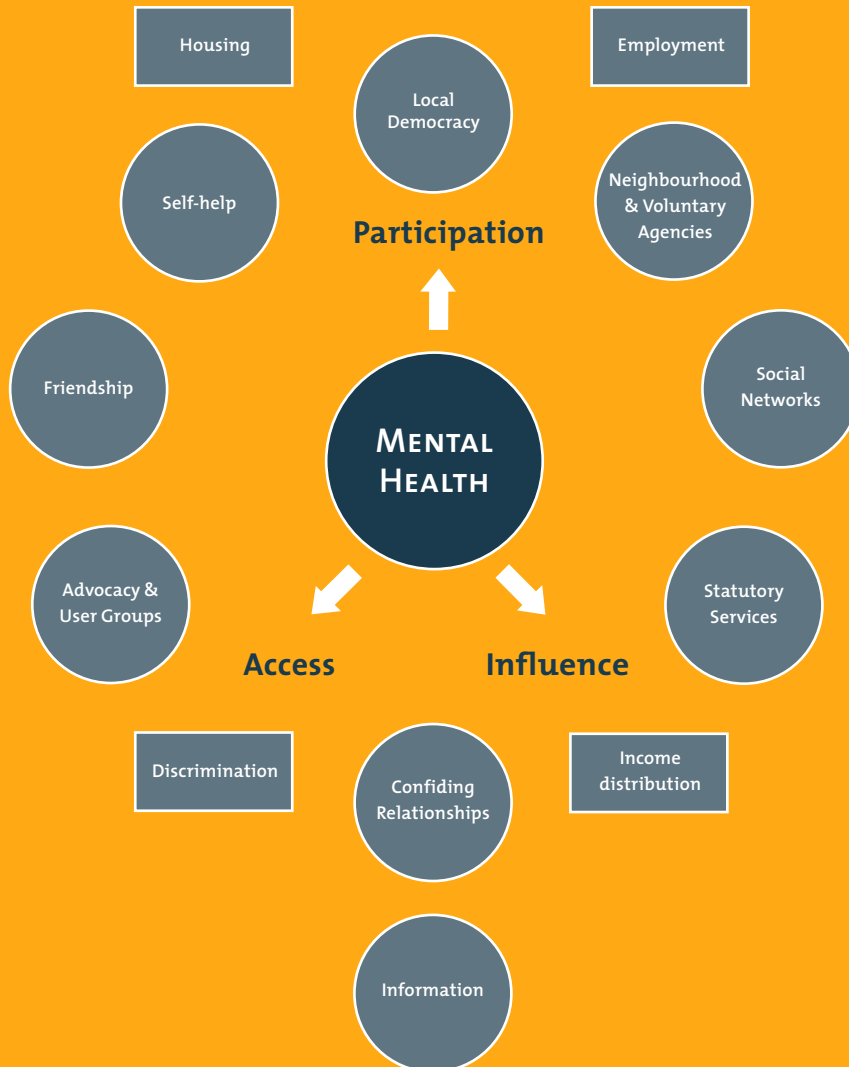
## Introduction

- 9.1 ● This chapter identifies strategies and initiatives which are effective in strengthening communities. It first discusses the key elements of a healthy community and then examines the community development approach to mental health as a way forward.

### What is a Healthy Community?

- 9.2 ● People living in communities where they feel connected and which are high in social capital, may view their neighbourhood as healthy (Chappell and Funk, 2004). Communities which are ‘healthy’ may also be low in crime and develop solutions to problems from the community itself (McCulloch and Boxer, 1997). They may also display community structures which support inter-personal relationships, for example: a family focus, voluntary groups, local politics, religion, and a maximum participation in decision-making (McCulloch and Boxer, 1997) (cited in a submission made to the Project Team). A report by the King’s Fund (Cameron *et al*, 2003:16) argues that *“healthy communities are characterised not only by close relationships between groups of residents of similar backgrounds, but also by acceptance of groups and individuals who live different kinds of lives.”*
- 9.3 ● WHO initiatives such as ‘Healthy Cities Europe’ show how different aspects of city life could contribute to promoting and maintaining health, such as supportive communities, participation of the population in decisions and good communications (cited in Department of Health, 2001). A healthy city is *“one that is continually creating and improving the physical and social environments and expanding the community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential”* (WHO website<sup>56</sup>).
- 9.3 ● What makes a community is often the nature of the relationships between people, and the social networks of which they are a part (Lee and Newby, 1983; Smith, 2001). In other words, interaction enables people to build communities, to commit themselves to each other, and to knit

**Figure 9.1** Factors Influencing the Mental Well-being of Communities



Source: The Department of Health, (England), 2001.

the social fabric (Beem, 1999). Key supportive elements include strengthening social cohesion, enhanced civic engagement, and increased awareness and recognition of mental health and well-being issues (see Figure 9.1).

- 9.5** ● A growing body of research suggests that where trust and social networks flourish, individuals, firms, neighbourhoods, and even nations prosper economically (NESF, Report No. 28, 2003). High levels of social support reportedly reduce the likelihood of a first occurrence of mental health problems (Pevalin and Rose, 2002). Moreover, networks of people with mental health problems — ‘user networks’ — can provide essential support structures.



- 9.6 ● One key element to tackling exclusion is the connection of marginalised groups to mainstream resources and services through mechanisms of bridging social capital which unites excluded groups with the majority (Putnam, 2000; WHO, 2005).

### Civic Participation

- 9.7 ● Participation in community and volunteering programmes are some of the successful actions identified through EU projects to improve social inclusion (European Commission, 2005). Research shows that high rates of civic participation have better health outcomes (Marmot and Wilkinson, 1999). Ireland has experienced a fall in levels of inter-personal trust and in voter turnout (NESF Report No. 28, 2003) but is rich in terms of informal social networks compared to many other economically developed countries (Taskforce on Active Citizenship, 2006).
- 9.8 ● The *Report of the Taskforce on Active Citizenship* (2007) found that a large majority of the population, 71%, are not engaged actively in any community organisation or form of regular volunteering. At just 29% of the adult population, an estimated 860,000 people were involved as active members of their community. This varied according to occupation. Those in paid employment or paid self-employment were much more likely to be actively involved than those who were not — including homemakers, the unemployed and students. Levels of volunteering/involvement in a community group were much lower for the unemployed and those with a disability/illness (16.5%), than compared with the total sample (29%). This suggests that people with experience of mental ill-health, as part of the disability sample, would also be less likely to be actively involved in the community, a finding also supported by research in England (Social Exclusion Unit, 2004). In terms of social support, 50% of the national sample had 8 close friends or more. The Taskforce Report shows that informal social contact and support were much lower for particular disadvantaged groups including the unemployed and those with a disability.
- 9.9 ● A recent study in Dublin found that community involvement varied from richer to poorer areas. The poorer areas surveyed showed higher levels of community involvement than more affluent areas (Dublin City Council, 2007).
- 9.10 ● In terms of effective strategies for community engagement, volunteering has been examined in England. In one survey, 90% of people with experience of using mental health services said that volunteering gave them a sense of purpose and achievement. More than 80% also said that it had a positive effect on their mental health, and 40% said it had increased their chances of employment (Social Exclusion Unit, 2004). Preliminary research in the Capital Volunteering Project suggests a strong link between volunteering and recovery from mental ill-health (Institute of Psychiatry, 2006). Even taking part for less than a year, 85% of participants felt they had already gained. One said, *“I feel part of the community. When you have been excluded for a long time you don’t feel part of anything. It’s hard to find a niche to get into. I have now.”* However, research suggests

that in England, people with mental ill-health are less likely to volunteer as a result of their condition and that volunteering organisations are not doing enough to make volunteering a reality for this group (The Social Exclusion Unit, 2004<sup>57</sup>).

- 9.11 ● In England, increasing focus has been placed on co-production and time-banking. Co-production is where service users work alongside professionals as partners in the delivery of services; it has the potential to be of real significance to services in addressing social inclusion for people with mental health problems. Time-banking, a form of co-production, engages communities by bringing people together and rewarding them for sharing their time and skills. Participants 'deposit' their time in the bank by giving practical help and support to others and are able to 'withdraw' their time when they need something done themselves.

### Example of Good Practice: Time Bank

The Rushey Green Time Bank, in Lewisham in South East London operates out of a primary health care centre. The Rushey Green Central Clinic serves over 6,000 people. The clinical team is made up of GPs, district nurses and a range of health practitioners, from psychologists to counsellors. The practice serves large Afro-Caribbean and Turkish communities. A growing number of patients are also refugees and those recently moved to the area for work. Time bank is where patients provide support and help to each other through carrying out a task for others. The most popular requests were help with small errands, letter writing and form filling, simple home repairs and companionship. And because the time bank is a way of giving as well as getting help, people offered everything from 'someone to go to the pub with', to 'help growing your own fruit and vegetables.' Remarkably, young parents and older people shared many of the same needs for informal, low-level practical support. Ultimately GPs, where appropriate, would be able to prescribe time credits rather than medication. Equally time bank members would be encouraged to 'earn' their credits contributing their skills and energies in a whole variety of ways<sup>58</sup>.

- 9.12 ● There are key social and community activities that can enhance positive mental health. Arts projects can make a unique contribution to enhancing well-being and self esteem (Health Development Agency, 2000; Cohen, 2005) as can community sports activities. The physical environment also has a role in stress reduction and the promotion of well-being (Dept of Health, 2001, p. 108) and religious involvement is associated with positive mental health outcomes (Ellison and Levin, 1998). Participating in the arts can increase confidence; self-determination and community empowerment; and can improve local image and promote greater social cohesion

57 <http://www.socialexclusionunit.gov.uk>

58 <http://www.phmovement.org>, <http://www.timebanks.org>

(Matarasso, 1997). The NESF (Report No. 35, 2007, p. 107) argues that “*the arts contribute to and strengthen social capital and, as the growing body of international evidence shows, this in turn is associated with higher economic growth, greater social equality, and increased levels of well-being and life satisfaction.*”

- 9.13 ● There is recognition that the reduced participation in sport among lower socio-economic groups is a contributor to social exclusion (ESRI, 2006). The ESRI (2006) report, *Fair Play? Sport and Social Disadvantage in Ireland*, outlines the inequalities in access and participations in sports. It found that those with low income are many times less likely to participate. It argues that to re-engage people in sport there needs to be targeted initiatives directed at particular groups.
- 9.14 ● An evaluation of arts therapies in Scotland concluded that arts-based approaches to promoting social inclusion, health improvement and recovery within a mental health context should be recognised supported and developed. They “*have the potential to provide innovative, person-centred solutions to often complex psychological issues and challenges, exacerbated by social exclusion, discrimination and stigma*” (Mental Health Foundation, 2006:11; ADU/UCLAN, 2005).
- 9.15 ● *A Vision for Change* outlines how social support is a key resource in particular for older people. Self help, support networks and volunteering have been identified as protective factors against poor mental health as well as helping people recover from stressful life events like bereavement. The evidence suggests that these interventions are most successful when linked closely with other community development initiatives.
- 9.16 ● Interventions to build social capital at a community level include:
- Strengthening social networks: e.g. employing community development workers to support communities;
  - Building social organisations: e.g. support the voluntary and community sector;
  - Strengthening community ties: e.g. bring groups together normally divided along ethnicity, class, gender and religious grounds; and
  - Strengthening civil society e.g. introduce policies which support community development approaches (Adapted from WHO, 2005).

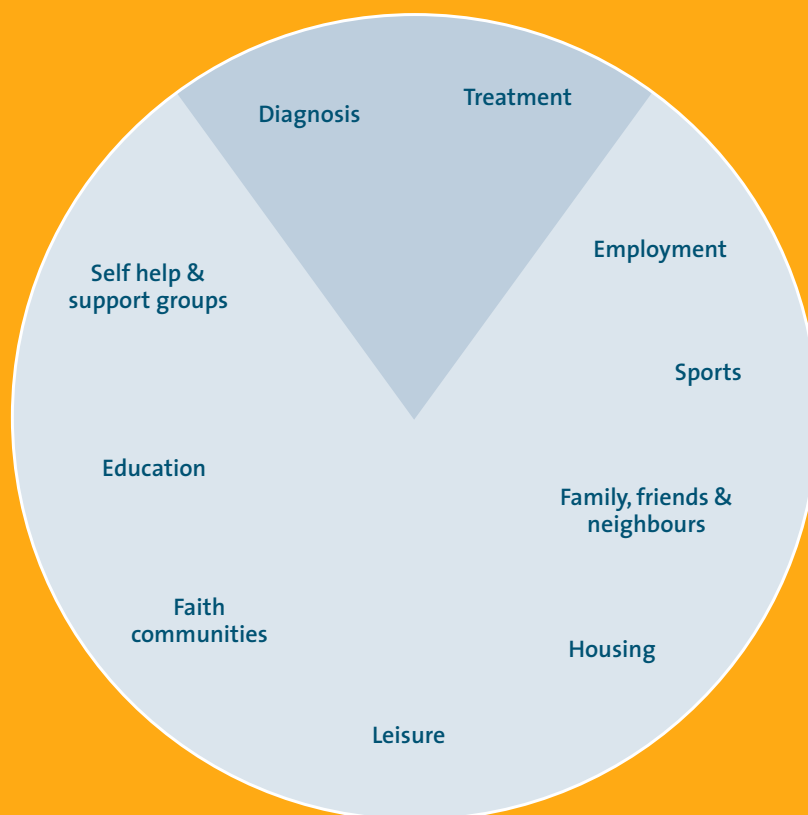
### **The Voluntary and Community Sector**

- 9.17 ● The contribution of the voluntary and community sector cannot be overstated in supporting people with mental ill-health. As mentioned in Chapter 3, the largest organisations, Mental Health Ireland, GROW, Schizophrenia Ireland, Aware and others provide job-clubs, drop-in centres, peer support and carers’ groups, social events, courses, training and information, work with the media, educational material for schools and many other supports. These supports are run voluntarily and take place around

the country in cities and isolated pockets of rural Ireland, connecting people in need with information, guidance and support. These activities and groups often operate in a vacuum, in the absence of sufficient or in some cases, any public services. The Project Team considers this work in local communities is key to a recovery model of mental health and should be better supported and resourced. Greater co-ordination between organisations would also benefit the development of these services strategically.

- 9.18** ● Mainstream community supports and opportunities are an important part of recovery: as Sayce and Morris (1999) argue, “the more mainstream opportunities people with mental ill-health are supported to take up, the more accepted people with mental health problems are likely to become”.
- 9.19** ● As other chapters on integrated services and strategies for social inclusion show, the supports that people need and use fall largely outside mental health services, diagnosis and treatment. The Department of Health in England demonstrates that most sources of support are found outside of mental health services (see Figure 9.2).

**Figure 9.2** Sources of Support for People with Mental Ill-health



- 9.20 ● The full extent of wider voluntary and community work in this area is not known, but is estimated to be considerable. Every city, town and village in Ireland includes people with common mental health problems. The extent to which these issues impact on community groups around the country is not fully known. However, the submissions received by the Project Team do suggest that for many community groups and organisations, supporting people with depression and anxiety and addiction-related issues is a big part of their routine work. One indication of the growth in this work is reflected in the submission received from the Community Foundation of Ireland who operates small grants schemes for community and voluntary groups. In 2006, they received over 114 applications, totalling €350,000, for projects with a health or mental health focus.
- 9.21 ● The movement in and out of medical care should not remove people from their local communities. What is often missing, however, is an anchor in the community for people who are in crisis. One key element in the potential of the voluntary and community sector is through the route ‘back in’, when someone is working towards their own recovery and may have stepped aside from their previous local supports. As the submission from the Community Foundation of Ireland argues, *“there is a great need for ongoing supports for people who have recently left institutional care and are moving into independent living within the community. Initiatives such as Befriending Schemes and Mentoring Programmes should be expanded and made accessible to all those leaving institutional care.”*
- 9.21 ● The wider community and voluntary sector have a key role to play in supporting social activities. These could be as simple as weekly lunch clubs, bingo and cinema clubs, where all members of the community are invited and people with mental ill-health take part alongside everyone else. Increasing social contact with service users has been effective (Department of Health, 2001). As the submission made by the Community Foundation of Ireland notes, *“these are particularly important in more isolated and rural areas of Ireland where opportunities and facilities to socialise and interact are often scarce and inadequate. Unfortunately, the availability and accessibility of transport, particularly in rural areas, still serves as a major barrier for this type of activity. While the Rural Transport Initiative is doing commendable work to improve the transport situation, it is imperative that their efforts and work in this area are further supported and developed.”*
- 9.22 ● One useful tool to assist with increased community engagement is a map of local health, employment, housing and other services. Most maps for local areas are produced for tourists but this kind of community assistance map could be an invaluable resource for newly arrived members of the community as well as those who are new to particular services.

### *Examples of Good Practice: Map of Drumchapel*

The Drumchapel Map of Community Resources was produced by COPE, a registered charity in Scotland offering a professional, confidential and effective bespoke service to individuals experiencing mental/emotional distress (see Annex 4). Drumchapel is a large post war housing estate in Glasgow, with high levels of social and economic disadvantage. One of COPE's objectives is to ensure access to services and information and to this end they have produced a variety of resource maps and at a glance guides, in consultation with service users and the community in general. This map of resources and services which includes all community information in a readable format including mental/emotional health centres and services<sup>59</sup>.

The English National Social Inclusion Programme's website presents examples of organisations and projects in the community working with people with mental ill-health. It presents an interactive database of bridge-building projects<sup>60</sup>. This database contains information on projects that enable people with mental health issues to engage with their local communities. It builds on the work done by the National Development Team for the Making Inclusion Work project (2002) which mapped over 400 projects that helped to 'build bridges' for people with mental health issues to support them to take up social roles and relationships in the wider community alongside the general public.

## **What Can Community Development Contribute to Mental Health?**

- 9.23** ● Increasingly, community development is regarded as a key strategy for building social capital, particularly in facilitating communities in a self-help approach to providing solutions to collective problems such as ill-health (Wakefield and Poland, 2005). Community development approaches may help to build the capacity of disadvantaged groups to articulate and pursue their own needs, may combat their isolation, create opportunities for personal development, foster a climate of mutuality, and help to combat discrimination and stigma (from the Pobal submission to the Project Team). Community development is different from community engagement in that the former supports local people to identify the problems that need to be addressed and can help shape the solutions, that is, it is an empowering process, rather than the latter, where consultation is at the lower level (Sainsbury Centre for Mental Health, 2005).
- 9.24** ● The Combat Poverty Agency (2000) define community development as a process whereby those who are marginalised and excluded are enabled to gain in self confidence, to join with others and to participate in actions to change their situation and to tackle the problems that face their community. Community development involves collective action which aims

<sup>59</sup> <http://www.cope-scotland.org.uk>

<sup>60</sup> <https://clarahost.clara.net/www.socialinclusion.org.uk>

to bring about social change with a strong importance placed on empowerment and participation as well as the need to focus on the process as well as outcomes (Combat Poverty Agency, 2006).

- 9.25** ● Community health projects employ a community development approach to improving the health and well-being of people within a defined community. These projects may be initiated by local people themselves or they may be stimulated through the activities of health-related professionals (Mahony *et al*, 2003). However, what differentiates a community development approach in health is the following:
- It is about a process – galvanising the community into action;
  - It increases the community’s sense of identity and the capacity of individuals to act for themselves;
  - The community contributes to defining and addressing the problem with appropriate help from professionals. This relationship between professionals and the community is sometimes described as ‘doing with, not doing for’;
  - There is recognition and harnessing of individuals’ expertise regarding their own problems and how to resolve them;
  - The root cause of the problem is identified and addressed, not just the symptoms; and
  - It creates an ongoing process at community level which has its own momentum independent of organisational change (Kennedy, 2003).
- 9.26** ● On the role of community development in tackling wider health inequalities, Burton and Harrison state that *“the community development approach to health is positive and proactive and can enable people who do not normally access existing services to access them. As it seeks to redress the balance and to help communities help themselves it can begin to reduce inequalities in health and ensure that those with the greatest need have the best care”* (1996:31).
- 9.27** ● A community development approach recognises the socio-economic influences on health and also recognises that the context in which people live directly influences health status and affects the way decisions are made regarding health (Black Report, 1980). As Cox and Findlay (1990) note, the process of involvement and participation is itself health promoting, building self-esteem and confidence. As such, a community development approach to health takes time; it may take two to three years to foster trust and involvement, as well as an appreciation of issues and concerns within the community (Department of Health and Children, 2004). Moreover, in its *Guidelines for Community Involvement in Health*, the Department of Health and Children (2004a) also makes the case that community participation results in better decisions and more effective and efficient services and improved health outcomes. Indeed, health professional advocates of community development such as Longest argue

that many health service organisations under-appreciate the myriad of benefits of such an approach and that they should “*aggressively engage in community development*” (Longest, 2006: 102).

