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Mental Health Reform
Promoting Improved Mental Health Services

Guiding A Vision for Change – Manifesto
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Guiding A Vision for Change - Manifesto

Foreword by Eddie Molloy, Chairman, Mental Health Reform

In 2006, following the most exhaustive consultation with all relevant stakeholders, A Vision for Change was published and declared as official Government policy for the reform of the mental health services. At the time it was widely acclaimed as an enlightened, progressive statement of intent.

In the six years since publication, however, implementation of A Vision for Change has been disappointingly slow. The Independent Monitoring Group in their most recent report commented: ‘Overall, it is the view of the Independent Monitoring Group that slow progress was made during 2010. The challenge of implementing AVFC by the HSE, Independent bodies and Government Departments has been hindered by the lack of resources available to mental health, the imposition of the public service moratorium and a lack of dedicated corporate leadership.’

Today, in the face of the collapse of the Government’s finances and deep cuts in the health budget, HSE and Government spokespersons are dampening down expectations regarding further progress on A Vision for Change implementation. Between 2007 and 2011 funds promised for the reform of mental health services did not materialise.

Notwithstanding the commitment of €35 million to implementation in the most recent budget, our worst fears are that the underlying philosophy of A Vision for Change, i.e. the adoption of the Recovery paradigm, may be at risk.

Faced with the prospect of further loss of momentum in implementing A Vision for Change caused by the economic crisis, Mental Health Reform is issuing this Manifesto.

The purpose of the Manifesto is to reassert, with up-to-date support from our own recent, national consultation with stakeholders, who in effect were the co-authors of A Vision for Change, the enduring validity of the policy and reform programme set out in A Vision for Change.

The Manifesto is intended to:

• Remind all concerned of the central tenets and recommendations of A Vision for Change.

• Add value to A Vision for Change in the light of the experience gained during the past six to seven years in implementation, and in the light of new insights from the broad field of mental health.

• Spell out clearly the priorities for action that are essential to sustaining the implementation of A Vision for Change.

Just a year ago, I visited a mental hospital which had been found by the Inspector of Mental
Health Services to be in serious breach of the most basic stipulated standards of care. People were sitting in locked wards, in their pyjamas, with no stimulation and over-reliant on medication. Mary Raftery, the recently-deceased campaigning journalist exposed the scandal which continues to the present day of vulnerable people languishing in unsuitable facilities and/or with impoverished care programmes.

When asked a final question in the pre-general election TV debate “what will be your priority if you get into government?”, now Taoiseach Enda Kenny replied “I feel the priority should be the 300,000 people who suffer from mental illness and the 75,000 people who attempt self-harm and those who have the tragedy of suicide visit their families.” Also, Michael D. Higgins in his inauguration speech declared that he would visit “the most excluded in our society, including those in institutional care.”

So, we have a published national policy now for 6 years with the support of the Taoiseach and our President for the kind of service that is set out in A Vision for Change, but there has been a failure to implement the policy with any sense of urgency. Committed Junior Ministers including John Moloney and Kathleen Lynch have made some progress but they face a constant battle to secure follow-through on promises.

Mental Health Reform, with the benefit that comes from extensive recent consultation, sets out in this Manifesto a focussed programme of action to sustain and accelerate implementation of A Vision for Change. While our emphasis is on the actions that need to be taken by the authorities in the Department of Health, the HSE and other agencies directly involved in mental health services, our message is intended for a wider audience.

A striking feature of our mental health services is the unevenness of service quality across the country. Whatever the financial constraints, a significant cause of this patchiness is the variable quality of leadership, management, staff engagement and local community involvement. While we seek to protect the mental health budget from further, disproportionate erosion and continue to advocate that the proportion of total health spending allocated to mental health services be progressively raised to that of exemplar countries, we firmly believe that a great deal more can be done through initiative ‘from the middle’ and the ‘front line’ and from community mobilisation and action.

The Recovery paradigm which permeates A Vision for Change relies almost entirely for its implementation on supports to be found in the local community. Above all, the transformation of our mental health services will depend on cultural change – change in attitudes and underlying values pertaining to mental health – both throughout the services and in wider society.

Each of us can make a difference.
Foreword by Orla Barry, Director, Mental Health Reform

To be listened to, to have a consistent supportive relationship with a professional and an offer of treatment that is not exclusively focused on medication

The need for a more humane, person focused service was the consistent message from the many people Mental Health Reform spoke to during the wide consultations that informed this Manifesto. This message holds the essence of what needs to happen to reform mental health in Ireland. A request as easily understood as it is misunderstood, the meaning seemingly varying between the many perspectives of service users, families, professionals, service providers and advocates. How has our inability to find a shared meaning affected our capacity to modernise our mental health services, to gain public confidence, to affect the implementation of a modern and progressive policy, A Vision for Change?

Mental Health Reform is committed to the full implementation of A Vision for Change. This manifesto seeks to recharge this goal four years out from the delivery date, 2016. A Vision for Change describes the structure of a modern community based mental health service and a value system enshrined in the recovery ethos. The vision: a humane, person focused, accessible and responsive service.

In Mental Health Reform’s Manifesto - Guiding A Vision for Change, we seek to make our meaning clear and call on our members, service users, professionals, public representatives and the general public to consider what it means to deliver a good quality mental health service. A service where people feel listened to, consistently supported by trusted professionals and consulted on the therapeutic options best suited to support their recovery. A service where multi-disciplinary staff teams are resourced and developed to effectively deliver accessible, quality, modern therapeutic interventions.

We do not underestimate the challenge involved in transforming Ireland’s mental health services. The transition from the old psychiatric institutions requires massive structural and cultural change. The greatest challenge is to ensure the beliefs, attitudes and behaviours of the institution do not transfer into the community. This is a very real threat. The closure of old hospitals and the move to community services has been happening over the last thirty years and the phrase ‘wards in the community’ aptly describes this experience of moving premises and holding the old cultural regime.

Institutionalisation is a process whereby the system and culture of a service robs people of their personal autonomy, individuality and power. The greatest effect is on service users; however, staff also suffer in the blunting of personal and professional values. Changing this culture is an absolute priority if we are to transform mental health in Ireland. Structural change, in service design, standards, legislation and policy must support the empowerment of service users and promote a transparent, open culture in the mental health services.

Modernisation is happening and examples of good practice can be seen across the country. However, quality is uneven and there is no guarantee that the good service in one area is available in another community. Building on good practice is a priority, as is educating service users, families and staff in what to expect in a quality service. A Vision for Change was written by professionals and advocates who understand this change. It is time to make it happen for everyone.
Recovery is a very personal process and a recovery ethos may be seen as a metaphor for the values, beliefs and culture conducive to supporting people in this process. The change in power dynamics between professionals, service users and families inherent to the recovery ethos is potentially challenging for all: for professionals who need to soften the expert role, for service users taking greater personal responsibility and for family members to expect to be consulted more on their needs. Recovery is also about people having real opportunities to live as full citizens. Housing, social welfare, education and employment services must play their part in facilitating each person's recovery journey. A cross-departmental structure is needed to underpin this coordinated support on the ground.

Modernising the mental health services requires equal access to affordable, sustainable and high quality primary care and specialist mental health services for everyone in need. Mental Health Reform considers that the reorganisation of roles and workload in multi-disciplinary community mental health teams is crucial to improving the satisfaction of service users and families. In principle, the most experienced staff should assess people newly referred; service users should have a consistent relationship with a member of the team; medication should be one of many therapeutic options; and the range of therapeutic expertise on the team should be accessible to more people.

In our consultations, a number of issues emerged: The involvement of families/significant others is very inconsistent. Family members' need for personal support was strongly voiced. The need for services to meet the needs of all members of the community, including those in the Traveller community, asylum seekers, members of the LGBT community, people who are deaf, people with physical and intellectual disabilities, people who are homeless or who have been in prison was also raised. Fear of making a complaint was widely raised. This is heightened by a fear of loss of liberty, an issue very specific to mental health and the enforcement of the Mental Health Act 2001. Mental Health Reform is now advocating for an independent complaints procedure for mental health services. Structural reforms such as an independent complaints procedure, the facility for advance directives within the proposed capacity legislation and a review of the power invested in doctors under the Mental Health Act 2001 would hopefully strengthen the confidence of service users in the system and support the redress of power.

Increased accountability, transparency and governance in the implementation of A Vision for Change and the management of mental health services are priorities for Mental Health Reform. The announcement of the establishment of a Directorate for Mental Health as part of the new structure for the HSE and the inclusion of €35M from within the health budget to develop community mental health teams, new mental health services in Primary Care and implementation of the national suicide prevention strategy are significant achievements for Mental Health Reform. However, the overall the mental health budget has been reduced and is at an all-time low and the effect of staff retirements and the embargo on recruitment is causing significant strain on services across the country.