- 9.28** ● Wells *et al* (2004) argue that a community intervention approach is a promising one for extending the reach of mental health services interventions into diverse communities. One of the primary reasons for employing a community development approach within mental health services in England has been the fact that “*the fear and stigma associated with mental ill-health has been associated with the avoidance of services and a failure to get help ... community development is charged with facilitating earlier access to services*” (Sainsbury Centre for Mental Health, 2005: 88).
- 9.29** ● One initiative which has been effective in West Cork was the establishment of the West Cork Mental Health Forum, an informal network of stakeholders in the area with an interest in improving community supports for people with mental ill-health in the area. West Cork Mental Health Forum<sup>61</sup> involves a coming together of service users, carers, community organisations, voluntary sector organisation and the individuals from the health service. It has informal monthly meetings and works towards:
- Providing a channel for the voices of service users;
  - Identifying supports for families who have experienced problems and acts as a signpost for existing services/supports;
  - Engaging the local community with mental health issues and so promoting ownership and understanding of these issues; and
  - Challenging the stigma of mental health.
- 9.30** ● Community development is a key element of the English action plan to tackle discrimination and inequality in mental health services and has been used directly to engage people from black and ethnic minorities (BME). A report by the Sainsbury Centre for Mental Health (2005) recommends that Primary Care Teams include and fund a role for community development workers. It documented the fear among BME service users and carers of using mental health services, feeling they fail to meet their needs. It is important in our growing diverse and multi-cultural society that these lessons are learnt in advance of this fear and mistrust developing. The ongoing work of CAIRDE here in examining cultural differences in mental health is welcomed by the Project Team and it is hoped that any emerging conclusions can be used to develop mental health services and community development work in this area.

---

<sup>61</sup> Information supplied by Dr Pat Bracken, who was a member of the Project Team.



### Example of Good Practice: Gaining Ground

Gaining Ground is a participatory action research project on mental health in Tallaght. It produced a recent report, *Ground Gained* which found that people with a mental health issue experience prejudice and stigma on a daily basis (Gaining Ground, 2007 p. 72). Working with people in the local area and using a community development approach, it identified ways of promoting mental health awareness and shows how such an approach can include people with mental ill-health in research as well as provides supports. The research also makes recommendations for the best way of working in a community development context with people who have mental disabilities.

- 9.31 ● The Project Team supports many of the recommendations made in the Report by the *Taskforce on Active Citizenship (2007)* which are valuable in this context, including:
- (i) To strengthen the social and community networks and activity. In particular the recommendation for community and voluntary organisations to undertake proactive initiatives to reach out and engage with newcomers to Irish society is welcomed as this would help in supporting the mental health of migrants and ethnic minorities;
  - (ii) To establish an Active Citizenship Office. The Project Team would encourage this Office to consider the mental health benefits of volunteering and active citizenship in all forms, and to make health and well-being a key aspect of this work;
  - (iii) To strengthen funding schemes to support capacity development among community and voluntary organisations particularly in the area of training at both national and local level; and
  - (iv) To expand education for citizenship in the school system and in the youth and adult education sectors, with the health and well-being benefits of social and community supports emphasised in this work.
- 9.32 ● Using existing networks to promote positive mental health has been demonstrated as effective in Scotland, where Choose Life, the suicide prevention strategy and organisation, uses the expertise of community-based workers, many of whom become advocates for suicide prevention. There, community development approaches build on existing networks and groupings. Other Scottish examples of good practice are outlined below.

### Examples of Good Practice: Community Development and Mental Health

CHANGES is a project in East Lothian, established by the Scottish Association for Mental Health, which aims to work in partnership with local individuals and professional services to promote the emotional well-being of people in the community by providing them with information and experiences to facilitate them in managing and understanding their mental health needs. Its functions and activities include: self help groups for those experiencing panic attacks and depression; running courses such as 'Positive Thinking and Relaxation' to help deal with stress; an enquiry service on sources of support for people experiencing stress; and a small resource library about parenting and common emotional and mental health problems. It also runs the Positive Parenting Forum (PPF) which leads parenting courses with professionals and parents working together, as opposed to parents being told how to be a good parent (Kennedy, 2003).

LETS Make It Better (LIMB) is local exchange trading system in the Stirling and Alloa area of Scotland where members of a group offer goods and services to each other for a number of units and then trade within the group for goods and services they require. LETS for people with mental health issues is expanding in the UK with over 25 systems in operation and is seen as way of responding to labour market needs and promoting social inclusion. Its activities include LETS trading, social support, publicity, a drop-in café, arts and crafts, promoting health and well-being, and partnership. For all members *"the project provides a structure for the day, a meeting place and a focus which is all too often absent for people recovering from mental ill-health"* (Kennedy, 2003; 90). LIMB has facilitated some members in moving to paid employment and further education. The relationship between the project and health professionals is crucial to its success and many professionals have joined LETS and this has facilitated breaking down barriers.

### Young People

- 9.33 ● The submissions detailed the role youth organisations play as an initial point of contact with children and young people, with one submission recommending that: *"Youth organisations throughout the country must be adequately resourced to ensure the provision and development of social and personal development, and life skills programmes specifically targeted at children and young people. Funding should be available to provide those working in the youth sector with training and support materials on mental health promotion and suicide prevention, including identifying and responding to the risk factors associated with suicidal behaviour and self-injury."*

- 9.34 ● According to another submission, *“there is a substantial network of youth services throughout the country, most of them state-funded, and we would strongly recommend that at least some of these would be encouraged to incorporate awareness raising of mental health in their programmes and to offer a referral service for those who need specific support.”*
- 9.35 ● Spun Out<sup>62</sup>, a recent web-based information service run by Community Creations, a non-profit organisation founded by a group of young business, media and cultural studies graduates, provides young people with youth-friendly factsheets on health and lifestyle issues, a directory of relevant services, a moderated discussion forum and opportunities to be involved in youth media and advocacy. Their campaign, Tough Times, was commissioned and joint funded by Console, Turning the Tide of Suicide (3Ts), and the National Office for Suicide Prevention.

### Evaluation

- 9.36 ● One of the shortcomings of employing a community development approach is the lack of systematic evaluations of such interventions. As Wells *et al* advocate, in the long-run research must focus on *“whether such approaches achieve either more enduring or far-reaching reductions in the individual and societal burden of mental ill-health for diverse communities, in which burden is defined at least partly in community terms”* (Wells *et al*, 2004, 960).
- 9.37 ● The Combat Poverty Agency’s Building Healthy Communities Programme has recently been evaluated. This evaluation found evidence of:
- Establishment of a range of procedures to facilitate working relationships involving community-based groups, health and other service providers;
  - Successful completion of community-based courses;
  - Greater participation in activities by more disadvantaged individuals as well an increase in voluntary involvement in a range of consultative mechanisms;
  - Increase in the extent to which health issues have featured on various community development programme and project agendas;
  - Increase in awareness about issues linking to health and poverty within and between projects participating in the programme; and
  - More productive working relationship between community groups and service providers (Nexus, 2004).

---

62 <http://www.spunout.ie>

- 9.38** ● The challenge for community development then, lies in the integration of individuals with mental health problems in activities designed for everyone in the community (Cameron *et al*, 2003). Huxley and Evans (2001) suggest that urban initiatives which aim to improve quality of life or mental health need to promote security, increase leisure opportunities, foster social capital and build up the image of the area. As such community development initiatives are most effective when they involve strengthening communities in the wider sense as well as highlighting positive mental health.
- 9.39** ● The community and voluntary (C&V) sector plays an important role in this country in the delivery of public services in many sectors (NESF Report No. 34, 2007a). As identified by The Wheel, the challenges here are *“the lack of information on the overall nature and size of the sector in Ireland; the need for a broadening and deepening of the relationship between the voluntary and community sector and the State (it is currently largely reliant on funding from the State); and a lack of detailed information about the variety of different roles played by the sector, particularly in terms of the promotion of the healthcare needs and relationship with the statutory sector”* (The Wheel, 2005; 16).
- 9.40** ● Community development means building on the strengths that already exist in a community. This capacity-building could mean less reliance on mental health services and development of greater community supports and protective factors. All members of the community should be facilitated to have a role in community development — mental health service users participating in such capacity-building may reduce the stigma of mental ill-health as other members of the community get to experience the reality, rather than the stereotype of mental illness (from a submission made to the Project Team).
- 9.41** ● For this purpose, communities should be facilitated to profile their own health and social needs, with ‘impact on mental health’ being an integral measure of the potential benefits of any planned community development. Community profiling using such tools as Health or Community Impact Assessments could identify good practice, highlight areas of inequality and be used to develop targeted or universal measures to tackle poor mental health and encourage good mental health. *The Mental Well-being Impact Assessment Toolkit*, previously discussed in Chapter 5, could be a valuable resource to this end (CSIP, 2007).
- 9.42** ● The Local Development Social Inclusion Programme which aims to counter disadvantage and to promote equality and social and economic inclusion should include mental ill-health as part of its targeting of disabled people. As outlined by Pobal (2006) in *Enabling Participation*, progress indicators on disability include the number of groups of disabled people that are at pre-development stage or established, and which focus on mental health issues as part of pilot actions or research projects; as well as the number of groups with service users participating in networks. These could be focused more directly on people experiencing mental ill-

health. If developed in this way, community development under this programme could help meet the needs of people with mental ill-health by: collectivising individual experiences and enabling them to develop appropriate responses; building their capacity to become confident and active in their local communities; increasing their level of participation in their own communities; and enabling people to become actively involved in addressing both the causes and consequences of their marginalisation and exclusion (adapted from Pobal, 2006).

- 9.43 ● Some of the challenges in this community development approach include the amount of time it takes to build up skills and confidence and to create opportunities with longer term outcomes that are hard to measure. There is also a tension between creating a safe space that offers support, and encouraging people to extend their networks and step out of a potential comfort zone. Finally there is the need to constantly engage new people so that when others move in, the work continues; and the challenges of short-term funding, which makes it difficult to plan and develop services (adapted from The Sainsbury Centre for Mental Health, 2005).

## Conclusions

- 9.44 ● As Putnam (2000) so effectively argues, social capital can be developed and strengthened but without support and active engagement it can slip away with devastating effects. Positive mental health is determined, in part, by these valued social networks, supports and sense of belonging. If ‘no man is an island’ (John Donne), then an island which builds on its social networks and recognises the basis of its well-being and health is through social and community support, would be in a stronger position to tackle rising chronic mental ill-health for the few, and foster positive mental health for the many. The Project Team concludes that strengthening communities to support positive mental health is critical to any successful social inclusion strategy. This should include sufficient and effective resources for community-wide initiatives, as well as offering integrated supports for those experiencing mental ill-health.
- 9.45 ● Engaging in the local community is one element of positive mental health and supporting civic engagement is an effective way to both support healthy communities as well as positive mental health for individuals. A nationwide volunteering programme as outlined by the Taskforce on Active Citizenship should target people with mental ill-health as part of their recovery plans. This should involve training for peer support, befriending, mentoring and advocacy and be closely linked to groups such as GROW and the Irish Advocacy Network.

- 9.46 ● The work of the community and voluntary sector in relation to mental health should be more formally acknowledged and resourced. As much of this goes unrecorded, it would be valuable to know its extent and, to that end, the Project Team considers that, in the future, every community project (CDP and others) should be asked to assess the implication of inclusion of those with mental ill-health in their work.
- 9.47 ● The Project Team recognises the value of work to strengthen community well-being using a community development approach and encourages the recognition of success and good practice in this area. National events should be welcomed and encouraged which exchange ideas, information and learning in this area.
- 9.48 ● It would benefit and strengthen mental health if the voluntary and community sector would increase their focus on mental health supports as part of their ongoing work alongside its primary focus. In the view of the Project Team, this work should involve those with experience of mental ill-health but should not be exclusively targeted at this group.
- 9.49 ● There are no clear guidelines at present on the most effective way of supporting people with mental ill-health in the community. In this regard, the Project Team supports the development of supports for community groups. The Local Development Social Inclusion Programmes could provide the mechanisms with clear effective steps for supporting recovery and social inclusion. This support should be led by the HSE and developed in liaison with the mental health voluntary and community sector.
- 9.50 ● There are key social and community activities that can enhance positive mental health in terms of strengthening social capital and an individual's social inclusion and mental health recovery. These include arts and sports activities, volunteering, faith communities, nature and the physical environment. Strengthening and broadening social networks is a key part of increasing social inclusion: networks can perform a buffer role for stress as well as creating opportunities for meaningful social engagement and personal development, and in turn, reduce social isolation. In addition, the Project Team recognises the importance of creative projects and arts therapies as helping improve the quality of the lives of those who live with mental ill-health and these should be supported and resourced by Arts Officers in local authorities and the HSE (see NESF Report No 35, 2007b).
- 9.51 ● Local social support networks could be further developed and supported by Community Mental Health Teams, Local Development Social Inclusion Programmes and other groups as outlined in the *National Action Plan for Social Inclusion (NAPinclusion)*. These should also link in to physical and sporting activity, arts projects, participation in the community and volunteering programmes.

SECTION III

# Conclusions

10



## Conclusions

- 10.1 ● This report has highlighted how mental health is a key resource which contributes to the overall social, human and economic capital of our society. There is no health without mental health. As such, 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.
- 10.2 ● There is a consistent relationship between mental ill-health and indicators of social exclusion such as low income, poor education, unemployment and low social status. These in turn are linked to gender and ethnicity. Social exclusion factors are mutually reinforcing; combined they create a dynamic, vicious and complex cycle, and a serious challenge to policy-makers.
- 10.3 ● The population health approach aims to improve the health of the entire population and to reduce health inequities between population groups. This broader understanding of health recognises the range of social, economic and environmental factors that contribute to overall health. In addition, as the report has detailed in many cases, vulnerable groups and individuals in the process of recovery require particular action to reduce their stigmatisation, discrimination and marginalisation, and to support their full participation in community life.
- 10.4 ● This report has also drawn on several other additional perspectives which underpin the recommendations below. The Project Team recognises the importance of a rights-based approach to health and well-being, the social and economic determinants of health, a gender-based dimension as well as the fundamental role of the recovery model in mental health. Mental ill-health is included under the grounds of disability and is therefore protected under our equality legislation. This report should also be considered within and complementary to the existing policy framework of *A Vision for Change, Towards 2016*, *NAPinclusion*, *National Disability Strategy* and the *National Women's Strategy*.

## Recommendations

10.5 The report's recommendations fall under the following six strategic areas, outlined in Figure 10.1 and detailed below:

- Institutional and Budgetary Issues;
- Raising Awareness and Challenging Stigma;
- Young People;
- The Workplace and Supported Employment;
- Integrated Services; and
- Community Development.

### Institutional and Budgetary Issues

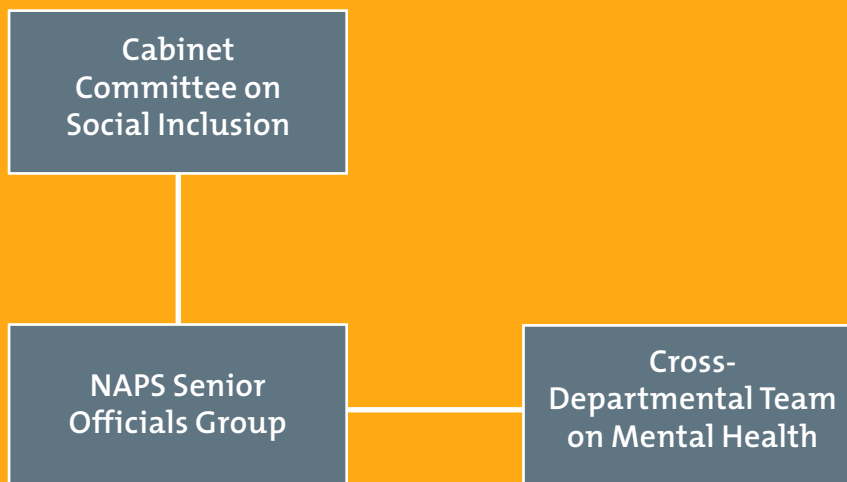
10.6 ● The Project Team recommends the following:

- a) With increasing emphasis on the value of a population health approach and its focus on health promotion, illness prevention and early intervention, the Project Team recommends that the Department of Health and Children, working with the Health Service Executive, develop a 'health public policy' strategy to advise and monitor all departments and agencies on population health issues, including mental health and well-being.
- b) Departments and agencies should regularly review and evaluate the impact of their policies on health, including mental health. As part of this approach, Health Impact Assessments, which are holistic and inclusive of mental health, should be used in the development and evaluation of all major policies, in consultation with service users. HIAs cover not only the delivery of public services by the statutory but also by the community and voluntary sector.
- c) The Project Team supports the full and timely implementation of the recommendations in *A Vision for Change* and seeks to complement and deepen the focus on social inclusion through the recommendations set out in this report. In addition, bodies with responsibility for vulnerable groups should prioritise policy and action to address their numerous and complex mental health needs.
- d) Given the significant links between poverty and mental ill-health, responsibility at national level for promoting vocational and social (non-health) outcomes, as detailed in this report and in *A Vision for Change*, should be vested at strategic level with the Senior Officials Group under the *National Action Plan for Social Inclusion (NAP-inclusion)*. This should be on the basis of active cross-departmental

involvement and participation, particularly that of the Departments of Health and Children; Enterprise, Trade and Employment; Education and Science; Social and Family Affairs; Environment, Heritage and Local Government and Justice, Equality and Law Reform. Particular attention should be given to strengthening the working relationship and services provision at local operational levels between these Departments and their executive agencies. As the Independent Monitoring Group on *A Vision for Change* noted recently, “*there has not been a systematic approach to the implementation of the recommendations across Government Departments*” (p.10). This issue also came to the fore during the course of the Project Team’s work.

- e) A cross-departmental team on mental health and social inclusion, reporting to the Senior Officials Group under the *National Action Plan for Social Inclusion (NAPinclusion)*, should be established, with specific responsibility to draw up targets, priorities, an implementation schedule and budgets. It should ensure that all policies, targets and actions for vulnerable groups are being met and that barriers to implementation should be identified and addressed as a matter of priority. Figure 10.2 overleaf presents this implementation structure.
- f) Although we are now among the richest countries in the EU, we lag behind poorer countries in regard to public spending on mental health. This is despite the international recognition that mental capital is a significant resource. Furthermore, spending is un-balanced, for example, between institutional and community care, and between service delivery and health promotion. Given the remit of the Independent Monitoring Group (2007) on *A Vision for Change*, and to avoid unnecessary duplication, the Project Team echoes that Group’s call for the HSE to draw up an implementation plan as a matter of urgency and to increase expenditure allocation, as necessary, to support this, as was previously agreed in *A Vision for Change*.
- g) Beyond expenditure on the provision of services proper, there is broader expenditure on mental health action and supports in the community and wider society, as outlined in the report, which it was not possible to quantify in the time available. The Project Team recommends a cost-benefit analysis should be conducted to quantify all these expenditures, as the basis to provide additional resources for the implementation of the recommendations made in this report. This should complement *A Vision for Change*.
- h) Quality research is vital to inform future policy development on mental health and well-being, particularly during this period of rapid societal change. To that end, more research is needed on health determinants; better information and evidence-based data on needs assessment; recovery and outcome indicators, as distinct from admission/treatment rates; and best treatment practices.

Figure 10.2 Implementation Structures



### Raising Awareness and Challenging Stigma

10.7 ● Stigma and discrimination are the greatest barriers to social inclusion, quality of life and recovery for people with mental health problems. There is persistent stigma in Ireland as indicated by attitudinal surveys. Effective strategies include targeted advertising campaigns and web-site developments, for example, those directed at young people; closing the gap in understanding between those experiencing mental ill-health and the community, through regular meetings and community activities; and media awareness campaigns. The forthcoming campaign by the National Office for Suicide Prevention is very much welcomed by the Project Team.

The Project Team recommends the following courses of action:

- a) Health and well-being education, including mental health, is critical for all children and adolescents and should be embedded in the curriculum at all levels. The Project Team welcomes the development of the Social, Personal and Health Education (SPHE) curriculum at secondary level by the Department of Education and Science to include mental and emotional health, which is particularly important for adolescents. Training and support for teachers in delivering this programme should be provided and the programme regularly evaluated and monitored by the Department. This should be strengthened further, by support for

exemplar projects initiated and supported in schools on skill development, suicide prevention and civic and social participation. In addition, there should be wider access to confidential psychology/counselling services at both second and third levels. The Project Team would welcome increased support for the National Educational Psychological Service (NEPS) and on a broader level and increased training and support for schools to help identify and support children and adolescents with mental health issues.<sup>63</sup>

- b) Continuing education and personal development in health and well-being, including understanding of mental health issues and mental health literacy, should be developed and rolled out nationally by the HSE in conjunction with the voluntary and community sector.
- c) High profile and sustained media awareness campaigns on mental health promotion, including training and materials for teachers, Garda and medical personnel, are needed at national and local levels to target specific settings such as the workplace, schools as well and wider community. These should be developed by the HSE, the National Office for Suicide Prevention, and other key groups. These should be aimed at promoting positive images of mental ill-health and creating a sea-change in attitudes, similar to the shift in attitudes towards intellectual disability at the time of the Special Olympics four years ago. The work of the National Office for Suicide Prevention in this area as well as the recently launched new national media monitoring programme for mental health and suicide (Headline) are highly commended and supported by the Project Team.

## Young People

**10.8** ● While this report has outlined some of the many vulnerable groups with mental health needs who are at risk of social exclusion, the Project Team considers that young people, in particular, warrant urgent action at this time. They are a huge demographic group with vulnerabilities to mental ill-health and suicide. There is a window of opportunity before onset of mental ill-health where early intervention and support could make a significant impact. Furthermore, there are barriers of access to services for this group which could be overcome with appropriate action. For this reason, the Project Team recommends the following actions:

- a) More creative ways of reaching young people are needed. Innovative projects, such as drop-in centres and information sources, should be developed and supported, for example, the Gaf in Galway and the website, Spun Out. These create open and friendly gateways for young people to access a wide range of services, including specialised mental health supports. They should also involve young people in their work and implement a partnership approach with all relevant stakeholders in their activities.

<sup>63</sup> The programme for Government 2007-2012 includes a commitment to increase the number of educational psychologists in the NEPS service to 200 by 2009

- b) Early intervention initiatives which are evidence-based should be supported nationally, particularly for children and young adults to aid recovery and to tackle the increase of mental health problems in all age groups.
- c) The youth sector, including both statutory and community and voluntary groups, working with adolescents and early school-leavers, should be supported more in developing training and support materials on mental health promotion and suicide prevention as well as enhanced social and personal development and life skills programmes, specifically targeted at children and young people.

### The Workplace and Supported Employment

- 10.9 ● Irish companies need to have better policies in place to respond to the mental health needs of their employees. This will entail promoting positive mental health across the workforce and responding when individual employees experience difficulties. Training and guidance for employers are not widely promoted or sufficiently specific on mental ill-health. However, most employers would welcome guidance and information in this area. There are many positive examples of good practice and policy initiatives which could help, such as charters, incentive schemes and encouraging action as part of corporate social responsibility.
- 10.10 ● Most people with severe and enduring mental ill-health, however, are not in employment and are at risk of greater social exclusion. This is despite work being long regarded as an important facet to mental health. The Project Team notes that meaningful occupation, whether paid or unpaid, is central to recovery and recognises that full social inclusion and participation in society is the key goal here, whether in or outside the labour market. Nevertheless, work remains a key route to social inclusion for many.
- 10.11 ● The provision of training, rehabilitation and employment services has tended to be locally driven and has not developed strategically at national level. Moreover, useful information is lacking on the availability of rehabilitative, training and employment opportunities. While there are programmes and supported employment schemes available, little is known about their effectiveness, quality or suitability. There are many examples of good practice outlined in the report; one of these is the Clubhouse Model.

The Project Team recommends the following:

- a) Under the aegis of *Partnership 2016*, the Department of the Taoiseach should arrange for the social partners to draw up and agree a Health and Well-being Framework Strategy for the Workplace. Elements for inclusion in such a strategy should include:

- Guidelines and information on good practice for the employment of people with mental difficulties designed, inter alia, to overcome employer reluctance in recruitment, stigma, disclosure, stress management, counselling, recovery and more generally to put procedures in place for managing staff with mental health problems;
  - A particular focus of this should be on the development of return-to-work strategies in consultation with employers; in addition to better and improved access to education and training packages. Incentive schemes such as the Back-to-Work Scheme should be reviewed to improve their effectiveness, taking into account the special needs and extra costs that people with mental difficulties have to incur;
  - The social partners to participate and support campaigns to raise awareness and challenge stigma, along the lines of the present campaign to tackle bullying in the workplace; and
  - Guidelines, incentives and programmes to support people with mental health problems to stay in employment through, for example, adapted or flexible work schemes and schedules.
- b) The Health and Safety Authority, in consultation with other bodies such as the National Disability Authority, the Health Services Executive, the Mental Health Commission and the Equality Authority, should prepare a code of practice for employers and employees on their statutory obligations and duties of care and procedures in relation to health, safety or welfare.
- c) The Project Team recommends that an integrated strategic plan for the delivery of training, work and employment services for people with mental ill-health should be given priority attention by the cross-departmental team, as recommended above. As part of this plan, the Supported Employment Model (placement in competitive employment while offering on the job support) should be adopted where possible in all back-to-work initiatives.
- d) FÁS should review the reasons for low take-up of some of its training and employment schemes, in consultation with employers and employees, and on this basis, introduce better targeted and more effective programmes, particularly for people recovering from mental ill-health.
- e) With the precedent of the existing 3% target for employing people with a disability in the public sector, the Project Team recommends that statutory bodies such as the Health Services Executive, the National Disability Authority, the Mental Health Commission and the Equality Authority should lead by example by setting targets for employing people specifically with mental ill-health in their own organisations. The private sector should be encouraged to follow suit, and as mentioned in the report, awards, charters and special incentives can be effective in this regard.

- f) More and better training on the specific needs of people with mental ill health is needed for the staff in the above bodies.
- g) Employers should be encouraged to undertake training and employment initiatives as part of their corporate social responsibilities (drawing on the experience of the King's Fund in the UK).
- h) The pay and working conditions for those in sheltered employment should be reviewed by the HSE in conjunction with the Departments of Health and Children and Enterprise, Trade and Employment.

### Integrated Services

- 10.12 ● Provision of integrated services can be more effective and is key to tackling social exclusion and mental ill-health. At present, there is no co-ordinated strategy at the individual, social and structural level to link together employment, housing and mental health services. Vocational services need to be more closely integrated with mental health services. To this end, key Departments and agencies should take greater responsibility for the non-health aspects of mental health prevention.

The Project Team recommends the following:

- a) Vocational support for people with mental health needs should be available within primary care and community mental health services as part of a supported employment model.
- b) Person-centered and integrated services with appropriate interdisciplinary input, including counseling; social work; nursing; vocational expertise; and occupational therapy should be provided at primary care level, with the development of 'one-stop-points of contact' and simpler forms and less bureaucracy.
- c) These services should be underpinned with case management approaches, action plans, mapping, targeting of disadvantaged groups, along the lines advocated in the recent NESF report on *Improving the Delivery of Quality Public Services* (NESF Report No. 34, 2007a).
- d) The current development of primary care provides a unique opportunity to co-ordinate the functions and actions of Community Mental Health Teams, Community Outreach Services and Primary Care Teams in a person-centered manner.
- e) These integrated teams should be adequately resourced, in terms of both staff and budgets, with their primary focus on community care as far as possible and away from medication and long-term stay in institutions.



- f) Mental health professionals need to move towards a recovery model of treatment. Barriers to this should be addressed through: training and continuing education for GPs, other medical staff, pharmacists, etc; integration of medical with non-medical services; gender awareness training for medical students; recovery- oriented practices and care; and with the participation of service users, their families, carers and advocacy groups.
- g) Provision of step-down services, by both statutory and voluntary bodies, are needed, including housing, day-care facilities, social outlets, housing, training and social supports for vulnerable groups and individuals recovering from mental ill-health.
- h) Suitable housing and accommodation is important to the recovery process. The Department of Environment, Heritage and Local Government and the local authorities should play a stronger role to ensure increased housing accommodation, with greater flexibility to more adequately meet needs. A co-ordinated response from statutory bodies and voluntary agencies is essential for this purpose as part of the *National Housing Strategy for People with Disabilities*, recognising the particular barriers of stigma in relation to mental ill-health. Furthermore, housing is more than bricks and mortar and housing provision should be integrated with appropriate social and resettlement supports, where needed.

## Community Development

- 10.13 ● There are key social and community activities that can enhance positive mental health in terms of social capital and an individual's social inclusion and mental health recovery. Strengthening and broadening social networks is a key part of increasing social inclusion: networks can perform a buffer role for stress as well as creating opportunities for meaningful social engagement and personal development, and in turn, reduce social isolation. The community and voluntary sector is currently making a valuable contribution in supporting mental health services in this transition period from institutional to community care as agreed in *A Vision for Change*.

The Project Team recommends the following:

- a) Community development and local support networks, such as those already supported under the Community Development Programme and the Local Development Social Inclusion Programmes, should be further developed and resourced by the Department of Community, Rural and Gaeltacht Affairs, with the involvement of the community and voluntary sector. Innovative approaches to community development should be fostered and supported such as new ways of involving communities, creating links between local businesses and residential areas, greater links between mental health support services and the wider community.

- b) To that end, (i) an audit of public services, and of existing work by community groups in this area, should be resourced and supported, with particular reference to successful pilot projects, in order to tackle the gaps in meeting current levels of need; and (ii) a guide for more structured support for this work should be prepared by the Department of Community, Rural and Gaeltacht Affairs, setting out clear effective steps by local communities to support the needs of those in recovery.
- c) In addition, further development of community support services such as volunteering, befriending, mentoring programmes and peer groups should be supported and encouraged in local communities in tandem with the community and voluntary sector and official bodies such as Pobal, the Area Partnerships and Leader. These support services should also include targeted initiatives for vulnerable groups in the community.



# References

## References

- Amárach Consulting (2004), *Quality of Life in Ireland*. Report prepared for Diageo Ireland. Dublin: Amárach Consulting.
- Amnesty International (2003), *Mental Illness: The Neglected Quarter-Summary*. Dublin: Amnesty International (Irish Section).
- Amnesty International (2003a), *Mental Illness: The Neglected Quarter-Children*. Dublin: Amnesty International (Irish Section).
- Amnesty International (2003b), *Mental Illness: The Neglected Quarter-Homelessness*. Dublin: Amnesty International (Irish Section).
- Amnesty International (2003c), *Mental Illness: The Neglected Quarter-Marginalised Groups*. Dublin: Amnesty International (Irish Section).
- Anthony, W. A., Howell, J., and Danley, K. S. (1984), Vocational rehabilitation of the psychiatrically disabled. In M. Mirabi (Ed.), *The chronically Mentally Ill: Research and Services* (pp. 215–237). Jamaica, NY: Spectrum Publications. Cited in Marwaha and Johnson (2004) op. cit.
- APU/UCLAN Research Team (2005), *Mental Health, Social Inclusion and Arts: Developing the Evidence Base*. Final Report from Phase 1: The State of the Art in England. Chelmsford: Anglia Polytechnic University.
- Aslam, A. and Corrado, L. (2007), *No Man is an Island: The Inter-personal Determinants of Regional Well-Being in Europe*. Cambridge: University of Cambridge.
- Australian Centre for Health Programme Evaluation (2002), *Mental Health and Illness in the Media: A Review of the Literature*. Melbourne: Australian Centre for Health Programme Evaluation.
- The Bamford Review (2006), *Mental Health Improvement and Well-being: A Personal, Public and Political Issue*. Belfast: The Bamford Review of Mental Health and Learning Disability.
- Barnardos (2006), *An Evaluation of the Da Project*. Written by Working with Men. Dublin: Barnardos.
- Barry, M. (2005), Creating a mentally healthy society: lessons from a cross-border rural mental health project in Ireland. *Journal of Public Mental Health*, 2(4), 26–36.
- Barry, M. (2003), Designing an evaluation framework for community mental health promotion. *Journal of Mental Health Promotion*, 4(1), 30–4.
- Barry, M. and Jenkins, R. (2007), *Implementing Mental Health Promotion*. London: Churchill Livingstone Elsevier.
- Barry, M. Friel, S. Dempsey, C. Avalos, G. and Clarke, P. (2002), *Promoting Mental Health and Social Well-being: Cross-border Opportunities and Challenges*. Armagh: The Centre for Cross Border Studies and the Institute of Public Health in Ireland.
- Batt, V. and Nic Gabhainn, S. (2002), *Perspectives on the Provision of Counselling for Women in Ireland*. Dublin: The Women's Health Council.
- Battersby, M.W. (2004), Commentary: Community models of mental care warrant more government support. *British Medical Journal*, 329, 1140–1141. Cited in Department of Health and Children (2006) op. cit.
- Beard, J.H., Propst, R.N. and Malmud, T.J. (1982), The Fountain House model of psychiatric rehabilitation. *Psychosocial Rehabilitation Journal*, 1, 47–53.
- Becker, D.R. and Drake, R.E. (1993), *A Working Life: The Individual Placement and Support (IPS) Program*. Concord, NH, New Hampshire-Dartmouth Psychiatric Research Center. Cited in Bond et al (2001) op. cit.
- Beem, C. (1999), *The Necessity of Politics: Reclaiming American Public Life*, Chicago: University of Chicago Press. Cited in Smith (2001) op. cit.
- Bergin, M. and Clarke, J. (2005), Mental health in the community. In Quin and Redmond (2005) op. cit.
- Bergin, M. (1998), *A Descriptive Study of the Work of Community Psychiatric Nurses*. Unpublished MMedSci thesis, Dublin: UCD. Cited in Quin and Redmond (2005) op. cit.
- Black Report (1980), *Inequalities in Health: Report of the Research Working Group*. London: HMSO.

- Bond, G.R. (2004), Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal* 27 (4), 345.
- Bond, G.R., Becker, D.R., Drake, R. E., Rapp, C.A., Meisler, N., Lehman, A.F., Bell, M.D. and Blyler, C. R. (2001), Implementing supported employment as an evidence-based practice. *Psychiatric Services*, Vol. 52 (3): 313–322.
- Bradley, N. (2006), *Rural Isolation: Men's Education and Health. The Personal Reflections of an Outreach Worker*. Co. Donegal: Mevagh Resource Centre.
- British Occupational Health Research Foundation (2005), *Workplace Interventions for People with Common Mental Health Problems: Evidence Review and Recommendations*. London: British Occupational Health Research Foundation
- Brosnan, L. (2006), *What Part of the picture? Perspectives of Service Users and Carers on Partnerships within Mental Health Service*. Galway: The Western Alliance for Mental Health.
- Brosnan, L., Collins, S., Dempsey, H. Maguire, L., Maria, Morrin, N. (2002), *Pathways: Experiences of Mental Health Services from a User-Led Perspective*. Galway: Western Health Board and Schizophrenia Ireland.
- Burton, P. and Harrison, L. (1996), *Identifying Local Health Needs: New Community-Based Approaches*. Bristol: Policy Press.
- CAIRDE (2006), *Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin's North Inner City: A Case Study of a Community Development Approach to Health Needs Assessment*. Dublin: CAIRDE.
- Cameron, M., Edmans, T., Greatley, A. and Morris, D. (2003), *Community Renewal and Mental Health: Strengthening the Links*. London: King's Fund and the National Institute of Mental Health in England.
- Caplan, R. D., Vinokur, A. D. and Price, R. H. (1997), From job loss to reemployment: Field experiments in prevention-focused coping. In G.W. Albee and T.P. Gullotta (Eds.), *Primary Prevention Works*. pp. 341–379. Thousand Oaks: Sage.
- Centre for Health Promotion Studies Galway (2003), *SLAN Survey of Lifestyle, Attitudes and Nutrition 2002*. Galway: National University of Ireland.
- Chappell, N. and Funk, L. (2004), Lay perceptions of neighbourhood health. *Health and Social Care in the Community* 12 (3) 243–253.
- Clinch, P., Ferreira, S., Brereton, F., Moro, M and Bullock, C. (2006), Understanding and measuring quality of life in Ireland: sustainability, happiness and well-being. Briefing paper for Comhar Conference *Towards Sustainability in the National Development Plan 2007–2013*. 4th to 6th October 2006.
- Cohen, G. (2005), *The Creativity and Aging Study Final Report: The Impact of Professionally Conducted Cultural Programs on Older Adults*. NEA Study. Brooklyn, NY: National Centre for Creating Aging.
- Combat Poverty Agency (2006), *The Role of Community Development in Tackling Poverty in Ireland: A Literature Review for the Combat Poverty Agency*. Dublin: Combat Poverty Agency.
- Combat Poverty Agency (2006a), *Financial Exclusion in Ireland: An Exploratory Study and Policy Review*. Dublin: Combat Poverty Agency.
- Combat Poverty Agency (2000), *The Role of Community Development in Tackling Poverty*. Dublin: Combat Poverty Agency. Cited in Combat Poverty Agency (2006) op. cit. p. 2
- Committee into Current Care and Treatment Practices in the Central Mental Hospital (2007), *Report of the Committee into Current Care and Treatment Practices in the Central Mental Hospital 2006*. Dublin: Mental Health Commission.
- Condon, M. (2001), (Ed.). *The Health and Dental Needs of Homeless People in Dublin*. Dublin: Northern Area Health Board.
- Conroy, P. (2005), *Mental health and the workplace*. In Quin and Redmond op. cit.
- Constantopoulos, A. (2006), Steering Paper. 2nd Thematic meeting on the Commission Green Paper on Mental Health, *Social Inclusion and Fundamental Rights in Mental Health*, Vienna, 16 - 17th March, 2006.

- Coptly, M. and Whitford, D. L. (2005), Mental health in general practice: Assessment of current state and future needs. *Irish Journal of Psychological Medicine*, 22 (3), 83–86.
- Cox, R. and Findlay, G. (1990), *Cambridge Community Development Project: Review of Achievements so far*. Cambridge Health Promotion Service. Cited in Burton and Harrison (1996) op. cit. p.31.
- Crowther, R.E., Marshall, M., Bond, G.R. and Huxley, P. (2001), Helping people with severe mental illness to obtain work: systematic review. *British Medical Journal*, Vol. 322, 27.
- Cryan, E. (2000), Women and depression: The mental health perspective: Clinical symptoms and treatment. Proceedings of the conference, *Mental Health and the Workplace: Challenges and Opportunities*. Trinity College Dublin, 13th March 2000.
- CSIP (2007), *Mental Well-being Impact Assessment: A Toolkit*. Cheshire: Care Services Improvement Partnership, North West.
- CSO (Central Statistics Office) (2006), *EU Survey on Income and Living Conditions*. Dublin: Stationery Office.
- CSO (Central Statistics Office) (2007), *Vital Statistics Yearly Summary 2006, Quarterly National Household Survey*. Dublin: Stationery Office.
- CSO (2002), *Statistical Yearbook of Ireland*. Dublin: Stationery Office.
- Cunningham, K., Wolbert, R. And Brockmeier, M.B. (2000), Moving beyond the illness: Factors contributing to gaining and maintaining employment. *American Journal of Community Psychology*, 28: 481–494. Cited in Marwaha and Johnson (2004) op. Cit.
- Daly, A. and Walsh, D. (2006), *Irish Psychiatric Units and Hospitals Census 2006*. Dublin: Health Research Board.
- Daly, A., Walsh, D., Comish, J., Kartolova O'Doherty, Y., Moran, R. and O'Reilly, A. (2005), *Activities of Irish Psychiatric Units and Hospitals 2004*. Dublin: Mental Health Research Division, Health Research Board.
- Dein, S. (1997), ABC of mental health: Mental health in a multiethnic society. *British Medical Journal*, 315:473-476.
- Department of the Environment, Heritage and Local Government (2006), *Delivering Homes Sustaining Communities- Statement on Housing Policy*. Dublin: The Stationery Office.
- Department of the Environment, Heritage and Local Government (2006b), *Homelessness: An Integrated Strategy*. Dublin: The Stationery Office.
- Department of Health (UK) (2001), *Making it Happen: A Guide to Delivering Mental Health Promotion*. London: HMSO.
- Department of Health (1966), *Report of the Commission of Inquiry on Mental Illness*. Dublin: The Stationery Office.
- Department of Health and Children (2006), *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: The Stationery Office.
- Department of Health and Children (2006a), *Action Plan Progress Report. Quality and Fairness: A Health System for You 2005*. Dublin: The Stationery Office.
- Department of Health and Children (2005), *Reach Out: National Strategy for Action on Suicide Prevention*. Dublin: The Stationery Office.
- Department of Health and Children (2004), *Review of the National Health Promotion Strategy*. Dublin: The Stationery Office.
- Department of Health and Children (2004a), *Guidelines for Community Development in Health: Position Paper*. Dublin: The Stationery Office.
- Department of Health and Children (2004b), *The National Primary Care Steering Group-Progress Report*. Dublin: The Stationery Office.
- Department of Health and Children (2001), *Quality and Fairness: A Health System for You*. Dublin: The Stationery Office.
- Department of Health and Children (2001a), *Primary Care: A New Direction*. Dublin: The Stationery Office.
- Department of Health and Children (2000), *National Health Promotion Strategy 2000–2005*. Dublin: The Stationery Office.
- Department of Health and Children (1984), *Planning for the Future*. Dublin: The Stationery Office.

- Department of Health, Social Services and Public Services (2003), *Promoting Mental Health: Strategy and Action Plan 2003–2008*. Belfast: Department of Health, Social Services and Public Services.
- Department of Justice, Equality and Law Reform (2007), *The National Women's Strategy (2007–2016)*. Dublin: Government of Ireland.
- Dillon, B. and Collins, E. (2004), *Strategies to Promote the Mental Health of Lesbians and Gay Men*. Gay HIV Strategies and Health Promotion Department. Northern Area Health Board.
- Disability Rights Alliance (2006), *Response to the Green Paper A New Deal for Welfare: Empowering People to Work*. London: Disability Rights Alliance.
- Dobbins, T. (2000), *Managing the Work-Life Balance*. European Industrial Relations Observatory On-Line. <http://www.eurofound.europa.eu/eiro/2000/09/feature/ie0009155f.html>
- Downie, R.S., Fyfe, C. and Tannahill, A. (1990), *Health Promotion Models and Values*. Oxford, England: Oxford University Press.
- Drake, R. E., Becker, D.R. and Bond, G.R. (2003), Recent research on vocational rehabilitation for persons with severe mental illness. *Current Opinion in Psychiatry*, 16, 451–455.
- Dublin City Council/Communities First Taskforce (2007), *Bowling Together Alone: An Action Plan for Social Capital and Active Citizenship in Dublin City*. Dublin: Dublin City Council.
- Duggan, M. (2002), Modernising the social model in mental health: a discussion paper. SPN paper 1. *Social Perspectives Network for Modern Mental Health*. With Cooper, A. and Foster, J. London: Social Perspectives Network.
- Dunn, J. (2002), *A Population Health Approach To Housing: A Framework for Research*. Ottawa: Canada Mortgage and Housing Corporation and the National Housing Research Committee
- Dunne, E. (2006), *The Views of Adult Users of the Public Sector Mental Health Services*. Dublin: Mental Health Commission.
- Durkheim, E. (1897), *Le Suicide*. Paris: Alcan.
- Eardly, J. (2002), *Bullying and Stress in the Workplace: Employers and Employees – A Guide*. Dublin: FirstLaw Limited.
- Eckersley, R. (2006), What's wrong with the official future? In G. Hassan (Ed). *After Blair: Politics After the New Labour Decade*. London: Lawrence and Wishart.
- Elliott, I. (2005), *Health Promotion and Mental Health*. In Quin and Redmond *op. cit.*
- Ellison, C. G., and Levin, J. (1998), The religion-health connection: Evidence, theory, and future directions. *Health Education and Behavior*. 25: 700–720.
- ESRI (2006), *Fair Play? Sport and Social Disadvantage in Ireland*. Dublin: Economic and Social Research Institute.
- ESRI (2007), *Bullying in the Workplace: Survey Reports*. Written by P. O'Connell, E. Calvert and D. Watson. Dublin: Economic and Social Research Institute
- European Anti-Poverty Network Ireland (2007), *Flash no. 179*. Dublin: EAPN Ireland.
- European Centre for Health Policy (1999), *Health Impact Assessment: Main Concepts and Suggested Approach*. WHO Europe. Brussels: ECHP.
- European Commission (2006), *Mental Well-being. Special Eurobarometer 248*. Brussels: European Commission.
- European Commission (2005), *Green paper: Improving the mental health of the population: Towards a strategy on mental health for the European Union*. Brussels: Health and Consumer Protection Directorate, European Commission.
- European Commission (2004), *The State of Mental Health in the European Union*. Brussels: European Commission.
- European Commission (2003), *The Social Situation in the European Union. Luxembourg*: European Commission.
- European Commission (2000), *Guidance on Work-Related Stress. Spice of Life, or Kiss of Death?* Luxembourg: Office for Official Publications of the European Communities.