Mental Health Reform’s Manifesto accompanies Guiding A Vision for Change – Agenda for Action. It lays out our considered views on what is required to stimulate the reform of Ireland’s mental health services. I trust that what we propose is relevant and timely and will stimulate discourse and action for reform of our mental health system.

Mental Health Reform is a growing movement of twenty three organisations and thousands of supporters promoting improved and prioritised mental health services.

Join us in creating hope and making positive change happen.
A Service User’s Journey through Good Quality Mental Health Services

Imagine what it would be like to seek help from a good quality mental health system. When you go to seek help from your GP, you would be listened to. Your GP would take the time to hear what is bothering you and to ask what is going on in your life as well as how you are feeling and thinking. Your GP may contact the local community mental health team for guidance on how to support your recovery. Your GP would give you information on different treatments or supports that could help you recover. Your GP could refer you to psychological therapy, bibliotherapy, an exercise programme, family therapy or addiction therapy as a first option and through these you might find ways to manage your life. Or your GP might refer you to other community supports, peer support or self-help groups. If these did not work, he/she might explore the risks and benefits of medication as a temporary measure to ease your feelings or thinking. Through this range of supports you would learn how to look after your mental health and recover your wellbeing.

If necessary, your GP would refer you to a mental health team. A mental health professional would meet with you, take the time to hear what is bothering you and ask what is going on in your life as well as how you are feeling and thinking. S/he would ask you about what you want to improve in your life, your goals and aspirations. S/he would ask you what you enjoy and what helps you to stay well. S/he might suggest that you go into hospital for a short time or might offer intensive support at home. With your agreement and after discussion of the risks and benefits, s/he might prescribe medication if necessary and the minimum amount to ease your feelings and thinking. You would then meet with a team of professionals who could offer you different supports – counselling/talking therapy, occupational therapy, job coaching, help with your benefits and housing, depending on what you need. If you agreed, the team could work with your family on how they could support you. Together, you would work out a recovery plan. Together you would work on the plan. You would learn how to manage your condition and engage with life with regular support from a key team member. You would link in with other supports in the community – peer support groups, community education programmes, psychological therapies, etc. You would have regular contact with your key team member who could be anyone on the team. When you were ready, you would be discharged from the mental health services knowing that if things got unmanageable again, you could return for support.
Introduction

Ireland’s mental health policy, A Vision for Change, was introduced in 2006. It is, even now, widely accepted to be a progressive and inspiring document that, if fully implemented would see Ireland have a modern approach to the mental health of the population and mental health services befitting the 21st century. However, in reality, the majority of Irish mental health services are not yet the progressive, recovery-led, community-based services envisaged in A Vision for Change.

In this Manifesto, Mental Health Reform sets out our position on how to achieve full implementation of A Vision for Change. The Manifesto is based on consultation with service users, peer advocates, family members, staff from non-governmental organisations, mental health service providers and national and international experts.

Mental Health Reform’s goal is for an Ireland where people with mental health difficulties can recover their good health and live their lives to the fullest.

Mental Health Reform believes that it is important to provide mental health services at local level so that service users can stay within their local community and receive the services they need.

Mental Health Reform works towards mental health services that are based on the best international practice and fully respect human rights standards, where people have equal access to good quality services and these services are available equitably across the country.

This Manifesto offers concrete, pragmatic and realistic solutions to bridge the gap between excellent policy document and painstakingly slow implementation of A Vision for Change. It has identified three essential components that can transform the Irish mental health services into a quality, modern, humane mental health service: 1) Promotion of the Recovery Ethos, 2) Modernisation of the Mental Health Services and 3) Increased Accountability, Transparency and Governance.

This Manifesto sets out Mental Health Reform’s priorities for influencing Government over the next few years. It represents the combined views of stakeholders from across the mental health sector in Ireland. Mental Health Reform’s Manifesto is based on international and national good practice. It accompanies Guiding A Vision for Change - Agenda for Action.
Promotion of the Recovery Ethos

"When you are vulnerable, they say what you need to do and they don’t listen to how you feel.” (Mental Health Reform consultation)

A person who uses the Irish mental health services should be treated with empathy, respect and dignity by the mental health professionals they encounter on their way to recovery. Recovery is a very personal process. Regardless of how somebody is feeling at any one particular time, the supports must be available to allow them to live their life to the fullest.

While the recovery approach is recommended in A Vision for Change, its meaning is not spelled out. A commonly cited definition of recovery is that of William Anthony (1993). According to Anthony, recovery is

“… a deeply personal, unique process of changing one’s attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” 1

Anthony well captures the emphasis on the individual’s personal recovery journey. However, the recovery ethos also reflects a desire to be liberated from the traditional approach to mental health care. It is important to remember that the ‘recovery’ movement and vision essentially originated in the service user and ‘survivor’ movement and most of its outcomes consist of co-operations between people with a lived experience and people without. 2 Judi Chamberlin was an ex-service user and an early advocate for an alternative to the traditional psychiatric approach to mental distress, publishing her book On Our Own in 1977. She described her recovery journey in this way:

“…it was only when I became involved in the self-help and advocacy movement that I found what I had been looking for in the mental health system but never found there. That was people who were willing to listen, willing to accept my experiences, take me at face value, not start labeling my feelings and thoughts as symptoms, and that we can do this for one another, that it was a mutual activity - it was mutual support.” 3

The recovery approach underpins a shift in the relationship between service users and professionals. Only the individual affected can determine what constitutes his or her own recovery. Thus a recovery approach demands person-centred services that value the expertise of the individual affected and that are structured around that person’s own life goals. This interpretation of recovery is supported by the Mental Health Commission. 4

“The person who is unwell is the expert themselves. They need to have control over their own condition. I know a woman who had numerous suicide attempts but said to her doctor she wanted to try an alternative. Her doctor supported her to do that. She did the WRAP programme and now she is medication free.” (Mental Health Reform consultation)

However, it demands a fundamental shift in the mindset of many mental health professionals. The major questions to be answered currently are:

1) How can those of us who work in the mental health system free ourselves from an institutional mindset, centred on an ethic of control?

2) How can we get beyond the narrow biomedical paradigm that currently shapes our understanding of mental health problems and guides our interventions?

3) How can we move from paternalism to collaboration in the relationship between professionals and patients?  

Recovery is something distinct from reducing symptoms; it includes developing skills in managing one’s condition as well as being able to participate in valued activities and achieving valued roles in one’s community. Recovery in this sense is possible even when symptoms continue as long as those symptoms do not inordinately interfere with a person’s daily life.  

“People also must take responsibility for their own wellbeing and need to be supported in their own recovery.” (Mental Health Reform consultation)

Mental Health Reform believes that core components of a recovery-orientated service are:

- Hope – Mental health professionals must convey an expectation of recovery and must demonstrate belief in the individual’s strengths and capacities.

- Listening – Mental health professionals must listen to service users – to their personal understandings of their condition, to their aspirations and goals, and to service users’ own knowledge about what helps them to recover and stay well.

- Partnership – Service users and mental health professionals must work with each other as equals to foster recovery. Wherever appropriate, services should reach out to family members/significant others as partners in providing support. Service users should be involved in planning, delivering and monitoring services at every level.

- Choice – Service users must be offered choices – of treatments and therapies, of who provides their care, of when and where supports are provided. Mental health professionals must provide balanced information to enable service users to make informed choices.

- Social Inclusion – mental health services support service users to participate in their communities, have social relationships and engage in meaningful activities including education and employment. Services must support people to claim their rights and entitlements. A cross-departmental group to ensure that good mental health is a policy goal across a range of people’s life experiences including education, employment and housing should be established.

At a one-to-one level, working with service users as equal partners in their own care is essential to re-balancing the traditional power imbalance between service users and professionals in the mental health services. Service users often know from their own experience what works best for them in maintaining their mental health and what is ineffective. They know their experience of side effects from medications. They often know what triggers their mental distress. They know how they will define their own recovery.

5 Correspondence from Dr. Pat Bracken to Mental Health Reform.


Participation is a core component of an approach based on human rights and is underpinned in the preamble of the Convention on the Rights of Persons with Disabilities. Participation by individuals in decisions affecting them is a crucial element of the right to health. Ireland has ratified the International Covenant on Economic, Social and Cultural Rights which recognises the right of all persons to the highest attainable standard of physical and mental health (Article 12).