- European Foundation for the Improvement of Living and Working Conditions (2006), *Employment Guidance Services for People with Disabilities*. Loughlinstown: European Foundation for the Improvement of Living and Working Conditions.
- Evans, G. (2004), The environment of childhood poverty. *American Psychologist*, 59, 2, 77–92.
- Evans, J. and Repper, J. (2000), Employment, social inclusion and mental health. *Journal of Psychiatric and Mental Health Nursing*, 7, 15–24.
- Evans, R.G. and Stoddart, G.L. (2003), Consuming research, producing policy. *American Journal of Public Health*, 93(3):371–379. Cited in WHO (2005) op. cit.
- E.V.E. Limited. (2004), *Just Ask! A Handbook for Employers and Employees*. Dublin: Eastern Vocational Enterprises Limited.
- Fahey, T. (2007), How do we feel? Economic boom and happiness. In T. Fahey, H. Russell and C.T. Whelan (Eds.) *Best of Times? The Social Impact of the Celtic Tiger*. Dublin: Institute of Public Administration.
- Fakhoury, W. and Priebe, S. (2002), The process of deinstitutionalization: an international overview. *Current Opinion in Psychiatry* 15: 187–192 Cited in Bergin and Clarke (2005) op. cit.
- Feeney, A., McGee, H.M., Holohan, T. And Shannon, W. (2000), *Health of Hostel-dwelling Men in Dublin*. Dublin: Royal College of Surgeons in Ireland.
- Ferguson, D.M., L.J. Horwood, and A.L. Beautrais. (1999), Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry* 56 (October):876.
- Fine-Davis, M., McCarthy, M., Edge, G., O'Dwyer, C. (2005), *Mental Health and Employment: Promoting Social Inclusion in the Workplace*. National Flexi-work Partnership work-life balance project/EQUAL Community Initiative. Dublin: Centre for Gender and Women's Studies Trinity College.
- Fine-Davis, M. and McCarthy, M. (1998), *Trinity Horizon Project*. Dublin: Centre for Women's Studies, Trinity College.
- Finnish Ministry of Social Affairs and Health (2006), *Health in All Policies: Prospects and Potential*. Finland: Ministry of Social Affairs and Health.
- Fitzgerald, M. (2007), Celtic tiger: Child and adolescent mental health. Presentation made to the *IMO Conference*, Killarney, 13th April, 2007.
- Fratiglioni, L., Wang, H., Ericsson, M. Maytan and B. Winblad. (2000), Influence of social network on occurrence of dementia: a community-based longitudinal study. *The Lancet*, Volume 355, Issue 9212; 1315–1319.
- Frazer, E. (2000), Communitarianism. In G. Browning, A. Halcli and F. Webster (Eds.) *Understanding Contemporary Society: Theories of the Present*. London: Sage. Cited in Smith (2001) op. cit.
- Frese, F., Stanley, J., Kress, K. and Vogel-Scibilia, S. (2001), Integrating evidence-based practices and the recovery model. *Psychiatric Services*, 52:1462–1468.
- Fryers, T., Melzer, D. And Jenkins, R. (2003), Social inequalities and the common mental disorders: a systematic review of the evidence. *Social Psychiatry and Psychiatric Epidemiology* 38 (5): 229–37. Cited in Gould (2005) op. cit.
- Gaining Ground (2007), *Ground Gained: A Participatory Action Research Report on Mental Health in Tallaght*. Dublin: Gaining Ground.
- Galloway, J. (1991), *The Trick is to Keep Breathing*. London: Minerva. Cited in Evans and Repper (2000) op. cit.
- Gannon, B. and Nolan, B. (2007), *The Dynamics of Disability and Social Inclusion*. Dublin: The Equality Authority and The National Disability Authority.
- Gilbody, P. (2004), *What is the evidence on effectiveness of capacity building of the primary health care professional in the detection, management and outcome of depression?* WHO Regional Office for Europe's Health Evidence Network (HEN). Copenhagen: WHO Regional Office for Europe.
- Gilligan, R. (2000), Promoting resilience in children in foster care. In G., Kelly and R., Gilligan R (Eds), *Issues in Foster Care: Policy, Practice and Research*. London: Jessica Kingsley.

- Goldberg, K., Norman, R., Hoch, J., Schmitz, N., Windell, D., Brown, N. and Malla, A. (2006), Impact of a specialized early intervention service for psychotic disorders on patient characteristics, service use and hospital costs in a defined catchment area. *Canadian Journal of Psychiatry*, 51, No. 14: 895–903.
- Gould, N. (2005), International trends in mental health policy. In Quin and Redmond (2005), op. cit.
- Government of Ireland (2007), *NAPinclusion/ National Action Plan for Social Inclusion*. Dublin: The Stationery Office.
- Government of Ireland (2007a), National Development Plan 2007–2013 *Transforming Ireland – a better Quality of Life for All*. Dublin: The Stationery Office.
- Government of Ireland (2007b), *National Women's Strategy 2007–2016*. Dublin: The Stationery Office.
- Government of Ireland (2006), *Towards 2016. Ten Year Framework Social Partnership Agreement 2006–2016*. Dublin: The Stationery Office.
- Government of Ireland (2006a), *Citizens Information Bill*. Dublin: Stationery Office.
- Government of Ireland (2005), *Safety, Health and Welfare at Work Act*. Dublin: Stationery Office.
- Government of Ireland (2005a), *Disability Act*. Dublin: Stationery Office.
- Government of Ireland (2004), *Education for Persons with Special Educational Needs Act*. Dublin: Stationery Office.
- Government of Ireland (2004a), *Equal Status Act*. Dublin: Stationery Office.
- Government of Ireland (2001), *Mental Health Act*. Dublin: Stationery Office.
- Government of Ireland (2000), *Equality Act*. Dublin: Stationery Office.
- Government of Ireland (1998), *Employment Equality Act*. Dublin: Stationery Office.
- Government of Ireland (1989), *Safety, Health and Welfare at Work Act*. Dublin: Stationery Office.
- GROW (2003), *Soul Survivors: Volume Two*. Dublin: GROW.
- GROW (1996), *Soul Survivors: Volume One*. Dublin: GROW.
- Hayes, C. and Morgan, M. (2005), Evaluation of a psycho-educational program to help adolescents cope. *Journal of Youth and Adolescence*, 34, 111–121.
- Health and Safety Authority (2007), *Code of Practice for Employers and Employees on the Prevention and Resolution of Bullying at Work*. Dublin: HSA.
- Health and Safety Authority (2002), *Work Related Stress: A Guide for Employers*. Dublin: HSA.
- Health and Safety Executive (2006), *2005/06 survey of Self-reported Work-related Illness*. London: Health and Safety Executive.
- Health Development Agency (2000), *Art for health: A review of good practice in community-based arts projects and initiatives which impact on health and well-being*. London: Health Development Agency.
- Health Research Board (2007), *Happy Living Here... A Survey and Evaluation of Community Residential Mental Health Services in Ireland*. Dublin: Mental Health Commission.
- Health Research Board (2006), *Family Support Study: A Study of Experiences, Needs and Support Requirements of Families with Enduring Mental Illness in Ireland*. Dublin: Health Research Board.
- The Healthy Ageing Project (2007), *Healthy Ageing: A Challenge for Europe*. Stockholm: The Swedish National Institute of Public Health.
- Healy, T. (2005), *Social capital and well-being in Ireland*. Presented at the Annual Conference of Religious in Ireland Conference on Social Policy, 4 October 2005.
- Homeless Agency (2007), *A Key to the Door: The Homeless Agency Partnership Action Plan on Homelessness in Dublin 2007–2010*. Dublin: Homeless Agency.
- Homeless Agency (2007a), Holistic needs assessment and care plan. *Cornerstone*. March, 30; 4. Dublin: Homeless Agency.
- Hooper, R. (1996), Adult education for mental health: A study in innovation and partnership. *Adults Learning*. November, 71–74. Cited in Evans and Repper (2000) op. cit.
- HSE (forthcoming), *National Intercultural Health Strategy 2007–2012*. Draft. Dublin: Health Service Executive.
- HSE South Western Area and Irish College of General Practitioners (2004), *Mental Health and Primary Care Report*. Dublin: Irish College of General Practitioners.

- HSE West (2006), *Addressing the Mental Health Needs of Minority Ethnic Groups and Asylum Seekers in Ireland*. Report from the National Conference. HSE West, 31st January, 2006.
- Huxley, P and Evans, S. (2001), Regenerating minds. *Community Care*, November, pp. 8–14. Cited in Cameron *et al* (2003) op. cit.: 15.
- ILO (2001), *Code of Practice on Managing Disability in the Workplace*. Geneva: International Labour Office.
- ILO (2000), *Mental Health in the Workplace*. Geneva: International Labour Office.
- Independent Monitoring Group (2007), *A Vision for Change: First Report on Implementation*. Dublin: Independent Monitoring Group.
- Inspectorate of Mental Health Services (2007), *Report of the Inspector of Mental Health Services 2006*. Dublin: Mental Health Commission.
- Institute of Psychiatry (2006), *Evaluation of Capital Volunteering: Interim Report on the First 60 Participants*. London: Kings College London.
- Institute of Public Health (2005), *One Island, Two Systems. Health and Social Services for Older People in Northern Ireland and the Republic of Ireland*. Dublin: Institute of Public Health in Ireland.
- The Institute of Public Health in Ireland (2006), *Health Impacts of the Built Environment: a Review*. Dublin: The Institute of Public Health in Ireland.
- The Institute of Public Health in Ireland (2003), *Inequalities in Perceived Health: A Report on the All-Ireland Social Capital and Health Survey*. Written by Kevin Balanda and Jane Wilde. Dublin: The Institute of Public Health in Ireland.
- The Institute for Public Policy Research (2005), *Fit for Purpose: The Reform of Incapacity Benefit*. London: Institute for Public Policy Research.
- The Irish Psychiatric Association (2007), *Vision in Hindsight: One year progress Report of a vision for change*. Dublin: Irish Psychiatric Association.
- The Irish Times (2007), *Dismay at Mental Health Services*. Article by Eithne Donnellan, 21/06/07, The Irish Times.
- Jacobson, N., and Curtis, L. (2000), Recovery as a policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, 23(4) 333–341.
- Jahoda, M. (1982), *Employment and unemployment: a social psychological analysis*. Cambridge: Cambridge University Press.
- Jané-Llopis, E. and Anderson, P. (2005), *Mental Health Promotion and Mental Disorder Prevention. A policy for Europe*. Nijmegen: Radboud University Nijmegen.
- Joint Committee on Health and Children (2006), *The High Level of Suicide in Irish Society*. Dublin: Oireachtas Joint Committee on Health and Children.
- Kagan, C. and Lewis, S. (1998), Editorial. *Community, Work and Family*. 1, 5–9.
- Katschnig, H. (2006), Quality of life in mental disorders: challenges for research and clinical practice, *World Psychiatry*. 2006 October; 5(3): 139–145.
- Katschnig, H. (1997), How useful is the concept of quality of life in psychiatry? In H. Katschnig, H. Freeman and M. Sartorius (Eds.) *Quality of Life in Mental Disorders*. New York: Wiley. Cited in Gould (2005) op. cit. p.18.
- Kay, A. (2006), Social capital, the social economy and community development. *Community Development Journal* 41 (2) 160–173.
- Kelleher, C. (2006), Determinants of social disadvantage. Presented at the *Tackling Poverty and Health Inequalities – A Social Determinants Approach Conference*. Combat Poverty Agency and the Institute of Public Health in Ireland, 20th September 2006.
- Kennedy, A. (2003), *Insight: Case Studies in Community Development and health in Scotland*. Edinburgh: NHS Scotland.
- Kennedy, H.G., Monks, S., Curtin, K., Wright, B., Linehan, S., Duffy, D., Teljeur, C. and Kelly, A. (2004), *Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners*. Dublin: National Forensic Mental Health Service.

- Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R. and Walters, E.E. (2005), Lifetime prevalence and age-of-onset distributions of SDSM-IV disorders in the National Co-morbidity Survey Replication. *Archives of General Psychiatry*. 62: 593–602.
- Keyes, C. L. M. (2005), Mental health and/or mental illness? Investigating axioms of the complete state model of health. *Journal of Consulting and Clinical Psychology*. Vo. 73, No. 3, 539–548.
- King's Fund (2000), *Briefing Note: Age Discrimination in Health and Social Care*. London: King's Fund.
- Kruger, A. (2000), Schizophrenia, recovery and hope. *Psychiatric Rehabilitation Journal*. 24: 1: 29–37.
- Laffan, C. (2006), *Estimates of the mobility of mental health: Results based on a binary health measure and Irish micro-data*. Unpublished paper. Downloaded January 2007 from <http://www.edge-page.net/jamb2006/paper/Laffan.pdf>.
- Lahtinen, E., Lehtinen, V., Riihonen, E. And Ahonen, Ju. (1999), (Eds.) *Framework for Promoting Mental Health in Europe*. Helsinki; National Research and Development Centre for Welfare and Health (STAKES) Cited in WHO (2005) op. cit.
- Lamb, M.E. (2004), (Ed.) *The Role of the Father in Child Development*. New Jersey: John Wiley and Sons. Cited in McKeown and Haase (2006) op. cit.
- Lansdowne Market Research (2006), *Lundbeck survey: Stigma and Mental Health*. Dublin: Lansdowne Market Research Ltd.
- Layard, R. (2006), *The Depression Report: A New Deal for Depression and Anxiety Disorders*. London: London School of Economics.
- Layard, R. (2005), *Happiness. Lessons from a new science*. London: Allen Lane.
- Layard, R. (2004), *Mental Health: Britain's Biggest Social Problem?* London: Cabinet Office Strategy Unit.
- Layte, R., Nolan, A. and Nolan, B. (2007), Health and health care. In T. Fahey, H. Russell and C.T. Whelan (Eds.) *Best of Times? The Social Impact of the Celtic Tiger*. Dublin: Institute of Public Administration.
- Lee, D. and Newby H. (1983), *The Problem of Sociology: An Introduction to the Discipline*, London: Unwin Hyman.
- Lehtinen, V., Sohlman, B. and Kovess-Masfety, V. (2005), Level of positive mental health in the European Union: Results from the Eurobarometer 2002 survey. *Clinical Practice and Epidemiology in Mental Health*, 1: 9.
- Longest, B. (2006), The community development potential of large health service Organisations. *Community Development Journal* 41 (1) 89–103.
- Maguire, A. (1995), Depression and stress. *Consumer Choice*, August. Cited in Fine-Davis and McCarthy (1998) op. cit.
- Maguire, M. and O'Connell, T. (2007), Ill-health retirement of schoolteachers in the Republic of Ireland. *Occupational Medicine*. 57(3):191–193.
- Mahony, P., Millar, M. and Barry, M. (2003), *International Literature and Policy Review on the Links between Poverty and Health, and of Community Development Approaches to Tackling Health Inequalities*. NUI Galway: Unpublished Report for the Combat Poverty Agency.
- Mancini, A., Finnerty, M., Dornan, D. and Felton, C. (2006), *Defining and Measuring Principles for Recovery-oriented care in Mental Health Organizations*, New York, NY: New York State Office of Mental Health.
- Martin, M., Carr, A., Burke, L., Carroll, L. and Byrne, S. (2006), *Mental Health Service Needs of Children and Adolescents in the South East of Ireland*. Clonmel: HSE South.
- Martin, T. and Associates (2003), *Evaluation of the National Pilot for the Supported Employment Programme*. Dublin: FÁS.
- Marmot, M. and Wilkinson, R. (1999), (Eds.), *The Social Determinants of Health*. Oxford: Oxford University Press. Marwaha, S. and S. Johnson (2004), Schizophrenia and employment: A review. *Social Psychiatry and Psychiatric Epidemiology* 39: 337–349.
- Matarasso, F. (1997), *Use or Ornament? The Social Impact of Participation in the Arts*. Stroud: Comedia.
- McAvoy, B. R. and Murtagh, J. (2003), Workplace bullying. *British Medical Journal*, 326, 776–777.

- McCrone, P., Dhanasiri, S., Knapp, M. (2006), *The impact of early intervention services on mental health care costs*. Unpublished Draft. London: King's College.
- McCulloch, G.F. and Boxer, J. (1997), *Mental Health Promotion, Policy, Practice and Partnerships*. London: Bailliere Tindall.
- McDaid, D. (2004), Mental health and social exclusion: An overview. In K. Thompson Coyle (Ed.) *Public Policy, Poverty and Mental Illness: Opportunities for Improving the Future. Occasional Paper No. 1*. Dublin: Schizophrenia Ireland.
- McDaid, S. (2006), *Equal and Inclusive User Involvement in the Mental Health Services in Ireland: Results from Participatory Action Research*. Dublin: Equality Studies Centre, University College Dublin with Schizophrenia Ireland 'Participating on Committees' Research Group.
- McDaid, D. and Thornicroft, G. (2005), *Policy Brief II: Balancing Institutional and Community-Based Care*. Geneva: World Health Organization 2005, on behalf of the European Observatory on Health Systems and Policies.
- McGorry, P. (2005), Every me and every you: Responding to the hidden challenge of mental illness in Australia. *Australasian Psychiatry*, Vol. 13, No 1, 3–15.
- McGorry, P.D. (2000), The scope for preventative strategies in early psychosis: Logic, evidence and momentum. In M. Birchwood, D. Fowler and C. Jackson (Eds.) *Early Intervention in Psychosis: A Guide to Concepts, Evidence and Interventions*. Chichester: Wiley. Cited in Barry and Jenkins (2007) op. cit.
- McKenzie, K., Whitley, R. and Weich, S. (2002), Social capital and mental health. *British Journal of Psychiatry*, 181, 280–283.
- McKeon, P. and Burke, S. (2006), *Depression in the Workplace: What do Employees tell their Employers?* Dublin: Depression Research Unit, St Patrick's Hospital/AWARE.
- McKeown, K. and Clarke, M. (2004), *Male Mental Health in Ireland*. Dublin: One Foundation.
- McKeown, K. and Haase, T. (2006), *The Mental Health of Children and the Factors Which Influence It: A Study of Families in Ballymun: Summary Report*. Dublin: Young Ballymun.
- McQuilken, M., Zahniser, J.H., Novak, J., Starks, R.D., Olmos, A. and Bond, G.R. (2003), The work project survey: Consumer perspectives on work. *Journal of Vocational Rehabilitation*, 18 (1): 59–68. Cited in Marwha and Johnson 2004 op. cit.
- Melzer, D., Fryers, T., Jenkins, R. (2004), (Eds.) *Social Inequalities and the Distribution of the Common Mental Disorders*. Maudsley Monograph 44. Hove and New York: Psychology Press. Cited in Barry and Jenkins (2007) op. cit.
- Mental Health Commission (2007), *Quality Framework for Mental Health Services in Ireland*. Dublin: Mental Health Commission.
- Mental Health Commission (2007b), *Annual Report 2006 Including the Report of the Inspector of Mental Health Services*. Dublin: Mental Health Commission.
- Mental Health Commission (2006a), *Multidisciplinary Team-working: From Theory to Practice*. Dublin: Mental Health Commission.
- Mental Health Commission (2005), *Annual Report 2005 Including the Report of the Inspector of Mental Health Services*. Dublin: Mental Health Commission.
- Mental Health Commission (2005a), *Reference guide Mental Health Act 2001*. Dublin: Mental Health Commission.
- Mental Health Commission (2005b), *A Vision for a Recovery Model: The Irish Mental Health Services. Discussion Paper*. Dublin: Mental Health Commission.
- Mental Health Economics European Network (2004), *Expenditure across the EU on Mental Health Services*. Cited in European Commission (2005) op. cit.
- Mental Health Europe (2007), *Final Results of the MHE Survey on Personal Budget*. Brussels: Mental Health Europe.
- Mental Health Foundation (2006), *Mental Health Initiative: Executive Summary of the Findings of Four Arts Therapies Trial Services 2003–2005*. Edinburgh: Healthier Scotland, Scottish Executive.