“Personal value is important, listening to people gives them value - using the person's experience to help them.” (Mental Health Reform consultation)

Recovery planning should involve a dialogue between service user, professional and carer (where relevant) in which meaningful communication about both, the understanding of the ‘problem’ and the steps towards recovery, takes place. Such dialogue between the service user and professionals needs to be an intrinsic part of clinic appointments. Service users also need to be given balanced information about the risks and benefits of possible treatments/therapies.

While service user involvement in care is increasing in Ireland, many service users are not adequately involved in making decisions about their care. De Burca, Armstrong and Brosnan found that of 100 service users, only 42% were aware that they had a care plan. On the positive side, only 8% of participants disagreed that they had been involved in making decisions about their care plan, but worryingly, 34% said they had not been involved in choosing their treatment and 20% said they had no say in the decision about their medication. The National Service User Executive has also found that service users and family members are not receiving enough information.

“It seems like the services don’t take family members seriously.” (Mental Health Reform consultation)

Family members and other carers are also an important part of the environment for mental health care. Carers are inevitably impacted by the mental health and social outcomes of their relative with a mental health condition. When family members have a good understanding of mental health conditions and ways of coping, they can play a positive role in supporting recovery. Carers also have their own needs for mental health and social support. The Mental Health Commission has stated that community mental health teams should provide support to family members, including on-going emotional support, respite care, assistance with accessing other types of services and education about mental health.

“Families should be educated about mental health.” (Mental Health Reform consultation)

The role of family and other carers is not adequately defined in A Vision for Change. Neither is the role of the family reflected in Ireland's mental health legislation.

Mental Health Reform seeks:

- A dedicated consultation with family members/ significant others and the voluntary mental health sector to develop a mental health carer framework.
- Provision in legislation for the role of carers and a duty on mental health services to assess carers’ support needs.
- Assessment of the needs of the children of adult service users where appropriate.

11 Ibid.
Implementing Recovery-Orientated Services

“We need to move from maintenance to recovery. Current services are stuck in maintenance.” (Mental Health Reform consultation)

“The attitude of mental health staff can be anti-recovery.” (Mental Health Reform consultation)

Implementing recovery-orientated services requires both structural and cultural change. It’s about visibly demonstrating the values as well as working from a recovery mind-set.

The recovery approach involves incorporating a new set of values into mental health care delivery; it requires ‘values-based practice’ alongside ‘evidence-based practice’. A Vision for Change clearly demands that the values set out in its principles of citizenship, respect, partnership and recovery are translated into practice.

Mike Slade explains what values-based practice means:

“Values-based practice highlights that the application of technology (e.g. assessment processes, treatments, outcome evaluation) is not a neutral activity. Awareness of and debate about implicit values is as important as discussion about the optimal treatment strategy. It points to the primacy of the patient’s values, the importance and limitations of evidence-based practice, and the centrality of language, communication and negotiation.”

One method of developing a shared understanding between mental health service users, family members and others in the community is through creating spaces where dialogue between diverse perspectives can occur. The ‘open dialogue’ approach is currently being run in Ireland through the Mental Health Trialogue Network. A trialogue is described by the network as: “a neutral space where communities can gather to develop their understanding of mental health issues, the challenges of maintaining mental health and to transform thinking on developing better services and healthy communities” (see www.trialogue.co). Another approach is through the development of consumer panels where service users and family members/significant others meet to discuss their experience of the services and then meet with local management to raise their concerns. Consumer panels have been in place in some parts of the country for several years and are now expanding. Both methods improve communication between service users, family members/significant others and service providers.

Key steps in implementing recovery orientated services are:

- Developing a service mission statement that reflects recovery values
- Developing service policies that foster hope, listening, partnership and choice
- Developing service procedures that operationalise recovery values such as positive risk management policies that promote self-determination
- Developing care planning that happens in partnership with service users and families and provides choice
- Measuring achievement of service users’ goals, social inclusion and discharge from services
- Providing recovery-fostering facilities that are open, pleasant and that do not separate out staff from service user areas
- Supporting service users to link in with local community services and supports
• Recruiting staff based on aptitudes and skills that are congruent with the recovery philosophy
• Training staff in the recovery skills: how to assess capabilities; identify and plan action towards recovery goals; support the development of personal meaning.
• Employing service users in the delivery of services, including peer support workers and reporting on the number of peer workers employed in the mental health services
• Supervising staff performance based on fulfilment of recovery values
• Supporting service users to challenge prejudice and discrimination in services and the wider community
• Ensuring that individuals’ human rights are protected, respected and fulfilled

(Based on Farkas, Gagne, Anthony and Chamberlin (2005), Slade (2009) and Higgins (2008)

There are local community mental health services in Ireland that are working to implement a recovery approach. Among them, the Loughrea service has consciously set out to incorporate the recovery principle into practice. They have held staff and service user meetings on the recovery ethos, moved to a multi-disciplinary case management approach and incorporated the Wellness Recovery Action Plan (WRAP) into how they provide support. The rehabilitation team in Castlebar is involved in a project to test a method for changing a service to a recovery-orientated approach (the IMROC project).

Case Study:
The West Cork mental health service has been pro-active in moving towards a recovery-orientated service. They have commitment from their clinical staff to the idea of ‘recovery’ and use multi-disciplinary team-working to develop individualised plans for recovery with service users and family members. They operate a 24-hour ‘listening service’ using a dedicated phone line and staff have trained and re-skilled as counsellors/psychotherapists so that talking therapies are rapidly available. They also have worked closely with voluntary sector providers such as the National Learning Network, Rehab Care and Employability West Cork to provide a service that is integrated with community supports. One significant element of their approach has been the appointment of a ‘team coordinator’ who acts as a first point of contact for many referrals, coordinates the input of team members and liaises with GPs. One outcome of their recovery-orientation has been a significant reduction in inpatient bed use.

The Mental Health Commission’s Pillars of Recovery Service Audit Tool (Higgins 2008) is a good way of measuring how well individual services are performing in implementing a recovery-orientated approach. Mental Health Reform would welcome regular reporting by the HSE on its mental health services against this audit tool. A more recent evaluation, published by the Bamford Implementation Rapid Review Scheme in Northern Ireland, recommends the Recovery Context Inventory and the INSPIRE measure which measure recovery orientation at the level of the individual service user. EVE day services are developing the Recovery Context Inventory in Ireland.

11 See http://www.centreformentalhealth.org.uk/recovery/supporting_recovery.aspx
Recovery orientated services also require adequate resources, though there is considerable scope for meeting resource needs through retraining existing staff and reorganising services. Staff capacity is needed to allow time for listening to service users and family members. The team must be able to provide a range of therapies to offer choices to service users. Service user involvement requires resources so that participants can receive training and compensation for their time and expenses.

**Social Inclusion and Equality**

Approximately 20% of the recommendations in *A Vision for Change* concern areas of life that are the responsibility of Departments other than Health. Some of these concern housing, education, income and employment for mental health service users. Others concern promoting mental health in the wider community. The National Economic and Social Forum (NESF) also developed recommendations on social inclusion and mental health in order to support implementation of *A Vision for Change*.

The Expert Group on mental health policy recognised that poverty is a key risk factor for poor mental health. *A Vision for Change* cites the World Health Organization Regional Committee for Europe:

> “Poverty and mental ill health form a vicious circle: poverty is both a major cause of poor mental health and a potential consequence of it.” 16

The relationship between social inclusion and mental health is bi-directional: homelessness, joblessness and low income are risk factors for poor mental health, while people with long-term mental health difficulties are at high risk of social exclusion, particularly unemployment.

However, today the social and economic lives of people with poor mental health are at risk in Ireland and people with a mental health condition experience social exclusion:

- People with a mental health disability participate in the Irish labour force at less than half the rate of the general population 17
- Adults with a mental health disability are more likely to have left their job due to their disability than people with other disabilities 18
- Over half of people stopped education due to their mental health disability where their mental health disability arose before completing full time education 19
- Almost a quarter of those in receipt of illness benefit in 2009 cited ‘stress’ or other mental health issues as the reason for their claim 20 while more than twenty per cent of people on Disability Allowance had a mental health disability as their primary condition 21

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19 Ibid., p.75.
20 The Irish Times ‘25% of sick claims cite mental health’, Wednesday, January 27, 2010 by Mary Minihan.
People identified as having a mental health condition also face stigma, prejudice and discrimination in Ireland:

- In 2006, only 7% of the public thought employers would be willing to hire someone with a mental health problem.\(^\text{22}\)
- In 2006, people were less comfortable living near a person with a mental health disability than a person with any other type of disability.\(^\text{23}\)
- In 2010, 47% of the public agreed that a diagnosis of a mental health condition would have a negative effect on their job and career prospects; 37% said it would have a negative effect on their relationships with their work colleagues.\(^\text{24}\)
- In 2010, research among more than 300 people with a history of poor mental health found perceptions of having been treated unfairly in every domain of social life including by friends, neighbours, family, health service staff, the police and in housing, education, work, public transport and welfare.\(^\text{25}\)

Such social exclusion is compounded for people who live with a mental health condition alongside another diagnosis or disability such as addiction, intellectual disability, physical or sensory disability. Furthermore, the particular challenges of some minority and marginalised groups such as people who are homeless, the Traveller community, asylum seekers and the prison population lead to social exclusion and increased mental health difficulties. Asylum seekers can be living in circumstances that severely exacerbate poor mental health. They often have no family supports and are living in isolated hostels leading to a lack of community support or integration. They have difficulty accessing services, education, housing, etc. Asylum seekers often have language barriers and post-traumatic stress disorder symptoms that lead to isolation within the hostels. Asylum seekers also face isolation within communities due to their meagre weekly allowance of €19.10.