- Mental Health Ireland (2003; 2005), *Attitudes to Mental Illness*. Millward Brown IMS. Dublin: Mental Health Ireland.
- Mental Health Ireland (2001), *Do you feel stressed? A Survey of the General Public*. Dublin: Mental Health Ireland.
- Mentality (2003), *Making it Effective: A Guide to Evidence Based Mental Health Promotion*. Briefing Paper 1. London: Mentality. Cited in Barry and Jenkins (2007) op. cit.
- Mind (2004), *Not Alone? Isolation and Mental Distress*. London: Mind.
- Mind (2002), *Creating accepting communities: Report of the Mind Inquiry into social exclusion and mental health problems*. London: Mind.
- Moran, J. (2005), Mental health and Ireland's new communities. In Quin and Redmond (2005) op. cit.
- Morris, D. (2006), Social inclusion and mental health policy in England. 2nd Thematic meeting on the Commission Green Paper on Mental Health, 'Social Inclusion and Fundamental Rights in Mental Health', Vienna, 16–17th March 2006.
- Morrow, M. and Chappell, M. (1999), *Hearing Women's Voices: Mental Health Care for Women*. Vancouver: British Columbia Centre of Excellence for Women's Health. Cited in The Women's Health Council (2005) op. cit.
- Mowbray, C.T., Bybee, D., Harris, S.H., McCrohan, N. (1995), Predictors of work status and future work orientation in people with psychiatric disability. *Journal of Psychiatric Rehabilitation*, 19 (2): 17–28. Cited in Marwaha and Johnson (2004) op. cit.
- Mustafa, N. (2005), What about gross national happiness? *TIME*, Jan 10. 2005.
- NACTE Steering Group (1997), *Employment Challenges for the Millennium: A Strategy for employment for People with Disabilities in Sheltered and Supported Work and Employment*. Cited in Tom Martin and Associates (2001) op. cit.
- National Alliance for the Mentally Ill (1999). *Facts About Mental Illness and Work*. August 1999 (www.nami.org) Cited in WHO (2000). op. cit.
- National Council for Special Education (2006), *Implementation Report: Plan for the Phased Implementation of the Epsen Act 2004*. Trim: National Council for Special Education.
- National Council on Ageing and Older People (2007), *The Quality of Life of Older People with a Disability*. Dublin: National Council on Ageing and Older People.
- NDA (2005), *Disability and work: The picture we learn from official statistics*. *Disability Research Series*. Dublin: National Disability Authority.
- NDA (2004), *Survey on Social Participation and Disability*. Dublin: National Disability Authority.
- NDA (2002), *Public Attitudes to Disability in the Republic of Ireland*. Dublin: National Disability Authority.
- NDA (2005), *Strategic Partnership Guide, Good Practice in Working with People with Mental Health Difficulties*. Dublin: The National Disability Authority.
- National Economics Foundation (2006), *The Happy Planet Index: An Index of Human Well-being and Environmental Impact*. London: National Economics Foundation.
- National Office for Suicide Prevention (2007), *Mental Health Awareness and Attitudes Survey Preliminary Findings April 2007*. Dublin: National Office for Suicide Prevention.
- NIMHE/National Institute for Mental Health in England (2006), *National Social Inclusion Programme: Second Annual Report*. London: NIMHE.
- NIMHE/National Institute for Mental Health in England (2005), *National Social Inclusion Programme: First Annual Report*. London: NIMHE.
- NIMHE/National Institute for Mental Health in England (2004), *National Social Inclusion Programme*. London: NIMHE. Nexus Research Co-operative (2004), *The 'Building Healthy Communities' Programme: Evaluation Report*. Dublin: Nexus.

- NESF (2007a), *Improving the Delivery of Quality Public Services*. Report No. 34, Dublin: The National Economic and Social Forum.
- NESF (2007b), *The Arts: Social Inclusion and Cultural Cohesion*, Report No. 35 Dublin: The National Economic and Social Forum.
- NESF (2005), *Early Childhood Care and Education*. Report No. 31, Dublin: The National Economic and Social Forum.
- NESF (2003), *The Policy Implications for Social Capital*, Report No. 28 Dublin: The National Economic and Social Forum.
- NESF (2002), *Re-Integration of Prisoners*: Report No. 22 Dublin: The National Economic and Social Forum.
- New Economics Foundation (2004), *A Well-being Manifesto for a Flourishing Society*. London: New Economics Foundation.
- O'Connell, P.J., Russell, H., Williams, J. and Blackwell, S. (2004), *The Changing Workplace: A Survey of Employees' Views and Experiences*. Dublin: National Centre for Partnership and Performance and The Economic and Social Research Institute.
- O'Connell, P. and Williams, J. (2001), *National Survey on Workplace Bullying*. Dublin: The Stationery Office.
- Office for National Statistics (2002), *Mental Health of Carers*. London: HMSO.
- Office of the United Nations (1991), *UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*. New York: The United Nations.
- O'Flynn, D. (2001), Approaching employment: Mental health, work projects and the Care Programme Approach. *Psychiatric Bulletin* (2001) 25: 169–171.
- O'Hara, A, P. (2001), Social enterprises and local development. In: C. Borzaga and J. Defourny J. (Eds.), *The Emergence of Social Enterprise*. London: Routledge. Cited in
- Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., and Ralph, R. O. (2002), *Mental Health Recovery: What Helps and What Hinders?* National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors.
- O'Shaughnessy, M. (2005), *National Profiles of Work Integration Social Enterprises: Ireland*. *European Research Network*. Working Paper No. 2, 2005. Liège, Belgium: European Research Network.
- Ostir, G. V., Markides, K. S., Black, S. A., and Goodwin, J. S. (2000), Emotional well-being predicts subsequent functional independence and survival. *Journal of the American Geriatric Society*, 48, 473–478.
- Paoli, P., (1997), *Second Survey on Working Conditions*. Dublin: European Foundation for the Improvement of Living and Working Conditions.
- Parkinson, J. (2007), A core set of National Mental Health and Well-being Indicators for Scotland-adults. Presented at 28th April, 2007, *UK Public Health Association Conference*, Edinburgh.
- Partnership for Workplace Mental Health. (2006), *A Mentally Healthy Workforce- It's Good for Business*. Arlington VA: American Psychiatric Foundation.
- Pavee Point (2005), *A Review of Travellers' Health using Primary Care as a Model of Good Practice*. Dublin: Pavee Point.
- Pavee Point (2004), *Summary of the Main Findings of the Travellers' Health Survey*. Dublin: Pavee Point.
- Pavee Point (1997), *Health of Traveller Women*. Dublin: Pavee Point.
- Pavis, S., Platt, S., Hubbard, G. (2002), Youth employment, psychosocial health and the importance of person/ environment fit: a case study of two rural Scottish towns. In L. Morrow, I. Verins and E. Willis (Eds.) *Mental Health and Work: Issues and Perspectives*. Canberra: Commonwealth of Australia: 92–109. Cited in WHO (2005) op. cit.

- Payne, S. (2000), *Poverty, Social Exclusion And Mental Health: Findings From the 1999 PSE Survey*. University of Bristol: Townsend Centre for International Poverty Research.
- Pearce, N. (2002), The Ideal Minister for (Public) Health. *Journal of Epidemiology and Community Health*, 56:888–889.
- Perkins, R. E. and Repper, J.E. (1996), *Working Alongside People with Long-term Mental Health Problems*, pp. 189–199. London: Chapman and Hall.
- Pevalin, D and Rose, D. (2002), *Social Capital for Health: investigating links between social capital and health using the British Household Panel Survey*. London: Health Development Agency.
- Phillips, D. L. (1993), *Looking Backward: A Critical Appraisal of Communitarian Thought*. Princeton, NJ: Princeton University Press.
- Pierce, M. (2003), *Minority Ethnic People with Disabilities in Ireland*. Dublin: The Equality Authority.
- Pobal (2006), *Enabling Participation: Using Community Development Approaches to Advance the Participation of Disabled People in Local Development Activities*. Dublin: Pobal.
- Price, R., Vinokur, A.D. and Friedland, D.S. (2002), The job seeker role as resource: Achieving re-employment and enhancing mental health. In: A. Maney and J.Ramos (Eds.) *Socioeconomic Conditions, Stress and Mental Disorders: Toward a New Synthesis of Research and Public Policy*. Washington, DC: Mental Health Statistical Improvement Program (MHSIP), National Institute of Mental Health.
- Price, R.H., Van?Ryn, M. and Vinokur, A.D. (1992), Impact of a preventive job search intervention on the likelihood of depression among the unemployed. *The Journal of Health and Social Behaviour* 33: 158-167
- Putnam, D. (2000), *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon and Schuster.
- Rankin, J. and Regan, S. (2004), *Meeting Complex Needs*. London: Institute for Public Policy Research.
- Rappaport, J., Seidman, Toro,P., Mc Fadden, L.S., Reischl,T.,Roberts, L., Salem.D., Stein,C., and Zimmerman.,M. (1985), Collaborative Research with a Mutual Help Organisation, *Social Policy*, 15, 12–24. Cited in Mental Health Commission (2005b), op. cit.
- Reynolds, C., Byrne, M. & Barry, M.M. (2004), *Final Evaluation Report of the Rural Mental Health Project (Phase 2)*. Unpublished Report, Centre for Health Promotion Studies, NUI, Galway, Ireland.
- Rosenfield, S.L., Keenan, P.M., Fox, D.J., Chase, L.H., Melchiono, M.W. and Woods, E. R. (2000), Youth perceptions of comprehensive adolescent health services through the Boston HAPPENS Program: *Journal of Paediatric Health* (14(2): 60–67.
- Russinova, Z., Wewiorski, N.J., Lyass, A., Rogers, S. and Massaro, J.M. (2002), Correlates of vocational recovery for persons with schizophrenia. *International Review of Psychiatry*, 14: 303–311.
- Ryff, C.D. and Singer, B. (2003), Flourishing under fired: Resilience as a prototype of challenged thriving. In C.L.M. Keyes and J. Haidt (Eds.) *Flourishing: Positive psychology and the life well-lived* (pp. 15–36) Washington DC: American Psychological Association. Cited in Keyes (2005) op. cit.
- Quin, S. and Redmond, B.(2005), (Eds.) *Mental Health and Social Policy in Ireland*. Dublin: University College Dublin Press.
- Quin, S. and Redmond, B. (1999), Moving from needs to rights: Social policy for people with disability in Ireland. In S. Quin, P. Kennedy, A. O'Donnell, and G. Kiely (Eds), *Contemporary Irish Social Policy*. Dublin: University College Dublin Press.
- Sainsbury Centre for Mental Health (2005), *Together We Will Change: Community Development, Mental Health and Diversity*. London: The Sainsbury Centre for Mental Health.



- Sainsbury Centre for Mental Health (2003), *Policy Paper 3: The Economic and Social Costs of Mental Illness*. London: The Sainsbury Centre for Mental Health.
- Sainsbury Centre for Mental Health (2003b), *Primary Solutions: An Independent Review on the Development of Primary Care Mental Health Services*. London: The Sainsbury Centre for Mental Health.
- Salem, D., Seidman, E. and Rappaport, E. (1998), Community treatment of the mentally ill: The promise of mutual-help organisations. *Social Work*, September–October.
- Sapouna, L. (2006), Tracing evidence of institutionalization in the process of de-institutionalisation. In P. Herman and Lydia Sapouna (Eds.) *Knowledge in Mental Health: Reclaiming the Social*. New York: Nova Science Pub.
- Sayce, L. and Morris, D. (2004), *National Programme for Improving Mental Health and Well-Being (2004) Mental Health Improvement 'Conceptual Definitions': Briefing Paper for the National Advisory Group*. Edinburgh: Scottish Executive.
- Scott, J. (1993), Homelessness and mental illness. *British Journal of Psychiatry*. 1993. Vol. 162 pp 314–324.
- Scott-Samuel, A. and O'Keefe, E. (2007), Health impact assessment, human rights and global public policy: A critical appraisal. *Bulletin of the World Health Organisation*, March 2007, 85 (3)
- Scottish Association for Mental Health (2006), *What's it Worth? The Social and Economic Costs of Mental Health Problems in Scotland*. Glasgow: Scottish Association for Mental Health.
- Scottish Executive Social Research (2006), *Evaluation of the First Phase of Choose Life*. Edinburgh: The Scottish Executive.
- Secker, J. and Membrey, H. (2003), Promoting mental health through employment and developing health workplaces: the potential of natural supports at work. *Health Education Research: Theory and Practice*, Vol. 18: no. 2. 207–215.
- Shaw Trust (2006), *Mental Health: The Last Workplace Taboo*. Chippenham: The Shaw Trust.
- Singleton, N. and Lewis, G. (2003), *Better or Worse: A Longitudinal Study of the Mental Health of Adults Living in Private Households in Great Britain*. Report based on surveys carried out by the Office for National Statistics in 2000 and 2001 for the Department of Health and the Scottish Executive Health Department.
- Smith, M. K. (2001), 'Community' in *the encyclopedia of informal education*, <http://www.infed.org/community/community.htm>.
- Smith, M., McGee, H.M., Shannon, W. and Holohan, T. (2001), *One Hundred Homeless Women*. Dublin: Royal College of Surgeons in Ireland.
- Social Exclusion Unit. (2004), *Mental Health and Social Exclusion*. Office of the Deputy Prime Minister London: HMSO.
- SPIRASI Medical Programme for Survivors of Torture (2002), *Submission to the Working Group on NAPS and Health*. [Unpublished] Cited in Pierce (2003) op. cit.
- Springs, N. and Allen, C. (2005), The communities we are regaining but need to lose: A critical commentary on community building in beyond-place societies, *Community Work and Family*, Vol. 8, No. 4, 389–411.
- Stewart, R. (2006), *The Mental Health Promotion Needs of Asylum Seekers and Refugees: A Qualitative Study in Direct Provision Centres and Private Accommodation in Galway City*. Galway: Galway City Development Board; Health Promotion Services HSE West.
- Stewart-Brown, S. (2006), Measuring the parts most measures do not reach. *Journal of Mental Health Promotion* 1 (2): 4 - 10. Cited in CSIP (2007) op. cit.
- Sturgeon, S. (2007), Promoting mental health as an essential aspect of health promotion, *Health Promotion International*, Vol. 21, No. S1, pp. 36–41.
- SUPPORT (2006), *Achieving well-being in the European Workplace: Laying the foundations for action*. Discussion Report based on an Expert EU Seminar. Edinburgh: SUPPORT Project.
- Swedish National Institute of Public Health (2005), *The 2005 Public Health Policy Report: Summary*. Stockholm: Swedish National Institute of Public Health.

- Swedish National Institute of Public Health (2003), *Sweden's New Public Health Policy: National Public Health Objectives for Sweden*. Stockholm: Swedish National Institute of Public Health.
- Taskforce on Active Citizenship (2007), *Report of the Taskforce on Active Citizenship*. Dublin: Department of the Taoiseach.
- Taskforce on Active Citizenship (2006), *Background Working Paper*. Dublin: Department of the Taoiseach.
- Taylor, B. J., McGilloway, S., Donnelly, M. (2004), Preparing youth adults with disability for employment. *Health and Social Care in the Community* 12 (2), 93–101.
- Thomson H, Petticrew M, Douglas M. (2003), Health impact assessment of housing improvements: incorporating research evidence. *Journal of Epidemiology and Community Health*, 57:11–16. Cited in WHO (2005)op. cit.
- Tom Martin and Associates (2001), *Sheltered Employment: A Review of the Literature*. Dublin: Tom Martin and Associates.
- TUC (2006), *Biennial Survey of Safety Representatives*. London: Trade Union Congress. Downloaded November 2006 from [http://www.tuc.org.uk/h\\_and\\_s/tuc-12596-fo.pdf](http://www.tuc.org.uk/h_and_s/tuc-12596-fo.pdf)
- United Nations Development Programme (2006), *Beyond Scarcity: Power, Poverty and the Global Water Crisis*. New York: United Nations.
- Substance Abuse and Mental Health Services Administration (2004), *Workplaces That Thrive: A Resource for Creating Mental Health-Friendly Work Environments*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Vaillant, G. (2003), Mental health. *American Journal of Psychiatry*, 160:1373–1384. Cited in WHO (2005)op. cit.
- VicHealth (2006), *Evidence-Based Mental Health Promotion Resource*. Melbourne: Public Health Group Victorian Government Department of Human Services.
- VicHealth (2005), *Framework for the Promotion of Mental Health and Well-Being*. Melbourne: Public Health Group Victorian Government Department of Human Services.
- Wakefield, S. and Poland, B. (2005), Family, friend or foe? Critical reflections on the relevance of social capital in health promotion and community development. *Social Science and Medicine* 60, 2819–2832.
- Weehuizen, R. (2006), *Mental Capital: a Preliminary Study into the Psychological Dimension of Economic Development*. Commissioned by the Dutch Council for Health Research. Maastricht, The Netherlands: UNU-MERIT.
- Wells, K., Miranda, J., Bruce, M.L., Alegria, M. and Wallerstein, N. (2004), Bridging community intervention and mental health services research. *American Journal of Psychiatry*, 161 955–963.
- The Wheel (2005), *The Value of the Community and Voluntary Healthcare Sector in Ireland: A Literature Review*. Dublin: The Wheel.
- Whitehead, M. (1990), *The Concepts and Principles of Equity and Health*. World Health Organisation Europe: Copenhagen.
- Whitty, P., Lydon, C., Turner, N., and O'Callaghan E. (2006), The influence of psychosocial rehabilitation on patients with a first episode of psychosis. *International Journal of Psychosocial Rehabilitation*. 10 (2) 17 - 27.
- Wilkinson, R.G . (1996), *Unhealthy Societies: The Afflictions of Inequality*. London: Routledge. Cited in WHO (2005)op. cit.
- Wittchen, H-U. and Jacobi, F. (2005), Size and burden of mental disorders in Europe – a critical review and appraisal of 27 studies, *European Neuropsychopharmacology* 15 (2005) 357–376.
- WHO (2006), *Economic Aspects of the Mental Health System: Key Messages to Health Planners and Policy Makers*. Geneva: World Health Organisation.
- WHO (2005), *Promoting Mental Health: Concepts, emerging evidence, practice*. A Report of the World Health Organisation, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne. Geneva: World Health Organisation.

- WHO (2005a), *WHO Resource Book on Mental Health, Human Rights and Legislation*. Geneva: World Health Organisation.
- WHO (2005b), *Mental Health Policies and Programmes in the Workplace*. Geneva: World Health Organisation.
- WHO (2004), *Promoting Mental Health: Concepts, emerging evidence, practice. Summary Report* of the World Health Organisation, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne. Geneva: World Health Organisation.
- WHO (2003), *Social Determinants of Health: The Solid Facts*. Denmark: World Health Organisation.
- WHO (2002), *Prevention and Promotion in Mental Health*. Geneva: World Health Organisation.
- WHO (2001), *Mental Health: New Understanding, New Hope*. World Health Report. Geneva: World Health Organisation.
- WHO (2001a), *Mental Health: Strengthening Mental Health Promotion*. Fact Sheet No. 220. Geneva: World Health Organisation.
- WHO (2000), *Mental Health and Work: Impact, Issues and Good Practices*. Geneva: World Health Organisation.
- WHO (1997), *Life Skills Education in Schools*. Geneva: World Health Organisation.
- WHO (1986), *Ottawa Charter for Health Promotion*. Geneva: World Health Organisation.
- WHO Europe (2005), *Mental Health Declaration for Europe: Facing the challenges, building the solutions*. Denmark: World Health Organisation Regional Office of Europe.
- Women's Health Council (2006), *Submission to the National Intercultural Health Strategy, 2006*. Dublin: Women's Health Council.
- Women's Health Council (2005), *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision*. Dublin: The Women's Health Council.
- Workway (2005), *Ability in the Workplace: A Disability Training Template*. Dublin: Workway.
- Workway (2004), *Guidelines on Employment of People with disabilities*. Dublin: Workway.
- World Health Ministers (2001), *Mental Health: A Call for Help by World Health Ministers. Ministerial Round Tables*. Geneva: World Health Organisation.
- WRC (2006), *A Strategy of Engagement: Towards a Comprehensive Employment Strategy for people with disabilities*. Dublin: National Disability Authority.
- Wren, M. A., (2003), *Unhealthy State: Anatomy of a Sick Society*. Dublin: New Island.
- Wynne, R., McAnaney, D., O'Kelly, C. and Fleming, P. (2006), *Employment Guidance Services for People with Disabilities*. European Foundation for the Improvement of Living and Working Conditions. Luxembourg: Office for Official Publications of the European Communities.

# Annexes

## Annex 1 Terms of References

The Project will focus on equality and disadvantage dimensions, including urban and rural aspects of the routes to social inclusion for those with mental health difficulties. It will provide a focused follow-through of the Expert Group on Mental Health's recent Report, *A Vision for Change*. One of its central points will be to identify and tackle barriers to positive mental health through a broad population health approach.

The Project Team will examine these broad areas:

- **Prevention and recovery:** What could integrated public services (e.g. health, social welfare, employment, education, training and housing) contribute to positive mental health, from timely identification through to recovery? What more can be done to support those with mental health difficulties in the workplace?;
- **Supports:** What complementary individual, social and community supports are needed to strengthen positive mental health and social capital for the population generally?; and
- **Stigma:** What practical steps can be taken to tackle prejudice, discrimination and disadvantage in Irish society?

The Project will adopt a problem-solving approach, drawing on evidence of best practice and policy innovation, both at home and abroad. It will include wide consultation with relevant individuals and bodies and a number of experts will be invited to contribute to the Team's work process.