The Expert Group on mental health policy who drafted *A Vision for Change* recognised that stigma/prejudice and discrimination are priority issues for people with mental health problems. Social inclusion is an integral part of recovery.\(^\text{26}\) Good quality mental health services support an individual’s integration into the community and help them to combat stigma/prejudice and discrimination. *A Vision for Change* recommends that people with a mental health condition should be treated equally in Irish society and that programmes should be put in place to tackle stigma. Yet the evidence above shows that there is still unacceptable inequality experienced by people identified as having a mental health condition.

Currently, there is no specific cross-departmental implementation plan on mental health; neither are there specific mental health actions evidenced in most of the relevant departmental sectoral plans under the National Disability Strategy. One positive example has been the dedicated chapter on mental health in the Housing Strategy for People with Disabilities, developed by the Department of Environment and Local Government. The Independent Monitoring Group for *A Vision for Change* has recommended that the Government develop an overarching implementation plan that covers all relevant Government Departments. The Independent Monitoring Group has also recommended a more structured process of evaluation of implementation across Government Departments.\(^\text{27}\)

\(^\text{23}\) Ibid., p.36.
\(^\text{27}\) Independent Monitoring Group Fifth Annual Report.
Mental Health Reform seeks a cross-departmental structure that will provide a forum for specific action to implement A Vision for Change. The Programme for Government commitment to “establish a cross-departmental group to ensure that good mental health is a policy goal across a range of people’s life experiences including education, employment and housing” is welcome. This group should work with the voluntary sector and service user and family member groups to develop the cross-departmental sections of an implementation plan for A Vision for Change. This structure must also enable transparent monitoring of mental health-specific actions by Government departments outside of health. Wherever possible, Government departments responsible for providing education, employment, housing and income supports should report regularly on their provision of and the usage of their services and supports by people with mental health disabilities.

Mental health services will be hampered in facilitating recovery if they do not have effective links with local housing, education and employment services. Where such links are currently in place, for example through the job coaching initiative in the DETECT early intervention service, mental health service users get a better quality service and a better chance of entering and sustaining employment. Similarly, where good links are established with housing services, for example in the Dublin-based homeless outreach mental health services, people at risk of homelessness are more likely to get coordinated housing and mental health support. Such links need to be the norm in mental health services across the country.

One barrier currently hampering employment of people with experience of a mental health difficulty is the lack of a national supported employment programme that follows international evidence on effectiveness. The evidence supports an ‘employment first’ approach to employment support where anyone who wants to work is eligible for supported employment. In Ireland, the FAS-funded supported employment programme has a ‘job ready’ criterion that acts as a barrier to individuals joining the programme and progressing into employment.

Despite the key role that social inclusion plays in recovery there is currently no nationwide measurement of the social inclusion outcomes for mental health service users. The HSE should ensure that indicators for housing, employment, education and income status are collected, on a routine basis, about people accessing mental health services in order to measure whether service users are achieving improved social and economic outcomes over time.

In order to fulfil the social inclusion recommendations in A Vision for Change, Mental Health Reform seeks:

- Mental health services that link effectively with mainstream social, housing, educational and employment services to provide seamless, coordinated social inclusion support for individuals.

- A cross-departmental implementation plan and monitoring structure as recommended by the Independent Monitoring Group.

- A cross-departmental implementation and monitoring structure at senior level with public access to information, comparable to the HSE’s HealthStat reporting.

- A cross-departmental employment strategy for the delivery of training, education and employment services for people with mental health conditions.

- An emphasis on the Individual Placement and Support model of supported employment, prioritising placement in open employment for anyone with a desire to work, with support and training available in the workplace.

• Support for employers to employ people with a mental health condition including an information helpline.

• Promotion of a greater awareness among people with a mental health condition of their rights under equality legislation and easier access to claiming their equality rights.

• A long-term public anti-prejudice and discrimination strategy with appropriate resources, targets, monitoring framework and indicators for improving attitudes and behaviours towards people with a mental health condition.

• Social inclusion status of service users and social inclusion outcome measures as part of mental health service data collection.

• Ratification and implementation of the Convention on the Rights of Persons with Disabilities and its Optional Protocol, to ensure equal access to rights and full participation for people with mental health problems. The Government should establish mechanisms to ensure that people with mental health problems have the opportunity to participate in developing, implementing and monitoring Ireland’s compliance with its obligations under the Treaty.

In summary, to achieve a recovery-orientated service, Mental Health Reform seeks:

• Development of an on-going programme of cultural change within mental health services.

• Dissemination of the charter of service user and family rights, set out in “You and Your Health Service: What you can expect from your health service and what your health service can expect from you” by the HSE to all service users and family members in the mental health services and primary care.

• Promotion of service user led services and service user employment as peer advocates.

• Development of a framework for the involvement and support of family members and carers.

• Establishment of a cross-departmental implementation plan and monitoring structure as recommended by the Independent Monitoring Group on A Vision for Change to ensure that mental health services link effectively with mainstream social, educational and employment services to provide seamless, coordinated social inclusion support for individuals.

• Ratification and implementation of the Convention on the Rights of Persons with Disabilities and its Optional Protocol.
Modernising the Mental Health Services

Government policy sets out a comprehensive community-based framework for mental health services that requires the development of multi-disciplinary community mental health teams with full-time involvement of psychology, social work, occupational therapy and other disciplines. It also requires that community teams work effectively to provide coordinated support and that the institutional mode of practice be changed to a community-orientated approach. Mental Health Reform seeks implementation of this community based, multi-disciplinary mental health system. When A Vision for Change is fully implemented, everyone in Ireland will be able to access a mental health service appropriate to their need.

The community based mental health services envisaged in A Vision for Change are specialist services with staff who have particular expertise in supporting a person's mental health. The core services offer a holistic range of supports and include staff from a range of specialist disciplines including clinical psychology, mental health nursing, occupational therapy, psychiatry and social work. In addition addiction therapy, creative arts therapy, counselling/talking therapy, family therapy, job coaching, peer support and psychotherapy will also be available.

Community-based mental health services enable someone to be treated for mental distress in their own community, either at home or at a hospital. They allow inpatient or day hospital stays to be minimised. They liaise with local community services such as vocational training, education, housing and voluntary support services to provide an integrated recovery service for the individual. They support staff in primary care services to provide mental health support. They liaise with teachers and other school staff, helping them to guide students and families to appropriate support. They help to educate people of all ages in the local community about mental health and how the community can support positive mental health.

“The home based service has been wonderful! I was a million times worse in hospital than before I went in. Hospital reminded me of a jail - the environment was depressing. Everything about it was depressing. The staff were ok. I was there for a week but it was like a year. The Home Treatment Team can give me my medication.”

(Mental Health Reform consultation)

Community-based mental health services have facilities throughout the community. They include acute wards in general hospitals, day facilities such as outpatient clinics, day centres and peer-run resource centres. They include a range of housing options where people can make the transition from being in hospital to getting ready for independent living.

Why Do We Need Community-Based Mental Health Services?

Our mental health services are undergoing immense change, from an asylum system of institutions into a modern, community-based model. Developing holistic community-based mental health services is vital to deinstitutionalisation – enabling the closure of large, old segregated hospitals and the transition of residents into community living.

Community based mental health supports help to reduce social exclusion by helping service users to become participants in their local community. Modern mental health services support individuals to live in their own home in local neighbourhoods. They support service users to participate in training, education, work and leisure activities with other members of the community. Loneliness resulting from social stigma can aggravate a mental health condition, leading to distress and a return to hospital. Good mental health services consider the needs of their service users who are isolated and develop appropriate supports.