## Annex 2 Summary of Submissions<sup>64</sup>

### Introduction

In September 2006, the Project Team placed a call for written submissions on *Mental Health and Social Inclusion* in the main national newspapers. 75 submissions were received from a range of individuals and organisations with an interest in or experience in this area<sup>65</sup>.

A significant proportion of the submissions were received from individuals, including mental health specialists, academics, researchers and people with experience of mental health difficulties. Submissions were also received from service providers working in a range of community and voluntary and health and social service settings, as well as from local services and statutory bodies. A list of the individuals and organisations that made submissions is provided at the back of this Summary.

In issuing the call for submissions, the Project Team highlighted the core focus of its work as being the equality and disadvantage dimensions of mental health and that this includes both urban and rural aspects of the routes to social inclusion. Consistent with this, a large proportion of the submissions focused on the three broad themes of the work, namely:

- Prevention of and recovery from mental health difficulties;
- Supports necessary to promote positive mental health; and
- Steps to remove stigma and social exclusion related to mental ill-health.

A high proportion of the submissions expressed satisfaction with the priority areas underpinning the Project Team's work and presented strategies for making positive advances in these areas. It was suggested, however, that the needs of parents and carers should be specifically named and that consideration be given to the domain of 'family life' as well as 'community life.' The adoption of a population-based approach was welcomed, with one submission noting the following:

*"While mental health services research has been limited in general, more so has been the exclusion of those with less severe forms of mental ill health, many of which never attend mental health services ... An approach that encompasses the population as a whole in terms of recovery, inclusion and stigma is welcome."*

While there was much agreement across the submissions about the issues impacting on people with mental health difficulties, there was much variation in the level and type of attention given to different diagnoses of mental illness. The areas covered primarily included depression, bi-polar disorder, schizophrenia, dementia and post-traumatic stress disorder. Causal relationships were also highlighted and in this respect, submissions emphasised the impact of structural inequalities on people's health and well-being. The impact of existing employment, education, housing and social welfare policy was emphasised throughout and there was much reference to the lack of adequate social and community supports.

<sup>64</sup> Compiled by Tracey O'Brien.

<sup>65</sup> A further 5 submissions were received by the Project Team after this Summary was completed.

A number of submissions gave considered attention to the relationship between mental illness and unemployment, homelessness, educational attainment and social/community networks. The needs of specific groups, namely children and young people, parents and carers of people with mental illness, older people, gay, lesbian and bisexual people, and ex-prisoners were mentioned.

The following is a summary of the main points raised in the submissions.

## Mental Health in Ireland

Numerous statistics were presented to draw attention to both the prevalence and consequences of mental health difficulties in Ireland. It was noted, for example, that *“one third of GP consultations are the result of psychological and social problems”* and that *“depression increases the risk of heart disease four fold.”* Real accounts of mental illness, provided by a number of the submissions, added considerable weight to these findings by highlighting the different ways mental illness impacts on people’s lives. In general, these submissions were critical of what was described as a ‘medical model’ of mental health provision:

*“Historically much, even most, of the experience and dialogue around mental ill-health has been occupied with the medical model and it needs to change and respond to individual needs. Other groups within the disability sector have managed to progress beyond this limitation and engage directly with the issues of living effectively in ‘the real world.’*

*“Because of the very segregated nature of the mental health services, the wider expectations and ambitions of those experiencing mental ill health (and their families) still remain on the edges of the social model.”*

Consistent with calls to adopt a social model of service provision, submissions stressed the need for a broad interpretation of mental health. According to one submission, for example:

*“Mental health is about the whole of being, about being socially, emotionally, physically and spiritually well. Mental health has to do with how we feel about ourselves and how we are able to meet the demands of life. It is fundamental to physical health, to happiness and to success at work and school, in our families and the health of our communities. We all have mental health needs even if we don’t have current mental health problems.”*

It was argued that effective responses to mental illness require a clear understanding of its causes. A broad range of issues were identified, including biological, psychological and environmental factors. On this issue, one submission noted:

*“Factors such as poverty, housing, employment, education, safe neighbourhoods, cohesive and social just societies are all recognised as influencing people’s mental health potential. Creating a mentally healthy society entails addressing the broader socio-environmental and political influences and working across diverse sectors in order to address the upstream determinants of mental health.”*

The link between mental health and exposure to prolonged and extreme stress was emphasised by a high number of submissions. Bereavement, separation, divorce, lifestyle change, financial difficulties, work pressures, family relationships, sexual orientation and personal experiences and expectations (to name but a few) were all identified as contributory factors to mental ill-health.

The impact of poverty and social exclusion on mental well-being was highlighted, for example:

*“People with a diagnosis of mental illness, as a group, are severely socially excluded in Irish society. A recent Quarterly National Household Survey showed 86% of people with ‘mental, nervous or emotional’ health difficulties were either unemployed or economically inactive (CSO 2004). 22.7% of people surveyed by Schizophrenia Ireland were unemployed (Schizophrenia Ireland 2006). With such a high rate of unemployment, it is self-evident that people diagnosed with a mental illness are at high risk of poverty.”*

There was also considerable reference to the high risk of social isolation for people experiencing mental health difficulties and that social isolation is exacerbated by prejudice and discrimination:

*“Mental health service users tell us that one of the biggest problems they face is prejudice. Irish research into public attitudes showed that only 55% of respondents thought people with a mental health disability should have the same employment opportunities as anyone else ... and only 30% were comfortable having someone with a mental health disability living in their neighbourhood (NDA 2003) ... Of particular concern, the negative public*

*attitudes experienced by many participants lead a number of them to be cautious about participating in any type of public advocacy. This suggests that people with a diagnosis of mental illness are disadvantaged in their opportunities to advocate for their civil, social and economic rights (McDaid 2006).”*

Isolation and loneliness were identified as a cause for concern for people with mental health problems living in rural communities. A number of submissions referred to the limited availability of mental health supports in rural areas and low levels of access to public transportation. Rural isolation was identified as being particularly problematic for a number of specific groups. In the case of lesbian, gay and bisexual people, for example, one submission noted the following:

*“... some young LGB [lesbian, gay and bisexual] people are rejected by their families when they come out, and this can cause serious social isolation. For others, because they live in rural or even remote areas of the north east, they can be very isolated ... This can fuel the cycle of depression, anxiety, alcohol dependence and low self-esteem.”*

A strategy for addressing the problem of isolation was identified as the availability of “complementary individual, social and community supports” and “[a] pro-active [approach] in reaching out to those most at risk.” A multi-disciplinary approach to mental health care provision was also emphasised, for example:

*“I think that initiatives such as Primary Care, which involves many professionals working together as part of a multi-disciplinary team, can go a long way to identifying problems when they first arise and offer help or*



*advice from the onset. This can eliminate unnecessary stress and anxiety, which may otherwise occur. When professionals work together as part of a multi-disciplinary team information is shared and strategies are more easily put in place.”*

Submissions welcomed a number of changes that have taken place in mental health provision in Ireland over the past 50 years. In particular, they noted improvements which have been made in moving away from a purely medical (or ‘institutional’) response to mental health care provision in Ireland. However, there was some criticism of the Government in terms of realising policy commitments in this area. One submission noted the following, for example:

*“The 1980s marked a ... change... In Ireland, John Owens, the current chairperson of the Mental Health Commission, published *Planning for the Future*. This was a tremendously visionary and hopeful document. It saw the closure of the large institution in favour of community based treatment. This treatment would be vigorously supplemented with work at rehabilitation and education. *Planning for the Future* is over 20 years old. Its implementation has been accompanied by consistent cuts in the proportion of money being placed into community mental health. What seemed like a revolution in mental health care has petered into a further hospitalisation of the community, where long stay hostels have become mini hospitals and where countless people have been offered no help other than medication.”*

While acknowledging the difficulties of the past, submissions strongly welcomed more recent Government commitments in this area, in particular the National Strategy for Action on Suicide and Prevention (2005 - 2014) and the Report of the Expert Group on Mental Health Policy, *A Vision for Change* (January 2006). One submission noted the following:

*“Perhaps we are now on the verge of a major breakthrough in Mental Health Care. Two recent documents ... indicate a belief in the value of a new way forward.”*

Particularly welcome is Chapter 4 of *A Vision for Change* with its focus on social inclusion and social capital. According to another submission:

*“If recovery is to be made real and accessible, its roots must lie equally in the development of good quality community mental health services and inclusive, flexible responses from social services, from employment services and from the wider community. Recommendation 4.1 of *A Vision for Change* says “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.”“*

The sentiment expressed in this excerpt was echoed across the submissions, with considerable reference to the need for a multi-disciplinary approach to mental health care provision in Ireland. There was some concern, however, about the Government’s commitment to realising the proposals contained in its policy documents on mental health, leading to repeated calls for developments in this area to be closely monitored over time.

## Prevention of and Recovery from Mental Health Difficulties

There was some criticism in the submissions of the methods for delivering services in Ireland, with one submission noting that:

*“Heretofore and still unfortunately the manner of delivering services has made it difficult for disadvantaged people to make contact or benefit from available provision. Services may not be accessible, may not be perceived as appropriate or may not meet client’s complex needs.”*

Submissions stressed the need for greater care in diagnosing mental illness and more caution in the use of psychiatric drugs. One submission put it as follows:

*“There is a need for Mental Health Services to adopt an approach to mental illness that includes the possibility of recovery rather than asking people to accept the diagnosis of a lifetime disorder that can be kept under control if they keep taking drugs ... There needs to be less reliance on psychiatric drugs to suppress and control devastating emotional distress through the provision of a broader range of therapeutic interventions.”*

For a preventive focus to be effective, it was felt that all public services must play a role in addressing mental health issues. The specific components of this role were identified in one submission as *“education, awareness raising, health promotion and myth busting.”* According to one submission, for example:

*“... there needs to be much greater understanding and awareness among the public of the concept of positive mental health, how poor mental health*

*can manifest itself, and what can be done by those directly affected and by others, to aid the recovery process.”*

In terms of enhancing people’s awareness of positive mental health, this submission emphasised the need for a specific awareness raising campaign. It noted that:

*“The awareness campaign will have to address the mass audience of Irish society in general (through use of the media, health promotion programmes etc.) and also to target groups such as employers, trade unions, and health and education professionals. We submit that appropriate services and responses can be developed once there is a clear understanding of the nature of the issues to be addressed.”*

Public education was identified as a priority and it was noted that this could be achieved using a variety of methods. While education through television, radio and the print media was advocated in a number of submissions, many also emphasised the need for mental health education in schools, particularly at second level where, it was felt, that *“some adolescents may be experiencing the early signs of mental illness and may be having behaviour changes which baffle both teacher and parents.”*

According to another submission, work towards supporting the prevention of mental illness is dependent on the principles of *“participation, empowerment, self-determination and equality”* and on the need for *“a holistic approach which takes account of all the needs of the person, [including] their personal, social, cultural, creative, education and working life needs ...”*

One submission noted the work which has already been done through the National Strategy for Action on Suicide Prevention on methods of preventing mental health difficulties from a preventative perspective. However, the slow pace of change in this area lead to a call for the initiatives presented in this Strategy to be implemented in full and in *“a speedy fashion, with outcome indicators, allocated resources and clear timelines.”*

Submissions strongly welcomed the recognition of the lack of recovery-oriented mental health services in *A Vision for Change* and the associated recommendations for improving mental health and wider support services. *“Recovery”*, according to one submission, *“is one of the most important concepts exercising the policy, service delivery and intensions of the mental health services recently.”* Another submission defined ‘recovery’ in the following way:

*“Recovery is about recognising the journey we all undertake and our respective roles and responsibilities in achieving the best for all.”*

A central component of mental health recovery was identified as *“recognising the whole life experience of people experiencing mental distress.”* On this issue, reference was made to the Pathways Report (Brosnan et al, 2002) which noted:

*“I dream of a service which has got clear exits, which show the way out of the system back into the real world.”*

There was general agreement about the strategy to be used to support recovery from mental illness. This involves a movement away from segregated services towards integrated and holistic service provision. For example:

*“If recovery is to be made real and accessible, its roots must lie in the development of good quality community mental health services and inclusive, flexible responses from the social services, from employment services and from the wider community.”*

To this end, submissions emphasised the need for regular and ongoing liaison between a range of professional service providers, including medical and health professionals, social workers, community welfare officers, home school liaison teams, local employment services, FÁS, money advice and budgeting, the Gardaí, schools and training centres. It was expressed that close co-operation between these different service providers should ensure the development of clear pathways for people with mental health difficulties and the availability of appropriate supports when they are needed most. Consistent with this, there were repeated calls for a multi-disciplinary approach to mental health care provision since, as one submission put it, *“it is now accepted that the main determinants of mental health and mental health inequalities lie outside the health sector and that intersectoral collaboration is needed to effectively address them.”*

A ‘continuum of services provision’ was advocated in a number of submissions. This was described in the following way by one such submission:

*“A continuum of service provision must recognise the need of the individual for support at different stages of well-being and ensure that there are mechanisms to engage appropriate services at the appropriate time when necessary. All too often in the current provision, a recurrence of illness results in the individual having to revert*

*exclusively to medical services and surrender their community placement/activity. The development of recovery-oriented services with designated initiatives to assist the individual maintain the position they have achieved is essential if progression is to be achieved and maintained.”*

While there was general support for greater inter-agency co-ordination and more integrated service provision, there was some variation in the submissions as to the methods for achieving this. According to one submission, the challenge involves finding a way of integrating the medical model of service delivery into a model which both encourages and supports recovery. Specifically:

*“... we need a system that identifies the type of illness or distress, provides the minimum amount of drugs needed and sees this as a starting point on a road to Recovery. A road that provides professional help of many kinds and that leads a person into personal support systems that provide mental health. Integral to the success of this is a gradual and appropriate reduction in medication and professional help as the person recovers.”*

Another submission suggested that greater co-ordination and integration could be achieved by switching the provision of activities currently offered by mental health services to provision in community facilities:

*“To date, many of the activities provided by mental health services with enduring mental illness are provided in isolation and in psychiatric day centres increasing stigma and exclusion of these individuals from the wider community. In addition, many of the activities that are provided in the community such as day outings occur in large groups as opposed to a more*

*individualised approach. It would better reflect a recovery and service-user oriented approach if these activities were run on a small group basis and whereby individuals were encouraged to develop personal hobbies and interests.”*

According to another submission:

*“A true shift to a community oriented model requires a change in culture and systems described and purported in A Vision for Change (2006). The culture must change from illness to mental health.”*

Submissions agreed that integrated service provision is a key requirement in promoting social inclusion for people with mental health difficulties and there was much reference to worked examples of this. One such example included the PINEL (Programme for Integration, Normalisation, Education and Learning) Project which offers a 20 week training course for people with mental health difficulties to assist them in identifying progression opportunities, including education, training and employment:

*“Prior to the project, mental health services in the Dublin 12 area were functioning in isolation from other services. PINEL encourages integrated approaches to service provision for people with mental health difficulties ... During 2006 the Advisory Steering Group is looking at how to further develop this local integrated approach, which brings together medical and social models of work with the clients, and at ways to progress the PINEL project to the most suitable mainstreaming option.”*

The Southwest Counselling Centre Ltd. was also identified as having a holistic view of mental health and as applying an integrated, multidisciplinary approach to addressing the factors that contribute to mental health problems. However, the Centre itself noted some difficulties arising from a lack of integration between the work of the Centre and the work of the psychiatric services. It therefore recommended the following:

*“This gap would be best filled by the creation of teams which support each person. The role of this team would be to come up with a comprehensive plan tailored to each individual’s needs – which can encourage them to tap into their own healing potential – aimed at reducing their over-dependency on medication and leading to a better quality of life. The team would be made up of appropriate professionals and differ for each individual.”*

An additional and significant barrier to the areas of prevention and recovery was identified as ‘labelling of people with mental health problems.’ One submission summarised this problem in the following way:

*“Many people currently labelled ill are repeatedly prevented from taking responsibility for their own situation because they are not deemed to be competent partners in the process. The slim and shifting line between mental health and mental illness should be recognised.”*

Reflecting this consideration, many of the submissions stressed the importance of ensuring that people facing mental health problems are empowered to play an active role in their own recovery. Capacity-building work was identified as crucial here, with one submission noting that the Project Team on Mental Health and Social Inclusion should:

*“... prioritise strengthening the capacity of people with experience of mental distress to work collectively to develop solutions to their social exclusion, and to advocate within their local community and nationally.”*

It was also argued that people with experience of mental ill-health and their representative organisations should play a key role in the development and implementation of all policy and practice on this issue. This view was shared by a number of the submissions received, with one noting that:

*“What is frequently missing is the connection between the lived experience of individuals and groups and the relevance of policies and ideals. Without the fundamental connection between the real and the ideal it is very difficult indeed to give a voice to marginalised groups who will remain outside the ‘debate’, cynical of any progress and convinced of a decreasing sense of their own worth.”*

Also identified as ‘missing’ was the necessary leadership to:

*“... create an environment, politically and socially, where the equal participation of people experiencing mental ill health is viewed as —a priority,— an advantage [and]—necessary.”*

In response to this, one submission recommended the setting up of a cross-departmental implementation team to oversee the achievement of existing targets and actions and to ensure the development and implementation of a code of practice for including people with experience of mental illness.

## Supports Necessary to Promote Positive Mental Health

There was a high level of satisfaction across the submissions for the type of mental health supports set out in *A Vision for Change*. In particular, submissions emphasised the Strategy's aim to ensure that these supports are 'person-centred, recovery oriented, community-based and multi-disciplinary.' There was also a high level of support for the investment package presented in the Strategy, with one submission noting the following:

*"[The Strategy] suggests that investment in mental health service provision can be increased by closing all psychiatric hospitals, selling the land and reinvesting the money received in community psychiatric services. [We] fully support this provision."*

There were therefore repeated calls across the submissions for the recommendations included in *A Vision for Change* to be implemented in full. It was felt that this would remedy the vast majority of existing support deficiencies and should, if implemented correctly, see increased investment from the Government in the area of mental health. One submission put this as follows:

*"With increased resources, improvements to existing mental health services could be realised at a national level. There currently exists a huge disparity between services in terms of the resources received and how these are used. A more equitable distribution of resources is necessary and accountability for how services use these resources is essential."*

One submission emphasised the specific contribution which could be made by the equality legislation, noting that:

*"Equality legislation could be usefully developed to place positive duties on employers and service providers to be proactive in promoting equality for people with mental health issues and to ring fence resources and provide entitlements to key service provision areas."*

A number of recommendations were presented to support organisations in adopting a more rights-based approach to service provision. These included:

- Adopting clear equality policies in line with the equality legislation and ensuring that these policies take account of the needs of people with mental health difficulties;
- Providing equality and diversity training to help improve staff capacity to implement equality policies and to meet the needs of those experiencing mental ill-health;
- Assigning responsibility for equality strategies to a dedicated equality officer or to a senior manager in order to ensure leadership within organisations in implementing equality strategies; and
- Ensuring that people with mental health difficulties have the opportunity to participate in the development of equality policies, to become self-advocates and to influence real change; and
- Enhancing the availability of reliable data on mental health to help tackle the myths and stereotypes that shape people's understanding of mental ill-health.

Early detection of mental ill-health was identified as crucial, with one submission advocating the need for a frontline advisory/counselling service, available without the risk of stigma. Specifically:

*“This would ensure that people could avail of both emotional and practical help before problems become too big or entrenched. Organisations such as Comhairle could easily be expanded to incorporate this service through the Citizen’s Information Centres that are located throughout the country.”*

In terms of the wider supports necessary to promote positive mental health, submissions emphasised the need for change in a number of policy arenas, for example:

*“Significant drivers of social exclusion such as low educational attainment, concentrations of worklessness, health inequalities, concentrations of crime and poor quality environments and homelessness need to be made priorities over the coming years if we are to consider mental health at a population level.”*

In this context, one submission stressed the need for a comprehensive mapping exercise in order to achieve the following:

*“... establish the current level of provision of rehabilitative, training and employment services for people with mental health difficulties. This would facilitate a clear identification of service gaps and would highlight duplication if it exists.”*

This submission also noted the need to support innovative service delivery modules and identified ‘Clubhouse’, in Co Kildare, as a model of good practice in this area. (This is a non-medical and community-based model of service delivery, offering people with mental health difficulties the opportunity to gain confidence by participating in a work-oriented programme). The support for ‘Clubhouse’ in *A Vision for Change* was also emphasised in the submission, specifically:

*“The Clubhouse Model, a service run by peers with the mental health system has recently opened up additional options for community support for service users and should be utilised by [community mental health teams] (A Vision for Change: 2006, p. 24).”*

In terms of specific policy areas, there were repeated calls to make social welfare and employment policy more responsive to people’s needs. Of particular concern was the loss of disability benefits when taking up work opportunities, leading one submission to state:

*“There appears to be a strong case for identifying the cost of the medical and other supports required by people with disabilities generally and ring-fencing payments towards these costs, so that they are payable regardless of employment status.”*

The positive impact that employment has on mental health was highlighted, with one submission stating that “every effort should be made to help people suffering from mental health problems to retain or re-enter employment.” However, submissions highlighted a number of potential barriers arising from a lack of understanding of mental illness on the part of many employers, poor recruitment and selection processes and inflexible workplace arrangements. On this issue, one submission noted that:

*“There are wider issues relating to the impact of poor mental health on work performance, and the capacity of people experiencing mental health problems to undertake certain kinds of work, and there is a significant challenge in creating a culture which ensures a satisfactory level of performance while providing appropriate support to employees with mental health difficulties. In this regard, a*

*clear understanding of mental health issues on the part of employers is essential.”*

Another submission advocated the use of ‘bridging programmes’ to support the transition between psychiatric treatment and entry to mainstream employment and further/higher education. While noting that many people participate in mainstream return-to-work programmes, it stressed the need for interventions which are specifically focused on the needs of people with mental health difficulties. It therefore called for a tailoring of pre-entry courses to meet the specific needs of those experiencing mental ill-health, stating that *“these [would not be] rehabilitative courses per se, though they [would] obviously have a rehabilitative and therapeutic element.”* The availability of flexible working arrangements, including part-time work, job sharing and flexible hours, was also emphasised in this submission.

In response to the lack of integrated service provision in this area, submissions stressed the need to enhance wider community and social supports for people with mental health difficulties and to ensure that the supports offered are appropriate to meet individual as well as group needs. One submission recommended the use of incentives to promote and encourage multi-agency working, as follows:

*“We believe that services should be incentivised to work around individuals as opposed to individuals working around the service. This will allow for professionals to provide a co-ordinated and personalised response that is based on a full understanding of an individual’s problems. Initiatives such as linking with probation services to support the person with resettlement*

*difficulties and consider issues such as employment, housing and family, training on vocational and social issues is also required with the other agencies involved in an individual’s care, i.e. staff in organisations such as FÁS, social welfare, housing, community care etc., all of which should support an integrated programme of care.”*

The local partnership approach to service delivery was presented as a model of working which may benefit mental health provision. Specifically:

*“The local Partnership Companies place a strong emphasis on community-based outreach initiatives and the provision of community-based supports, rather than the provision of services from central office locations. This approach to engagement with clients may be particularly helpful for those with mental health problems as it provides a non-threatening environment and overcomes the fear that individuals may feel in approaching statutory agencies.”*

In line with this, two submissions highlighted the contribution made by ‘the Gateway Project’ and suggested that this type of work could be replicated in other areas of mental health provision. Key to this Project is the fact that it is a community-based initiative focused on maximising opportunities for social, cultural, educational and labour market integration for people with mental health problems. This is achieved through the provision of a dedicated drop-in facility which provides personal development, creative activities, health, social and life skills and information services.



Submissions also emphasised the contribution that community development has and continues to make to this area. The supports gained from this were summarised in the following way by a person with direct experience of mental illness:

*“The ethos in community development is equality and empowerment and support. We have to work under this ‘ethos’ and it definitely makes a huge difference in my life as you’re part of a team.”*

Gaps in service provision were also highlighted for a number of specific groups and there was considerable reference to the needs of children and young people, in particular those aged 16 to 18 years. The problem arising in this area was summed up in the following way by one submission:

*“The mental health service for 16 - 18 year olds is provided under the Adult Psychiatric Framework. There is no capacity in the child and psychiatric services to provide for children aged 16–17. This framework is unsatisfactory to meet the specific needs of young people.”*

Concern was also expressed about levels of mental ill-health among young lesbian, gay and bisexual people, with one submission noting:

*“A significant trend over the last two decades has been the increasing young age that LGB people come out at ... The astonishingly high proportion of young people on prescribed medication in LGB youth groups in Ireland reflects the level of strain that too many of these teenagers are under. These children in particular need the best kind of support available – from parents and other family members – to be able to operate as effectively as possible.”*

A call for dedicated and comprehensive mental health services for children and young people featured in some of the submissions received, for example:

*“When one considers that the peak age of onset of many mental health problems is during adolescents, it reaffirms the importance of investing in the provision of a comprehensive mental health service for children and adolescents.”*

The focus of these services, it was argued, should be on early detection and intervention, with significant additional resources available to enhance young people’s long-term coping skills:

*“There is a real need for the provision of adolescent friendly health services throughout the country to meet the health needs of young people. Such health services should incorporate mental health services and provide comprehensive health care. The services should also provide a confidential, informative and flexible service. To work effectively, they also need to be well-resourced by professionals. They should also involve young people in their work and implement a partnership approach with all relevant stakeholders in all of their activities.”*

The level of alcohol consumption among young people featured in the submissions. This was in response to research which highlighted the involvement of alcohol in a high percentage of “deliberate self-harm episodes” among young people. This led one submission to call for the full implementation of the preventative initiatives presented by the Strategic Taskforce on Alcohol (2004).

In response to the onset of eating disorders among adolescents, one submission stressed the need to establish a specialised National Eating Disorder Centre for Young People. A further recommendation of this submission was the establishment of an Adolescent Addiction Service to:

*“... provide a treatment setting which offers a service which is adolescent specific by being located in accessible, youth-friendly environments, such as designated youth services, local drug taskforce projects and adolescent friendly health services.”*

Funding represented a key consideration here, with a number of submissions referring to low levels of expenditure on mental health services for children and young people to date. This led one submission to note that:

*“... the cost of funding the recommended services for children and young people up to age 18 would require the investment of an additional €80 million per annum, with a capital investment of €150m. Such funding would help to improve the complement of multidisciplinary teams – providing better quality treatment and assessment services.”*

The role that youth organisations play as an initial point of contact with children and young people was emphasised, with one submission recommending that:

*“Youth organisations throughout the country must be adequately resourced to ensure the provision and development of social and personal development, and life skills programmes specifically targeted at children and young people. – Funding should be available to provide those working in the youth sector with training and*

*support materials on mental health promotion and suicide prevention, including identifying and responding to the risk factors associated with suicidal behaviour and self-injury.”*

According to another submission:

*“There is a substantial network of youth services throughout the country, most of them state-funded, and we would strongly recommend that at least some of these would be encouraged to incorporate awareness raising of mental health in their programmes and to offer a referral service for those who need specific support.”*

Emphasis was placed on the important preventative and supportive roles played by parents and carers of children and young people. For example:

*“Within the family, parents need to be informed to help them identify potential risk factors that could increase their child’s vulnerability to mental health disorders while also being reassured that the health services are in place to provide the necessary treatments for their child.”*

Reflecting these considerations, strategies for preventing mental illness among children and young people and for supporting their long-term recovery concerned the following:

- *Reintegration*: providing vital services to young people with mental difficulties in terms of social supports, encouraging participation in everyday life and supporting reintegration during the course of their recovery;
- *Early intervention*: investing in the provision of comprehensive mental health services for children and adolescents, emphasising the importance of early detection and

intervention and empowering young people to seek the help they require; and

- *Reducing risk*: supporting youth work organisations to work with young people who have been identified as ‘vulnerable’ or ‘at risk’ and developing school programmes to educate and support young people from an early age.

While much of the focus of the submissions was on people directly affected by mental illness, the wider impacts of mental illness on family members, friends and other carers were also recognised. One submission noted the following, for example:

*“Mental health is an issue for parents and carers, both from their own perspective and from the perspective of those for whom they care ... The domain of family life is an important one for mental health, no less than employment and community life.”*

This led to a call for the establishment of a community-based counselling service for parents and young people which would:

*“... be broader in scope that the Community Mental Health Teams as it would be available to parents as well and would be more like a ‘drop in’ centre where supports would be available when needed. This open approach to services would also address some of the public stigma surrounding mental health disorders.”*

Further recommendations put forward in this area included ensuring that relevant services and supports (e.g. psychological support, training and respite) be made available to both paid and unpaid carers and that the needs of parents and carers be incorporated into mental health reform.

In the case of older people, submissions emphasised the need for strong community-based and community-led initiatives. Here it was noted that:

*“... the role of the community in promoting mental health will become more crucial in the future given that traditional forms of support (i.e. family) may be limited (due to smaller family sizes, greater geographical mobility of families ... etc.)”*

It was further noted that ageist attitudes towards older people and the stigma related to mental illness will need to be addressed in order to “encourage community action for older people with mental health difficulties.” The following issues were identified as crucial for older people:

- Initiatives that lead to a better understanding of ageing and older people among the population as a whole;
- A structured programme for regular liaison and consultation with older people at a local level to ensure that their needs are identified and included in the planning and delivery of any service designed to meet their needs; and
- The adoption by older people’s interest groups of community development approaches to working with older people.

The needs of ex-prisoners with experience of mental illness were singled out by one of the submissions received. It noted that:

*“[There is a] lack of continuity of care for people leaving prison who may have had access to limited psychiatric services while in prison but there tends to be no link in with community psychiatric services prior to release and no*

*follow-up upon release — that tends to be left to agencies such as PACE.”*

Recommendations presented for ex-prisoners included: (i) making additional resources available for psychiatric services in prison to ensure that prisoners are diagnosed and treated appropriately while in prison; (ii) enhancing the level and availability of one-to-one supports for ex-prisoners with mental health difficulties; and (iii) addressing the lack of long-term accommodation options for ex-prisoners.

Recommendations presented for lesbian, gay and bisexual (LGB) people included the following:

- Provide greater coverage of LGB mental health in professional education to ensure that medical, health and social care professionals are knowledgeable about LGB issues;
- Provide ongoing training to mental health professionals to ensure that they are sufficiently competent to meet LGB people’s needs;
- Support the delivery of dedicated community-based services for LGB people with mental health problems and ensure that they are sufficiently resourced to undertake this work;
- Ensure that the specific mental health issues of LGB people are taken into account in all future health and social policies and that LGB people are clearly identified as a target population of these strategies; and
- Undertake a positive awareness raising campaign targeted at mental health and other health and social care services to challenge negative perceptions of LGB people.

## Support Services

Further recommendations for providing the supports necessary to promote positive mental health concerned a number of key policy areas, namely employment, education and training, health, housing, and individual, social and community supports, as follows:

### Employment

- Provide the resources necessary to pilot Individual Placement and Support Programmes and to evaluate their effectiveness in an Irish context;
- Enhance knowledge and information about mental health problems among employers;
- Increase public awareness that people who experience mental health problems can work and that work can contribute to positive mental health;
- Develop appropriate occupational services that provide both work-and non-work based options, as well as activities to promote health, social gain and community reintegration; and
- Investigate ways to increase the number of people with mental health problems in employment through supported structures within the workplace, e.g. adapted or flexible work schemes and schedules.

### Education and Training

- Develop comprehensive education and training strategies across all public services to increase awareness and understanding of mental health issues;

- Ensure that the education and training strategies introduced challenge the prejudice and stigma associated with mental health illnesses; and
- Ensure that all learning institutions have practical and user-friendly mental health policies, along with clearly defined approaches for addressing mental ill-health in a partnership context.
- Develop preventative strategies and support services to ensure that people who are at risk of homelessness can sustain their tenancy;
- Ensure the availability of clear and accessible information on housing options; and
- Enhance access to housing support services.

### **Health**

- Enhance levels of integration between health and psychiatric services and ensure a more person-centred approach to mental health provision;
- Ensure that medical practitioners foster a greater understanding of mental health medication and its impact on patients;
- Ensure a greater balance between medical and wider mental health supports; and
- Develop an appropriate system of follow-up care and support after discharge from hospital.

### **Housing**

- Increase provision to enhance availability of emergency/short-term accommodation for people with mental illnesses;
- Provide a broader range of accommodation and housing options within local communities and support the need for community-based residential housing for people experiencing mental ill-health;
- Increase rent allowances to reflect the rising costs of rental accommodation;

### **Individual, Social and Community Supports**

- Support the development of more community-based advocacy services for people with mental health difficulties;
- Improve the availability of information on local social and community supports;
- Enhance the development and availability of community counselling and therapeutic services;
- Ensure the provision of holistic/alternative health treatment centres within communities;
- Develop local stress management programmes;
- Develop and deliver pro-active models of support designed to promote self-esteem, as well as general life and coping skills;
- Increase investment in public transport to enable access to vital services;
- Encourage participation in local activities and increased knowledge and awareness of their mental health benefits; and
- Acknowledge and support the role of the arts in enhancing and sustaining well-being.

Underlying each of these policy recommendations is the need for funding and resources, with one submission concluding:

*“Funding for Mental Health Services and voluntary organisations needs to be increased to a realistic level to sustain the necessary community supports to address social inclusion.”*

## Steps to Remove Stigma and Social Exclusion

Considerable attention was given to levels of stigma and social exclusion related to mental ill-health. In the case of older people, for example, one submission noted that:

*“... mental illness is often perceived as a sign of weakness and ... this stigma inhibits sufferers from seeking help. Furthermore, this may be compounded by a misunderstanding of the nature of older age on the part of the health and social care professionals. Many perceive mental disorders as a natural part of growing older and, as a result, they may be unwilling to initiate a comprehensive treatment package.”*

Education represented the single most important strategy for addressing the stigma attached to mental illness, with the vast majority of submissions highlighting the need to target people from a young age in particular, for example:

*“One of the best ways to address the issue of stigmatisation and social inclusion is to educate people from a very young age as to what mental health issues are and to remove some of the preconceived notions that exist. By targeting younger age groups this will eventually enable the issues to be addressed in a more positive way.”*

There were repeated calls for more appropriate levels of mental health education at individual, community and national levels to address prejudice and discrimination against people with mental health problems. In the case of older people, for example, it was argued that a comprehensive *“Public Education Programme be undertaken by the Health Services Executive in conjunction with the Department of Health and Children and other relevant agencies on the nature of mental disorders in older age.”* An equivalent programme for care professionals, including GPs, PHN’s, social workers, psychiatric nurses, occupational therapists etc., was also recommended.

While the Government was identified as having a strong role to play in the process of removing the stigma and social exclusion attached to mental ill-health, mental health education was identified as a collective and shared responsibility. The strongest emphasis of all, however, was placed on providing mental health education to children and young people. A person with experience of mental illness summed this up in the following way:

*“The only thing I can see [that] can change this [stigma] is education at school level. What’s learned at a young age generally stays with people.”*

Recommendations presented in this area included the following:

- Develop a national public awareness campaign to challenge the myths attached to different types of mental illness and to enhance people’s knowledge and understanding of mental ill-health;

- Provide education on mental health and well-being at primary and post-primary levels, including education on different types of mental illness;
- Provide frontline community-based supports to parents, teachers, youth workers and all those working with children and young people to assist them in identifying the onset of mental illness and in making referrals for treatment;
- Promote positive mental health from an early age, beginning at pre-school level; and
- Ensure that all staff are trained to understand and respond to the issues facing people with mental health difficulties.

The community-based approach advocated in the vast majority of submissions received was also considered essential to work on tackling prejudice and discrimination, for example:

*“A community-based project that provides positive, social supports for people with mental health problems in its design and operation, may at the same time serve to reduce social stigma.”*

According to another submission:

*“The intention to provide more treatment in the community should help to redress the current imbalance, though there is a huge need for community education to dispel the myths that currently inhabit the public consciousness.”*

It was argued that community-based supports would have the benefit of helping to strengthen people’s capacity to advocate on their own behalf and to promote a greater understanding of mental illness.

A national awareness-raising campaign was identified as central to moving forward, with repeated calls for this campaign to be developed in collaboration with people who have experience of mental illness. The form that this campaign should take was summed up in the following way in one of the submissions:

*“... there needs to be much greater understanding and awareness among the public of the concept of positive mental health, how poor mental health can manifest itself, and what can be done by those directly affected and by others, to aid the recovery process. The awareness campaign will have to address the mass audience of Irish society in general (through use of the media, health promotion programmes etc.) and also to target groups such as employers, trade unions, and health and education professionals.”*

Awareness-raising measures at community level were also strongly advocated, with a number of submissions stressing that this work should focus specifically on ‘health and well-being’, for example:

*“... greater awareness in the community (beginning at primary school) around the importance of health and well-being needs to be stressed. These campaigns need to be tackled in a way that doesn’t increase the stigma and single out mental health as being any different from physical health and well-being. Perhaps a ‘safe cross code’ approach to mental health would be of benefit.”*

Work on supporting the integration of people with mental health difficulties into mainstream society was considered crucial to addressing stigma and social exclusion, with one submission noting that:

*“Integrating people with mental health difficulties into mainstream society is an important mechanism for recovery and it can also provide a catalyst for change in attitudes, and public perception of mental illness.”*

Language and imagery associated with mental illness was mentioned in a number of the submissions, with some criticism levelled at the media in terms of *“perpetuating a negative stereotype of those with mental health difficulties.”* According to one such submission, for example:

*“The use of language and imagery associated with mental health needs to be re-evaluated ... The role the media plays in perpetuating a negative stereotype of those with mental health difficulties needs to be challenged and relegated. This can be achieved by media portrayal of mental health problems in a more inclusive and accepting manner through broadcasting and dissemination [of] more positive images of mental health.”*

Specific recommendations for the media included the following:

- Develop a specific education and awareness raising strategy on mental health for those working with and on behalf of the media;
- Develop a code of practice for the media in addressing mental health issues, including guidelines on the type of language and imagery to be used; and
- Engage people with experience of mental illness to educate and inform the media on issues concerning mental health and well-being.

A final point made in one of the submissions concerned the use of the term ‘stigma,’ specifically:

*“One of the main problems with practically tackling stigma is that the word itself is stigmatising. Stigma means that the person is marked in some way negative, like a brand ...”*

This submission therefore advocated the use of the terms ‘prejudice’ and ‘discrimination’ in place of the term ‘stigma.’ A further and concluding recommendation of this submission was that “discrimination on the grounds of mental ill health should be inserted into the Equal Status Act.”

## Conclusion

The issues outlined above were identified as essential to improving mental health provision and to enhancing social inclusion for those experiencing mental ill-health. A common point of reference was the need to move away from fragmented service delivery towards a more integrated and multi-disciplinary method of provision. In going forward, there is a clear need to realise the recommendations set out in *A Vision for Change* and to ensure that mental health reform remains high on the political agenda. A priority for many of the submissions is to create a mental health system which is co-ordinated, multi-disciplinary and based on strong partnership arrangements between medical, health and social care providers and those with experience of mental illness.



## List of Submissions

Name	Organisation
Confidential submission	
Confidential submission	
Dr Ken Addley M.D.	Faculty of Occupational Medicine
Mr Odhrán Allen	Gay and Lesbian Equality Network
Mr John Aspill	
Prof. Margaret Barry	Department of Health Promotion, NUI
Mr Damien Barry	Togher Family Centre Limited
Mr Tony Bates	National Centre for Youth Mental Health
Ms Geraldine Bergin	Schizophrenia Ireland
Ms Liz Brosnan	Western Alliance for Mental Health
Ms Mary Butler	
Ms Bernadette Byrne	Schizophrenia Ireland
Ms Sandra Byrne	Rathmines Community Partnership
Ms Sheila Cahalane	The Southern Branch of the Institute of Community Health Nursing
Mr Leigh Canham	
Ms Tara Coogan	The Equality Authority
Ms Sharon Cosgrove	Combat Poverty Agency
Mr Sean Crudden	IMPERO
Ms Aisling Culhane	Psychiatric Nurses Association of Ireland
Ms Aileen Curtayne	The West Kerry Primary Care Team
Ms Patricia Cussen	Dublin City Council
Ms Lisa Cuthbert	PACE
Ms Margret Fine-Davis	School of Social Science and Philosophy, TCD
Mr Gerard Finnegan	S.T.E.E.R Ireland
Mr Maurice Fitzgerald	
Ms Kay Forristal	
Ms Dorothy Gallagher	Consumers' Association of Ireland
Dr Kate Ganter	The Irish College of Psychiatrists
Ms Asta Ghee	Slí Eile
Ms Pauline Gill	National Forensic Mental Health Service
Ms Sheila Gorman	The Arts Council
Mr John Harding-Price	
Ms Therese Hicks	Gay Men's Health Project
Mr Brian Howard	Mental Health Ireland
Ms Brenda Kent	Voluntary Arts Ireland
Ms Fran Keyes	Pavee Point
Ms Alice Leahy	TRUST
Ms Judy Lee	
Mr Mark Lloyd	The Blue Box Creative Learning Centre

Ms Camille Loftus	OPEN
Ms Caroline Lydon	AOTI
Ms Murray Maeve	Galway City Partnership
Mr Louie Maguire	
Prof. Kevin Malone M.D.	St Vincent's University Hospital
Ms Marie Claire McAleer	National Youth Council of Ireland
Ms Shari McDaid	
Ms Ann McEaney	
Ms Brenda Molloy	HSE
Ms Rachael Mooney	The Community Foundation for Ireland
Ms Deirdre Murphy	Department of Psychiatry, Trinity College Dublin
Mr Dennis O'Brien	
Mr Maurice O'Connell	The Alzheimer Society of Ireland
Ms Margaret O'Donoghue	
Ms Louise O'Donovan	Parents Support
Mr Edmond O'Flaherty	
Mr Joe O'Neill	Galway City Council
Ms Áine O'Reilly	Dublin West and South West Mental Health Services
Ms Jeannie O'Reilly	Bodywhys – The Eating Disorders Association of Ireland
Mr Kevin O'Shanahan	
Ms Sinead Quill	National Council on Ageing and Older People
Prof. Suzanne Quin	School of Applied Social Science, UCD
Ms Bernardine Quinn	Dundalk Outcomers
Mr John Redican	Irish Advocacy Network
Dr Bairbre Redmond	College of Human Sciences, UCD
Ms Jennifer Rylands	Psychology Service for Refugees and Asylum Seekers
Ms Cliona Saidlear	Rape Crisis Network Ireland (RCNI)
Ms Lydia Sapouna	Department of Applied Social Studies, UCC
Ms Hilary Scanlan	Kerry Community Services, Care Group for Older People
Ms Geraldine Sheedy	Southwest Counselling Centre
Ms Joan Sheridan	GRCC
Mr Eamon Sweeney	
Ms Donna Tedstone-Doherty	Health Research Board
Ms Louise Tierney	Outhouse
Ms June Tinsley	Barnardos – National Office
Mr Niall Turner	DETECT Early Intervention Services
Ms Moira Tysall	Adult Mental Health, Laoise/Offaly
Ms Áine Uí Ghiollagáin	Cúram, Irish parent and carer NGO
Mr Mike Watts	GROW
Dr Margaret Webb	EVE Limited
Mr Toby Wolfe	Pobal

## Annex 3 Additional Figures

### Figure A.1 Selected Recommendations from *A Vision for Change* (Department of Health and Children, 2006)

#### Access to Services

---

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

#### Access to Education, training, income, housing and employment

---

4. 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.
5. 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.
6. 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.
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.