“CMHTs are vital if you are going to work towards a wellness and recovery programme.” (Mental Health Reform consultation)
Services can also help people to get care earlier and thereby improve their long-term life outcomes. By being more accessible to people and by raising awareness about mental health supports, community mental health teams can encourage people to seek help before their condition becomes a crisis.

“We need more community nurses. They are spread thin. Access to them is hard. A person who made a suicide attempt two weeks ago had no support.” (Mental Health Reform consultation)

Ultimately, having accessible mental health services in the community can help to normalise mental health and de-stigmatise mental health problems, reducing the prejudice and discrimination that people currently face.

Integration Between Addiction and Mental Health Services

While there is little systematic Irish evidence yet on the prevalence of co-occurring problematic drug and alcohol use and mental health problems in Ireland, evidence in the UK would suggest that such ‘co-morbidity’ is widespread among both addiction and mental health service users. A UK study published in 2003 found that 44% of mental health service users had previous year problem drug use or harmful alcohol use, while 75% of drug service users and 85% of alcohol service users had a ‘past-year psychiatric disorder’.

Workshops conducted by Dual Diagnosis Ireland in 2010 found that staff from the addiction services experienced frustration in trying to get their service users’ mental health needs met, a lack of coordination between addiction and mental health services and a perceived “lack of respect for addiction professionals by CMHT staff.” More recently, in a meeting with homeless sector staff from the Dublin region, Mental Health Reform heard that service providers continue to have difficulty getting mental health treatment for their service users if the individual concerned has problematic drug or alcohol use. This lack of effective service delivery for people with both conditions is likely to be resulting in higher than necessary costs.

Mental Health Reform seeks that:

- The HSE should take action to ensure better access to mental health treatment for people with co-occurring mental health problems and problematic drug or alcohol use.

Ensuring Mental Health Services Serve the Whole Community

Community mental health services have a duty to meet the mental health needs of all members of the community, including those in the Traveller community, asylum seekers, members of the LGBT community, people who are deaf, people with physical and intellectual disabilities, etc. Members of these groups are at higher risk of developing a mental health condition than the population at large, yet to date there has been little implementation of the recommendations in A Vision for Change that concern such groups. Mental Health Reform is concerned that the HSE is not giving adequate priority to ensuring that mental health services are serving the whole of the population. Under the international human rights framework, Government has an obligation to ensure that the health of disadvantaged groups is protected through targeted programmes.

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31 The UN Committee on Economic, Social and Cultural Rights’ General Comment No.14 on the Right to the Highest Attainable Standard of Health states that “even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programme.” (See Article 12).
Mental health services must also respond to mental health needs in a way that reflects the differences between men and women. A Vision for Change is gender blind in that it makes no specific recommendations about ensuring that services are appropriate based on gender, yet the differences in risk and presentation of poor mental health are widely known. Women are at higher risk of depression and anxiety, while men are more often diagnosed with schizophrenia and other psychoses. These differences indicate a need to ensure that mental health services are gender sensitive and also to ensure that mental health promotion and suicide prevention programmes are tailored to different gender populations.

“The involuntary treatment of pregnant woman with medications needs to be looked at.” (Mental Health Reform consultation)

“What frightens me are services not being culturally appropriate... services never reach out to traveller organisations.” (Consultation meeting at Pavee Point)

“There is a reluctance among [mental health] professionals to acknowledge the impact of sexual identity.” (Conversation with a BeLonGTo Youth Services staff member)

“In custody people can be stabilised but then upon release, it can be difficult to get services to be available in the community.” (Consultation with the Probation Service).

There is a severe gap in relation to services for people who are deaf in Ireland. There are over 5,000 people in the country who are deaf from early life. They belong to the Deaf Community and Irish Sign Language (ISL) is their first, preferred or, in some cases, only language. ISL is recognised as a national language by the EU and in Northern Ireland but not yet in the Republic of Ireland except for its use in education. Over 90% of people who are deaf are born in hearing families. Half of the causes of early profound deafness are genetic, mainly recessive. Other causes include birth problems, meningitis and rubella. Many causes of deafness can be associated with visual or neurological problems including learning disability. Because of parental choices and educational policies, many people who are deaf do not have access to sign language in early life, even when oral education is not successful. In addition, a deaf person’s written English may be poor or appear in sign language word order. Deaf people have the same range of mental health problems as the general population and have additional risk factors such as delayed language and social exclusion. However, their access to mental health services is very limited. Difficulties and delays in accessing assessment and treatment are common.

Mental Health Reform seeks that:

- The HSE engages in specific initiatives to ensure that community mental health services meet the mental health needs of all people living in local communities.
- The HSE sets out how it will implement the recommendations on mental health services for people with an intellectual disability.
- The HSE ensures that sign language interpretation is widely available in mental health and primary care services so that members of the Deaf Community can have equitable access to mental health services.
Integration Between Mental Health and Housing Services

“People are still being discharged to homelessness.”
(Consultation with Dublin homeless network)

People with poor mental health are at higher risk of becoming homeless than those who have secure housing. So too, people who are homeless are at higher risk of poor mental health. The Australian Human Rights and Equal Opportunities Commission found that:

“One of the biggest obstacles in the lives of people with mental illness is the absence of adequate affordable and secure accommodation. Living with a mental illness, or recovering from it, is difficult even in the best circumstances. Without a decent place to live it is virtually impossible.” 32

The provision of secure permanent accommodation with appropriate supports is vital to enabling recovery. So too, ensuring individuals are empowered with the skills to maintain their tenancy will help to provide a stable platform for their own recovery. Among Simon Community homeless services, 52% had at least one mental health diagnosis in 2010.33 Mental Health Reform has also heard of a range of barriers to the effective coordination of support between mental health and housing/homeless services, including gaps in communication between local mental health and homeless services and gaps in follow-up care after discharge from hospital. Of particular concern is the lack of specialist mental health support for people with a personality disorder who are homeless; this lack of support can leave homeless services as the last port of call for an individual with complex needs, but without adequate back-up to provide appropriate support.

The Housing Strategy for People with Disabilities has, through the agreed liaison protocol, already provided a framework for the development of effective links between local authority housing officers and community mental health team staff. This protocol needs to be brought to life in mental health services and local authorities across the country so that every person at risk of homelessness due to a mental health condition is provided with well-coordinated access to housing supports. Equally, local community mental health teams need to strengthen their communication practices with local homeless services.

Mental Health Reform seeks that:

- The HSE ensures that part 5 of the Mental Health Commission’s Code of Practice on being Admitted, Transferred and Discharged to and from Hospital is implemented nationally.
- The HSE sets out how it will implement Recommendation 15.8.1 to provide evidence-based interventions to people with borderline personality disorder.
- The Department of Environment, Community and Local Government and the HSE fully implement the mental health recommendations in the Government’s Housing Strategy for People with Disabilities.

Forensic Mental Health Services

The lack of modern, regional forensic mental health service as envisaged in A Vision for Change continues to result in a lack of appropriate mental health support for people involved in the criminal justice system. In his Judgment in D.P.P.v.B, Justice Sheehan noted in 2011 that the Central Mental Hospital is the only designated centre under the Criminal Law (Insanity) Act 2006. The fact that the CMH continues to be the only designated centre in the country means that prisoners from distant prisons must be transferred to Dublin for treatment, removing them from proximity to any social supports they may have such as family and friends. The human rights principle of community-based treatment must apply to prisoners as to any other patients and this includes having inpatient treatment within a reasonable distance to one’s own community. There is an urgent need to establish other designated centres to enable a wider range of options for treating individuals within the criminal justice system.

Mental Health Reform seeks:

- The Department of Health and the HSE should urgently progress the establishment of regional, appropriate acute inpatient units that can be designated centres under the Criminal Law (Insanity) Act 2006.

Community-Based Services for Children and Young People

“The fact that the young people themselves have a say in what clinicians do – I think they are led by what we need as opposed to being a group of adults sitting down and trying to figure out what we need – it saves time and it’s a more efficient way of working.”

“Jigsaw provides a much more comfortable setting – people when they come in they feel that it’s been almost vetted by young people and they trust the service more.” Quotes from a consultative meeting with Headstrong’s Youth Advisory Panel

Three quarters of mental health problems arise before the age of 25, and evidence is strong that early intervention in mental health difficulties improves long-term outcomes. The HSE prioritised development of CAMHS services in the early years after publication of A Vision for Change and this priority has borne fruit in terms of an increased number of child and adolescent inpatient beds, a reduced number of children and adolescents being admitted to adult wards, an increase in the total number of CAMHS community teams and a reduction of 20% in waiting lists for CAMHS services between 2010 and 2011. Government has also supported the establishment of five Jigsaw mental health projects around the country. The Government’s allocation of €16M for an additional 150 community CAMHS posts is very welcome as a means of continuing progress in services for children and young people.