#### Community and wider society

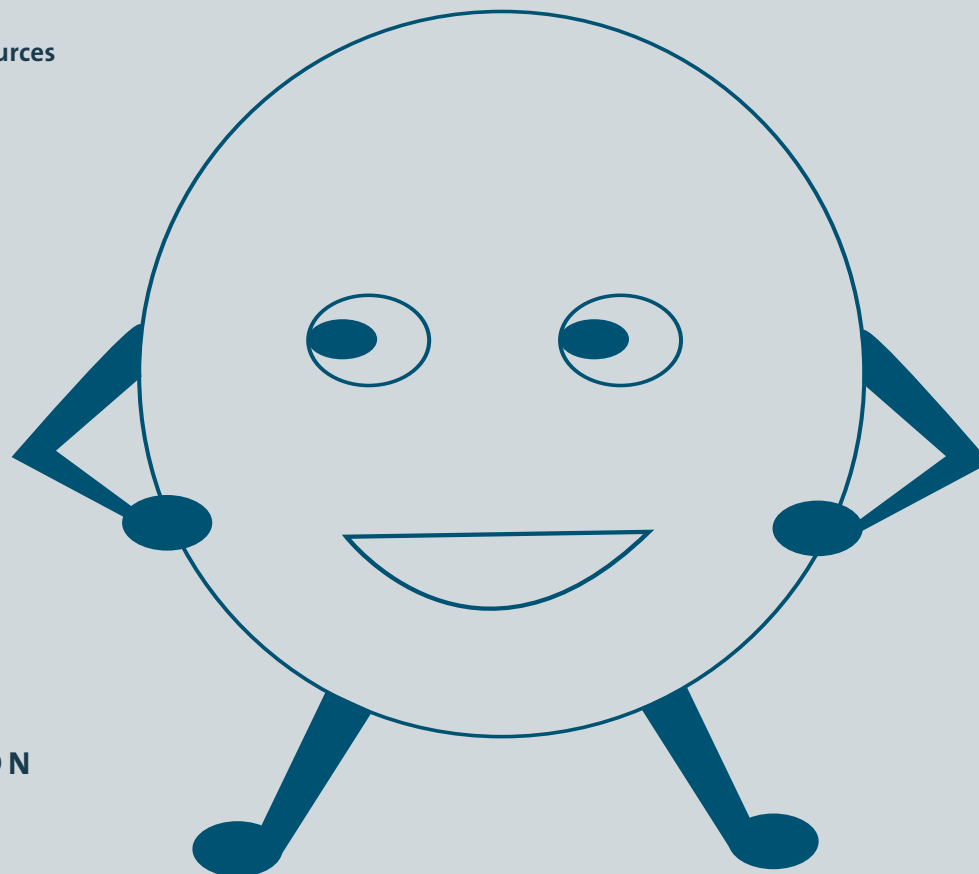
---

8. 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.
9. Evidence-based programmes to tackle stigma should be put in place, based around contact, education and challenge.
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.

**Figure A.2 Making a Recovery Map**  
 “Participation in a community of persons is the very process of recovery or personal growth”

**Community with resources**

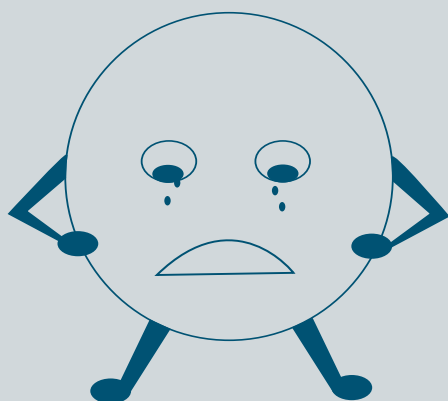
- I** Friendship  
**N** Mutual Help Groups  
**T** Work  
**E** Adult Education  
**G** Volunteering  
**R** Music  
**A** Neighbours  
**T** Sport  
**I** Hobbies  
**O** Church  
**N** Environment  
**N** Art  
**N** Meaning  
**N** Security  
**N** Self Esteem  
**N** Hope



**REINTEGRATION**

**Individual with needs and talents**

- D** Isolation  
**I** Fear  
**S** Shame  
**I** Pain  
**N** Injury  
**T** Loss  
**E** Despair  
**G** Experiences  
**R** Knowledge  
**A** Giftedness  
**T** Interests  
**I** Talents  
**O** Intelligences  
**N** Past Networks  
**N** Future Leadership



“Ultimately, the success or failure of efforts in community care will depend less on mental health professionals’ ability to create supportive environments or to teach specific skills and more on the ability to find and encourage naturally occurring niches. These niches are where people find meaning in life; mutual rather than unidirectional relationships; and consistent ongoing structures on which to depend. These are the settings that those who experience serious psychopathology often are unable to find. Mutual help organisations provide naturally occurring (that is, not professionally developed) settings that are available to people who are left to maintain themselves in the world when the professional, the aftercare workers and the volunteers have gone home.

(Rappaport *et al*, 1995)



## Annex 5 Seminar Attendance, Plenary Attendance and Consultation List

### Seminar Attendance

Name	Organisation
Dr Pat Bracken	West Cork Mental Health Services
Ms Frances Byrne	OPEN
Ms Tara Cogan	The Equality Authority
Ms Sheila Cronin	CORI
Ms Patricia Cussen	Dublin City Council
Ms Annie Dillion	National Women's Council of Ireland
Mr Liam Doran	ICTU/General Manager, Irish Nurses Organisation
Ms Maria Duggan	
Ms Alessandra Fantini	The Women's Health Council
Ms Maria Fox	Disability Federation of Ireland
Dr Maureen Gaffney	NESF
Ms Pauline Gill	Central Mental Hospital
Mr Liam Greenslade	DCU
Ms Jacinta Hastings	Mental Health Ireland
Ms Elaine Houlihan	Combat Poverty Agency
Ms Maureen Jubb	DCU
Ms Julia Kartalova	Health Research Board
Prof Cecily Kelleher	School of Public Health and Population Science, UCD
Dr Brendan Kennelly	NUI
Ms Fiona Keogh	Mental Health Commission
Ms Frances Keys	Pavee Point
Mr Andrew Logue	
Mr James McClean	PWDI
Ms Shari McDaid	Schizophrenia Ireland
Ms Breda McDonnell	Irish Countywomen's Association
Mr Stan Mellett	GROW
Mr Frank Mills	HSE
Dr Jeanne Moore	NESF
Ms Ros Moran	Health Research Board
Mr David Morris	National Institute for Mental Health in England
Mr Dan Neville	Fine Gael
Mr Seán Ó'hÉigeartaigh	NESF
Mr David O'Regan	Mental Health Commission
Ms Nuala O'Reilly	Department of Health and Children
Dr Pauline Prior	Queen's University
Ms Tonya Sanders	Cairde
Mr John Saunders	Schizophrenia Ireland/Lucia Foundation
Ms Clodna Sheedy	Peer Advocacy
Ms Donna Tedstone Doherty	Health Research Board
Ms Pearl Treacy	UCD

## Plenary Attendance

<b>Name</b>	<b>Organisation</b>
Mr Adrian Ahern	St. Brigid's Hospital
Mr Odhrán Allen	Gay and Lesbian Equality Network
Ms Jane Arigho	Headline
Mr John Aspill	
Ms Carol Baxter	The Equality Authority
Mr Patrick Benson	HSE West Mental Health Services
Ms Lilia Beshmelniesfoy	UNIFEM
Mr Seamus Boland	Irish Rural Link
Ms Eithne Breathnach	Department of Health and Children
Dr. Justin Brophy	Wicklow Mental Health Services
Mr Stephen Browne	National Association for Deaf People
Ms Vema Burns	Millward Brown IMS
Ms Frances Byrne	OPEN
Mr Martin Byrne	HSE Western Area
Mr Leigh Canham	
Mr Alan Chapman	FÁS
Ms Brid Clarke	Mental Health Commission
Ms Tara Coogan	Equality Authority
Ms Liza Costello	National Council on Ageing and Older People
Ms Bernadette Costello	Irish Deaf Society
Mr Tom Costello	Atlantic Philanthropies
Ms Sheila Cronin	CORI
Ms Katie Crowley	IRD Dunhallow
Mr Sean Crudden	IMPERO
Ms Aisling Culhane	Psychiatric Nurses Association of Ireland
Mr Sean Cunnane	County Kildare VEC
Ms Jenny Cunningham	Waterford Institute of Technology
Ms. Yvonne Curtin	IACP
Ms Patricia Cussen	Dublin City Council
Mr Geoff Day	HSE
Ms Breda Dempsey	Focus Ireland
Dr Margaret du Feu	National Association for Deaf People
Ms Emer Duffy	ICOS
Ms Aoife Farrelly	Focus Ireland
Dr Margaret Fine-Davis	School of Social Science and Philosophy, TCD
Mr. Pearse Finegan	Mayo Mental Health Services
Ms. Margaret Fleming	Monaghan Community Mental Health Team
Ms Fiona Flynn	Mind Yourself Project
Dr Maureen Gaffney	NESF
Ms Dorothy Gallagher	Consumers' Association of Ireland
Ms Pauline Gill	National Forensic Mental Health Service
Mr Scott Golden	Canal Local Employment Service Network

Dr John Harding-Price	
Ms Bernadette Hayes	OPEN
Mr Gregor Henderson	Health Department, Scottish Executive
Ms Dora Hennessy	Department of Health and Children
Mr Liam Henry	Meath County Council
Ms. Agnes Higgins	School of Nursing and Midwifery, TCD
Ms Elaine Houlihan	Combat Poverty Agency
Mr Paul Howard	Department of Health and Children
Prof. Cecily Kelleher	School of Public Health and Population Science, UCD
Mr Sean Kenny	Mental Health Association
Ms Mary Anne Kenny	Ocean Publishing Ltd.
Ms. Imelda Keogh	Mount Carmel Hospital
Ms Fran Keyes	Pavee Point
Ms Rosemary Kinahan	Fettercairn Health Project
Ms Helena King	Centre for Housing Research
Mr John Laffan	Department of Environment, Heritage and Local Government
Ms Alice Leahy	TRUST
Ms Dominique Lieb	Solas/OPEN
Ms Katie Lillis	OPEN
Ms Germaine Llyod	SPCTV Tallaght , CPD
Mr Andrew Logue	
Dr. Terry Lynch	
Ms Sara MacKenzie	Sara's Choice
Dr. Evelyn Mahon	Department of Sociology, TCD
Dr. Maeve Martin	South Eastern Health Board
Ms Marie Claire McAleer	National Youth Council of Ireland
Ms Kathleen McCann	Congress Centres Network
Ms Mary McCarthy	School of Social Science and Philosophy, TCD
Ms Shari McDaid	NDA
Ms Breda McDonald	Irish Countywomen's Association
Dr. Orla McDonnell	University of Limerick
Ms Finola McDonnell	IBEC
Ms Ann McEaney	
Dr Jarlath McKee	NESC
Ms Rosalind McKenna	Amnesty International (Irish Section)
Ms Avine McNally	Small Firms Association
Mr Frank Mills	HSE South West
Ms Brenda Molloy	HSE
Mr David Moloney	Department of Health and Children
Senator Paschal Mooney	Fianna Fail
Mr Dermod Moore	Psychotherapist
Dr Jeanne Moore	NESF
Ms Deirdre Mortell	The One Foundation



Ms. Geraldine Moylan	People with Disabilities in Ireland
Mr. Brian Neeson	HSE Mid Western
Mr Denis O'Brien	
Cllr Paddy O'Callaghan	AMAI
Ms. Mary O'Connell	HSE East Coast Area
Dr. Freeda O'Connell	HSE Dublin
Dr Rory O'Donnell	
Dr Fergus O'Ferrall	The Adelaide Hospital Society
Mr Michael O'Halloran	Age Action Ireland
Cllr. Kieran O'Hanlon	Limerick City Vocational Education Committee
Mr Seán Ó'hÉigearthaigh	NESF
Ms Áine O'Reilly	HSE, Dublin West and South West Mental Health Services
Ms Grainne O'Toole	OPEN
Ms. Mary Phelan	DCU
Ms Bernadette Phelan	Department of the Taoiseach
Ms. Denise Proudfoot	School of Nursing
Ms Sheilagh Reaper Reynolds	HSE
Ms Virginia Reed	HSE Donegal LHO
Ms Louise Richardson	Older Women's Network
Ms Marie Rooney	County Dublin VEC
Ms Fiona Ryan	Barnardos
Mr Mattie Ryan	
Ms Tonya Sanders	Cairde
Mr John Saunders	Schizophrenia Ireland/Lucia Foundation
Ms Hilary Scanlan	Kerry Community Services, Care Group for Older People
Ms Alex Scannell	Northside Partnership
Ms. Pat Seager	Schizophrenia Ireland
Mr Leo Sheedy	Department of Enterprise, Trade and Employment
Mr Alan Sheehy-Skeffington	Millward Brown IMS
Dr Ann Sheridan	School of Nursing, Midwifery and Health, UCD
Mr Eamon Sweeney	
Mr John Sweeney	NESC
Mr Kahil Thompson Coyle	Schizophrenia Ireland
Ms Nina Torbett	Healthy Working Lives
Ms. Mary Troy	HSE Northern
Ms Jillian Van Turnhout	Children's Rights Alliance
Mr Ronan Watters	Gay Men's Health Project
Mr Mike Watts	GROW
Dr Margaret Webb	EVE Limited
Ms Rachel Wright	Headline
Ms Krisztina Zimanyi	DCU
Ms Anka Zipf	OPEN

## Consultation List

<b>Name</b>	<b>Organisation</b>
Prof Margaret Barry	National University of Ireland
Ms Brid Clarke	Mental Health Commission
Mr Mick Coughlan	National Learning Network
Ms Fiona Crowley	Amnesty International (Irish Section)
Mr Niall Crowley	The Equality Authority
Ms Patricia Curtin	FÁS
Ms Breda Dempsey	Focus Ireland
Dr Barbara Dooley	Headstrong
Mr James Doorly	National Youth Council of Ireland
Ms Maria Duggan	UK Consultant
Ms Iris Elliott	National Disability Authority
Ms Aoife Farrelly	Focus Ireland
Dr Margret Fine-Davis	TCD
Ms Eithne Fitzgerald	National Disability Authority
Ms Claire Gavin	Department of Environment, Heritage and Local Government
Mr Matthew Hamilton	Headstrong
Ms Anna-May Harkin	Department of Health and Children
Ms Elaine Houlihan	Combat Poverty Agency
Mr Brian Howard	Mental Health Ireland
Ms Fiona Keogh	Mental Health Commission
Mr John Laffan	Department of Environment, Heritage and Local Government
Mr Andrew Logue	
Mr Fergal Lynch	Department of Health and Children
Ms Shari McDaid	National Disability Authority
Prof Hannah McGee	Royal College of Surgeons
Ms Shira Mehlman	FÁS
Ms Ros Moran	Health Research Board
Mr David Morris	National Institute for Mental Health in England
Prof. Joyce O'Connor	National College of Ireland
Dr John Owens	Mental Health Commission
Dr Pauline Prior	Queen's University
Dr Suzanne Quinn	UCD
Dr Bairbre Redmond	UCD
Mr Martin Rogan	HSE
Mr Dermot Ryan	Department of Health and Children
Prof. Chris Stevenson	DCU
Ms June Tinsley	Barnardos
Ms Jane Wilde	Institute of Public Health in Ireland
<b>Scotland</b>	

Mr Steve Bell	Scottish Centre for Healthy Working Lives
Mr Simon Bradstreet	Scottish Recovery Network
Ms Angela Hallam	Scottish Executive
Mr Gregor Henderson	Scottish National Programme for Improving Mental Health and Well-being
Mr Dougie Paterson	Choose Life

## Annex 6 Terms of Reference and Constitution of the NESF

1. The role of the NESF will be:
  - to monitor and analyse the implementation of specific measures and programmes identified in the context of social partnership arrangements, especially those concerned with the achievement of equality and social inclusion; and
  - to facilitate public consultation on policy matters referred to it by the Government from time to time.
2. In carrying out this role the NESF will:
  - consider policy issues on its own initiative or at the request of the Government; the work programme to be agreed with the Department of the Taoiseach, taking into account the overall context of the NESDO;
  - consider reports prepared by Teams involving the social partners, with appropriate expertise and representatives of relevant Departments and agencies and its own Secretariat;
  - ensure that the Teams compiling such reports take account of the experience of implementing bodies and customers/clients including regional variations;
  - publish reports with such comments as may be considered appropriate; and
  - convene meetings and other forms of relevant consultation appropriate to the nature of issues referred to it by the Government from time to time.
3. The term of office of members of the NESF will be three years. During the term alternates may be nominated. Casual vacancies will be filled by the nominating body or the Government as appropriate and members so appointed will hold office until the expiry of the current term of office of all members. Retiring members will be eligible for re-appointment.
4. The Chairperson and Deputy Chairperson of the NESF will be appointed by the Government.
5. Membership of the NESF will comprise 15 representatives from each of the following four strands:
  - the Oireachtas;
  - employer, trade unions and farm organisations;
  - the voluntary and community sector; and
  - central government, local government and independents.
6. The NESF will decide on its own internal structures and working arrangements.

## NESF Publications

### (i) NESF Reports

Report No	Title	Date
1.	Negotiations on a Successor Agreement to the PESP	Nov 1993
2.	National Development Plan 1994 – 1999	Nov 1993
3.	Commission on Social Welfare – Outstanding recommendations	Jan 1994
4.	Ending Long-term Unemployment	June 1994
5.	Income Maintenance Strategies	July 1994
6.	Quality Delivery of Social Services	Feb 1995
7.	Jobs Potential of Services Sector	April 1995
8.	First Periodic Report on the Work of the Forum	May 1995
9.	Jobs Potential of Work Sharing	Jan 1996
10.	Equality Proofing Issues	Feb 1996
11.	Early School Leavers and Youth Employment	Jan 1997
12.	Rural Renewal – Combating Social Exclusion	Mar 1997
13.	Unemployment Statistics	May 1997
14.	Self-Employment, Enterprise and Social Inclusion	Oct 1997
15.	Second Periodic Report on the Work of the Forum	Nov 1997
16.	A Framework for Partnership – Enriching Strategic Consensus through Participation	Dec 1997
17.	Enhancing the Effectiveness of the Local Employment Service	Mar 2000
18.	Social and Affordable Housing and Accommodation: Building the Future	Sept 2000
19.	Alleviating Labour Shortages	Nov 2000
20.	Lone Parents	July 2001
21.	Third Periodic Report on the Work of the Forum	Nov 2001
22.	Re-integration of Prisoners	Jan 2002
23.	A Strategic Policy Framework for Equality Issues	Mar 2002
24.	Early School Leavers	Mar 2002
25.	Equity of Access to Hospital Care	July 2002
26.	Labour Market Issues for Older Workers	Feb 2003
27.	Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues	April 2003
28.	The Policy Implications of Social Capital	June 2003
29.	Equality Policies for Older People: Implementation Issues	July 2003
30.	Fourth Periodic Report on the Work of the NESF	Nov 2004
31.	Early Childhood Care & Education	June 2005
32.	Care for Older People	Nov 2005
33.	Creating a More Inclusive Labour Market	Jan 2006
34.	Improving the Delivery of Quality Public Services	Feb 2007
35.	The Arts, Cultural Inclusion and Social Cohesion	Mar 2007

## (ii) NESF Opinions

Opinion No.	Title	Date
1.	Interim Report of the Task Force on Long-term Unemployment	Mar 1995
2.	National Anti-Poverty Strategy	Jan 1996
3.	Long-term Unemployment Initiatives	Apr 1996
4.	Post PCW Negotiations – A New Deal?	Aug 1996
5.	Employment Equality Bill	Dec 1996
6.	Pensions Policy Issues	Oct 1997
7.	Local Development Issues	Oct 1999
8.	The National Anti-Poverty Strategy	Aug 2000

## (iii) NESF Opinions under the Monitoring Procedures of Partnership 2000

Opinion No.	Title	Date
1.	Development of the Equality Provisions	Nov 1997
2.	Targeted Employment and Training Measures	Nov 1997

## (iv) NAPS Social Inclusion Forum: Conference Reports

1.	Inaugural Meeting on 30th January 2003	
2.	Second Meeting of the Social Inclusion Forum	Jan 2005
3.	Third Meeting of the Social Inclusion Forum	April 2006

## (v) NESF Research Series

1.	A Study of Labour Market Vulnerability & Responses to it in Donegal/Sligo and North Dublin	Jun 2005
2.	The Economics of Early Childhood Care & Education	Sept 2005
3.	Delivery of Quality Public Services	Sept 2006
4.	Mental Health in the Workplace	Sept 2007

## (vi) NESF Occasional Series

1.	Evidence-based Policy Making: Getting the Evidence, Using the Evidence and Evaluating the Outcomes	Jan 2005
----	--	----------