One transformative development has been the opening of Jigsaw projects around the country. The Jigsaw projects have brought innovation to services for young people by creating an accessible, acceptable gateway through which young people can seek support and, where necessary, access specialist services. Members of Headstrong’s Youth Advisory Panel rate Jigsaw highly for the way in which it has created a youth-friendly, de-stigmatising and peer-driven space within which to access mental health support.

The young people we spoke to emphasised the value of having non-stigmatising, non-medical gateways through which to get support. They also emphasised the need for a holistic approach to support that avoids labelling and focuses on the whole lives of the young person.

34 D.P.P. v. B. [2011] IECCC 1 at [5.18].
Despite the priority given to CAMHS services since 2006 there are still significant gaps compared to A Vision for Change recommendations. As of 2010, only 9 out of 39 CAMHS services accepted referrals of all young people up to and including 17 years of age. At the end of 2011, CAMHS services still had just 39 of the 108 inpatient beds recommended in A Vision for Change, even though this is a substantial increase on the 12 beds that were in place in 2007. CAMHS community teams also had just 42% of the total staffing recommended in A Vision for Change.

Mental Health Reform seeks:

- Fulfilment of the HSE’s planned 150 additional community team posts in CAMHS services.
- An end to all inappropriate admissions of children and adolescents to adult units.
- The HSE must develop protocols to ensure that every young person has a transition plan in place before transferring from child and adolescent services to adult services and that the young person is consulted in relation to such a plan.
- The HSE and mental health education providers should ensure staff working in CAMHS services are adequately trained to work with young people between the ages of 16 and 18.

Mental Health Services for Older People

Mental Health Services for older people are geared towards supporting older people with mental health problems in a respectful manner which preserves the dignity of the individual. The demand for these services is expected to increase along with an increase in life expectancy for the general population. There is a particular need to reflect the interdependence between physical and mental health in care for older persons. Primary care services have a key role to play in early identification of poor mental health in their patients. Home based health care is the preferred method of care amongst many older persons. Family members/significant others need support and education to assist them with caring for an older person with poor mental health. The Expert Group for A Vision for Change also considered that older people with pre-existing mental health problems should have the choice when they reach 65 years of age between being supported by mental health services for older people or continuing to receive their support from adult mental health services.

There are major gaps in service provision for older people compared to what is recommended in A Vision for Change. There is a lack of designated acute beds for older people in approved centres and some catchment areas have no access to long term beds. A Vision for Change recommends 39 Mental Health Services for Older People teams nationally; however only 22 such teams were in place in 2010 and these were understaffed. According to the Inspectorate, these teams are limited in the services they can provide because they lack multi-disciplinary staff and are incomplete. Additionally Mental Health Services for Older People teams lack bases from which to provide services such as day hospitals and centres and they have no administrative support. There is also a need for more outreach services to older people in rural communities including mobile clinics.

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36 Ibid., p. 11.
Mental Health Reform seeks that:

- The HSE sets out how it will fulfil the recommendations on Mental Health Services for Older People in A Vision for Change.
- The HSE sets out how it will support family members/significant others and carers of older mental health service users.
- Any programme to increase integration between primary care and mental health services includes a focus on mental health services for older people.

Multi-Disciplinary Teamworking

Part of the cultural change that needs to happen in the mental health services is the development of a teamwork approach, as contrasted with the traditional, hierarchical structure overseen by a consultant psychiatrist. In Ireland, “the traditional medical model is still dominant with the psychiatrist as clinical team leader” 38 Community teams in Ireland are poorly developed, with 80% of teams lacking a full complement of disciplines. 39 There continues to be a “medicalised model” of care provided predominantly by the disciplines of psychiatry and nursing, with relatively low levels of input from psychologists, social workers and occupational therapists. 40 And there are few peer workers as part of teams in Ireland.

As a starting point, effective teamworking and quality care requires an adequate range of multi-disciplinary input into the individual’s care. No single discipline can provide adequate care for an individual with a severe mental health problem. 41 But the community team approach is not just about having a range of disciplines in the team; it is about working together effectively. Having non-medical disciplines as full-time participants in mental health teams is linked to better team processes. This in turn leads to better service quality, clinical effectiveness and service management. 42 Well-functioning multi-disciplinary teams accept collective responsibility for service quality and outcomes. Good team working is also cost effective. 43 Case management and/or a key worker system are an accepted part of effective multi-disciplinary teamworking in other jurisdictions. 44

Mental Health Reform believes that attention must be paid both within the health services and in professional training programmes to developing effective multi-disciplinary teamworking processes. Mental Health Reform supports the recommendation made by De Burca, Armstrong and Brosnan that a programme of community mental health team development be undertaken. 45 The Mental Health Commission has produced valuable guidance on teamworking which can be used by health services to develop and monitor their team practices. 46

39 Ibid., p.98.
40 Ibid., p.101.
41 Byrne & Oryett (2010), p.5.
45 Ibid.
46 Byrne & Oryett (2010).
Furthermore, teamworking would also be improved through wider implementation of individual recovery and care planning. In 2007, the Mental Health Inspectorate found only an 18% compliance level with the Regulation on Individual Care Planning as it applies to inpatient units. As recently as 2011, the Inspector reiterated his concern at the “disappointing” level of individual care planning in approved centres. He commented that “in many cases, this is a mere ‘paper exercise’ and, in some cases, we found deliberate decisions not to implement the plans”. As signalled by the publication of the National Mental Health Services Collaborative Report on Individual Care Planning in 2012, a substantial body of work has been done since 2007 in order to develop local approaches to individual care planning. However, it is not yet clear how this work will be translated into practice, nor who will ensure that good quality individual recovery and care planning becomes the norm in mental health services in Ireland.

Multi-disciplinary teamworking is recognised internationally as integral to modern mental health care and is supported by Ireland’s Mental Health Commission who state that:

“Co-ordinated team-based individualised care that integrates with other health services and with generic, social and community services, is necessary to promote service users’ recovery, a good quality of life and community re-integration.”

This teamwork approach to care is encapsulated by De Burca, Armstrong and Brosnan:

“Modern community mental healthcare teams, however, are focused on providing service user-centred care from a multifaceted, but coordinated, approach to apportioning tasks, taking joint responsibility for reviewing the patient’s progress and making joint decisions about treatment plans.”

Good teamworking is necessary to provide a good quality service and full-time non-medical members of the team are necessary because this results in significantly better team processes and outcomes.

Furthermore, there is a systemic flaw in the mental health services in that trainee doctors, who are often the least experienced within the system, are charged with the most important initial assessment function. This may lead to extremely poor initial experiences on the part of people seeking help and the lowest level of diagnostic/assessment capacity at the most important point of contact, i.e. the first point of contact. It also fails to draw upon the breadth of disciplines that could be involved in assessment. The system needs to change at first point of contact, so that priority is given to people being met by the most experienced, most highly-trained and wisest mental health practitioners from the most relevant discipline.

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49 Byrne & Onyett (2010), p.5.
Service User and NGO Involvement at Management Level

The HSE’s establishment of the National Service User Executive and the involvement of service users at senior management level in planning the implementation of A Vision for Change have been key implementation achievements to date. Recent moves to establish consumer panels of service users and families/significant others in some areas are also encouraging and need to be mainstreamed to all service areas.

Mental Health Reform strongly endorses the involvement of service users and family members in planning, delivering and monitoring the mental health services which is an essential means of re-dressing the traditional power imbalance in the services as well as helping to improve the quality of services and ensure that services meet service user needs. Partnership working between service users, caring relatives/significant others and professionals has also been endorsed by the World Psychiatry Association who have developed a policy statement on good practice in such work.51 Employing service users as staff is useful for developing the recovery ethos.52 Research in Ireland has found that “[e]nabling equal user involvement in strategic decision-making requires more than arenas of participation – it requires comprehensively addressing service users’ structural disadvantages throughout the process of involvement.”53 In order for involvement to be on an equal footing, service users and family members should be supported with training and resources to participate, provided with information in Plain English and have access to mentoring/peer support. Professional staff also need to build their capacity to work collaboratively with service users and families/significant others.54

Mental Health Reform believes that partnership between the public mental health services and the voluntary sector (mental health and other voluntary organisations) is vital to implementing A Vision for Change. While voluntary organisations cannot replace a comprehensive, public mental health service, mental health voluntary organisations can provide complementary support services such as peer and family support groups, telephone help lines, information and education programmes that help people to manage their mental health. Community and voluntary organisations can educate members of the community about mental health and provide mental health promotion programmes in schools. NGO-provided services such as housing and vocational training services can provide essential supports for an individual’s recovery.

“There seems to have been a lack of thinking between the medical community services and the voluntary community services. There’s a gap between the two and although the voluntary sector is mentioned in AVFC there is no detail as to how the two pieces are going to come together, because when anybody enters into a service it needs to be a seamless service.” (Mental Health Reform Interviewee)

Mental Health Reform seeks a stronger commitment to partnership with the voluntary sector from the mental health services in planning and delivering mental health supports. Greater clarity is required about the roles of statutory and non-statutory services and supports, how they can work together to provide coordinated support to individuals and how non-statutory services can complement the work of the mental health service. The mental health services should ensure that representatives from the voluntary mental health sector are involved in planning and should specify the role that voluntary sector provision can play in prevention, care and recovery.

Mental Health Reform facilitates the development of local mental health alliances including service user, families and NGO’s to inform service delivery at a local level.

53 McDaid (2009).
54 McDaid (2009).
Legal and Advocacy Issues

“There is no such thing as involuntary or voluntary patients. All patients are involuntary. If a voluntary patient decides not to take their medication, they are changed to involuntary. If a patient questions their treatment they are thought to lack insight and are re-graded from voluntary to involuntary.”

The Independent Monitoring Group has recommended that the Government considers legislation to support the policy. This is important for two reasons: firstly, the citizenship principle in A Vision for Change implies that Ireland must have laws to protect individual’s human rights when they come in contact with mental health services. Secondly, the gaps in effective implementation to date have resulted in widespread calls for legislation to drive change.

The Mental Health Act, 2001 provided a significant improvement in the rights of people involuntarily detained and treated in the mental health services by requiring that every involuntary detention be reviewed by an independent tribunal. It also established the Mental Health Commission as a statutory agency responsible for promoting quality mental health services and provided for the regulation of inpatient services. These provisions have had a positive impact on the nature of mental health service delivery, most obviously by reducing the number of involuntary detentions in Ireland and recently by incentivising the closure of old psychiatric hospitals.

However, Ireland’s signing of the Convention on the Rights of Persons with Disabilities (CRPD) in 2007 provides the basis for a landmark shift in the way that people with poor mental health are treated in mental health services. The CRPD affirms that no person should be discriminated against solely on the basis of their disability, including a mental health disability. The CRPD also states that people with disabilities should enjoy legal capacity on an equal basis with others in all aspects of life (Article 12(2)). While the CRPD did not introduce new human rights for people with disabilities, it strengthens existing human rights and reaffirms the need for inclusion and equality. For people with experience of poor mental health, the CRPD affirms their equality in such a way as to potentially call into question existing mental health laws.

Having separate legislation that covers people who have a mental health condition is unhelpful to the agenda of reducing prejudice and discrimination because it entails treating a group differently under the law on the basis of their mental health status. Nevertheless, it is important that in seeking to de-stigmatise psychological and emotional distress there is no lessening of the human rights protections which have been established in the Mental Health Act, 2001. While in principle it would be best if there was no separate legislation to cover people who need involuntary detention and treatment for poor mental health, such a change would require widespread consultation and careful consideration.

Furthermore, the current mental health legislation falls short of protecting people’s human rights in a number of ways. Protection for users of inpatient services needs to be strengthened so that:

- the human rights of so-called ‘voluntary’ but incapacitated service users are protected
- all service users, both inpatient and outpatient, have a direct route to an independent body to make a complaint about the mental health services
- voluntary service users are given the right to information

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• voluntary service users are protected from coercion
• voluntary and involuntary service users’ right to make decisions about their treatment are protected
• voluntary and involuntary service users have a statutory right to advocacy underpinned by the law
• seclusion, physical and mechanical restraint are reduced
• the use of chemical restraint is regulated
• every service user has an individual care and recovery plan developed with their input
• the role of families is recognised in the law so that they receive information and support
• service users are adequately protected from abuse

Mental Health Reform seeks that the Government’s review of the Mental Health Act, 2001 addresses all of these concerns. Mental Health Reform also seeks that the Government commits to exploring how provisions on involuntary detention and treatment in the Act could be incorporated into capacity legislation so that people whose decision-making capacity is impaired by a mental health condition will be covered by the same law as all people whose capacity is impaired.

Mental Health Reform also seeks legislation to underpin implementation of A Vision for Change. In the current context of change within the public health services such legislation is more important than ever to ensure that mental health policy is not overshadowed by wider reform. Legislation should include:

• the requirement that all public mental health services be planned and provided in accordance with the principles set out in A Vision for Change
• an obligation on all mental health service providers to engage service users in planning their own care and to provide support for service users to make decisions about their own care where such support would enable them to do so
• a duty that the public mental health service provide community-based services
• a duty that the public mental health service provide a range of alternatives to medication including talking therapies, with an equitable allocation of services across the country
• an obligation on the public mental health service to develop an implementation plan for the mental health services every three years that contains specific targets, timeframes, persons responsible for each target and costings
• an obligation on the public mental health service to report annually to the Oireachtas on their progress in delivering the plan
• an extension of the standard-setting and inspection functions of the Mental Health Commission to cover community-based mental health services

Mental Health Reform believes that the legislative reform outlined above would provide a vital structural framework to incentivise the cultural change desired by service users.
Mental Health Promotion

“Mental health awareness training should be there for the general public.” (Mental Health Reform consultation)

Mental health promotion is aimed at promoting the well-being of the entire population and focuses on protective factors, prevention of mental health conditions and early intervention in mental health conditions. Mental health promotion acts on three levels:

- Strengthening individuals
- Strengthening communities
- Reducing structural barriers to mental health

Significantly, A Vision for Change notes that sectors other than health impact on the mental health of the population. It recommends a framework for inter-departmental cooperation on health and social policy. Chapter fifteen of A Vision for Change contains a section on suicide prevention that endorses the Reach Out national strategy for suicide prevention. It also states that the National Office for Suicide Prevention (NOSP) should be supported to coordinate statutory, research, voluntary and community activities.

However, the mental health promotion recommendations of A Vision for Change have been relatively neglected to date. While the most recent HSE survey results for A Vision for Change show mental health promotion and suicide prevention occurring, programmes are not specified. Furthermore, the survey results show that only 1 of the 13 Expanded Catchment Areas (ECA) was involved in setting and evaluating targets for mental health promotion programmes, while only 2 ECAs had a designated mental health promotion officer.

&Mental health education should be integrated into the [primary and secondary school] curriculum.” (Mental Health Reform consultation)

In terms of cross-departmental action on mental health, the Office for Disability and Mental Health facilitates cross-departmental discussion at senior official level. One practice that might improve cross-departmental action is to have all Government policies checked for their impact on the mental health of the population (this is called ‘mental health proofing’), for example, policies in the areas of housing, access to work, education and social protection. The Independent Monitoring Group on A Vision for Change has recommended that mental health proofing of Government policies take place.

As regards activities of the National Office for Suicide Prevention, for 2010 the HSE reported to the Independent Monitoring Group that NOSP had conducted two national mental health awareness campaigns, funded NGO mental health promotion initiatives, supported partnership initiatives with NGOs to reduce duplication and incorporated compliance with A Vision for Change into NGO Service Level Agreements.

57 A Vision for Change, pp. 44-45.
A Vision for Change concerns more than improving mental health service delivery – it is a policy for improving the mental health of the population:

“The mental health needs of the total population should be considered in this policy” (Principle – Population Health Approach)

Mental Health Reform seeks:

• The evaluation of national, regional and local mental health promotion programmes within the next two years and the putting in place of a plan for implementing effective programmes on a nationwide basis on foot of that evaluation.

• A designated mental health promotion officer in each service area.

• Mental health proofing of Government policy decisions as recommended by the Independent Monitoring Group.
**Mental Health and Primary Care Services**

“GPs should be more aware of mental health issues.” (Mental Health Reform consultation)

There are more than 3,000 General Practitioners (GPs) operating in Ireland and 489 Primary Care Teams providing primary care services in Primary Care Centres and other settings. This primary care system provides 90% of mental health care. There is also a mutually influencing relationship between physical health and mental health. As the WHO has stated, “There is no health without mental health.” Furthermore, it has been noted that:

> “Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis…”

Without effective mental health care at primary level, it is likely that inappropriate referrals to mental health services will occur, resulting in inefficient use of resources. Service users should also be able to get a recovery-orientated approach to their poor mental health in primary care as elsewhere in the mental health system. Efficient use of specialist mental health resources also requires good coordination and liaison between themselves and primary care services.

*A Vision for Change* sets out eleven recommendations relating to primary care; four key recommendations stand out:

7.3 “All mental health service users, including those in long-stay wards, should be registered with a GP.”

7.4 “Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing.”

7.5 “It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.”

7.11 (abridged here) “The education and training of GPs in mental health should be reviewed.”

*A Vision for Change* favours the consultation/liaison model of mental health in primary care (recommendation 7.5), though four models are summarised in Annex 7 and aspects of them appear in *A Vision for Change*’s discussion of the favoured model. The consultation/liaison model is a model of shared care between primary care and other levels of care. The Mental Health Commission supports the consultation/liaison model and has since recommended that a ‘stepped care’ model be adopted which can further specify the consultation/liaison approach, minimise inappropriate referrals and make best use of resources. In the ‘stepped care’ model, people receive low levels of support through primary care initially, progressing to more intensive support only if necessary. The Commission also recommends that community mental health and primary care services operate in close geographical proximity as this facilitates coordination.

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61 Byrne & Onyett (2010), p.15.


63 Byrne & Onyett (2010), p. 15.
The consultation/liaison model has yet to be implemented fully around the country and barriers to its implementation have been reported. One factor hampering the implementation of this model is the slow development of Primary Care Teams (PCTs) in some regions due to lack of resources for primary care. Other barriers include lack of community mental health teams, lack of priority given to mental health within PCTs and communication problems. Furthermore, nine expanded catchment areas did not have a liaison person as the anchor for the consultation/liaison model and six regions did not yet have a referral or discharge protocol as of the end of 2010.

While the ‘stepped-care model’ can be a useful framework for interaction between mental health and primary care services it should not be rigidly developed. Rather, a flexible approach should be adopted. Key to success will be the development of good working relationships between mental health and primary care staff. It has been reported that these good relationships can improve the quality of care and result in lower use of hospitalisation.

A major barrier to primary care as a source of mental health care is the cost of primary care services to the individual. From an early intervention perspective it is important to encourage individuals to seek help. The initial fee for seeing a GP plus the cost of prescribed medication can be a deterrent to individuals who may delay seeking support.

Mental Health Reform seeks:

- Robust implementation of the consultation/liaison model between primary and secondary/tertiary mental health services. The health services should develop an implementation plan with clear targets, timeframes and responsibilities for implementing the consultation/liaison model, with full implementation by 2016.

Availability of Psychological Therapies Services through Primary Care

“We need more counselling, psychotherapy and cognitive behavioural therapy.”

(Mental Health Reform consultation)

One of the areas that A Vision for Change omits is accessing psychological therapies through primary care services. There is a lack of information on the availability of such services in Ireland. As of 2003, many GPs reported not referring patients for counselling because of lack of services, waiting lists and cost. Since 2003, some local counselling services have been developed such as the MyMind service in Dublin and the North East Primary Care Counselling Service (PCCS). However the PCCS service is only available to people who have a medical or GP-visit only card. There is also poor availability of psychological therapies through mental health services, with a waiting time of up to two years for therapy.
An Irish review of the evidence has found that psychotherapy, either alone or in combination with other treatments/supports, is effective for a wide range of mental health diagnoses in adults, young people and children. The average success rate for participants in psychotherapy is 65-72%.\textsuperscript{68} Given the evidence base and the strong message from service users that they want greater choice in mental health care and services that provide listening, Mental Health Reform believes that individuals with an assessed need should have timely, affordable access to psychological therapy. There is little difference in positive outcome (69% to 72%) between the different modalities of psychotherapy. This reinforces the importance of the service user having choice in the modality that best suits him/her. The same study found that a majority of clients would require 20-45 sessions in order to recover.\textsuperscript{69} In keeping with the 'stepped care' model for mental health services in primary care, it would make sense for psychological therapies to be accessible through primary care for individuals who do not require specialist mental health care. It is also important that people receiving care through mental health services can have affordable, timely access to talking therapies.

Mental Health Reform seeks:

- that individuals with an assessed need should have timely, affordable access to psychological therapy.

Rapid access to professional psychological care should also be a standard component of the response to attempted suicide. Currently, for example, individuals often present to A&E, are assessed and referred to a psychiatric unit and may be discharged several days later with no clear diagnosis. The lack of psychological support means the individual's psychological needs in this situation are not met. This may lead to a cycle of admissions to A&E/psychiatric inpatient units without the individual's psychological needs being met. Psychological support should be provided by a professional, highly trained in the assessment of psychological need, and ideally by a full time clinical psychologist. Various psychological therapies for example, DBT, should be accessible rapidly.

In summary, to modernise the mental health services, Mental Health Reform seeks:

- Establishment of community-based, multi-disciplinary mental health services functioning as a team as set out in AVFC.
- Development of a Framework for the integration of specialist Mental Health and Primary Care Services.
- Increased emphasis on Mental Health Promotion.
- An overhaul of existing legislation affecting mental health services.
- Ensure that community mental health services meet the mental health needs of all.

This section referred to the following principles of A Vision for Change: Accessibility, Citizenship, Community Care, Coordination, Comprehensiveness, Effectiveness, Early Intervention, Equity, Inclusiveness, Partnership


\textsuperscript{69} Carr, A. (2007).
Increasing Accountability, Transparency and Governance

“You need a separate and independent complaints procedure; going to the person you have a problem with to make a complaint about them is ludicrous.” (Mental Health Reform consultation)

Reform of the mental health service will require both structural and cultural change. Structural change concerns the laws, policies, procedures, financial and human resources, management structure and other visible influences on reform. Cultural change concerns beliefs, values, attitudes, mindsets, ethos and other subtle, invisible influences on reform. Structural change can influence cultural change and vice versa; without both, implementation of A Vision for Change will not happen.

In order to increase accountability, there needs to be a direct route for an individual to complain to an independent body about the mental health services. The default route for an individual to make a complaint about their detention or treatment in the mental health services is through the HSE’s Your Service, Your Say complaints procedure. For mental health service users who do not have a variety of options for their care, this is a highly dissatisfactory situation. In practice, it means that a person may be required to submit their complaint to a staff member who could involuntarily detain and treat them or prolong their involuntary detention and treatment. It is not surprising, then, that there are extremely few complaints made by current service users about the mental health services. Mental health service users must have a safe, accessible means of making a complaint that is independent of the service itself.

At an organisational level, there is a need for an HSE-wide change programme. Following the advice published by the Mental Health Commission, Mental Health Reform believes that this programme requires:

• A Directorate for Mental Health Services, including a National Director, a multidisciplinary management team, budgeting expertise and administrative support. The directorate must have authority to control the mental health service budget.

• A detailed, costed implementation plan with specific, measurable targets, timeframes, designated responsibilities, performance indicators and risk management.

• Establishing multi-disciplinary implementation teams at regional and local level including service user, [and family member] and voluntary sector input

• On-going, two-way communication with service users, family members and the wider community including local community development initiatives, education providers, psychotherapy organisations and other service providers

There is also a need for robust monitoring mechanisms both within and outside the HSE to be able to monitor progress on plans and identify areas where implementation is stalling in order to put in place quick remedial action.

It is also vital both for external and internal monitoring that the HSE develops transparent, reliable data collection systems to be able to report on progress. The HSE should develop a comprehensive set of key performance indicators aligned to A Vision for Change as part of its implementation plan and should report annually against these performance indicators. On an on-going basis, transparent, reliable financial and performance monitoring systems aligned to AVFC that systematically capture the voice of the service user must be put in place.
Resources

Without adequate resources, fulfilment of the vision set out in A Vision for Change is not possible. Mental health services are delivered by people and so the bulk of costs in the mental health services relate to staff costs. This is one reason why mental health services have fared poorly in the allocation of overall health resources in recent years.

To date, both the HSE and the Department of Health and Children have failed to provide adequate accountability for mental health expenditure. The Independent Monitoring Group has had difficulty in determining whether mental health expenditure is being spent effectively. Significant infusions of funding in the years immediately after A Vision for Change were diverted to meet deficits in other areas of health spending, with half of the €51.2M invested in 2006 and 2007 diverted to other health services. Additional development funding was then stopped completely in 2008 and only small amounts of development funding were provided by the Department of Health between 2009 and 2011. To date, Government is still not able to accurately and reliably report on the amount of money spent in the public mental health services due to a lack of a national accounting system by health care group.

In recent years, the same services have been the subject of severe expenditure cuts resulting from staff losses. Between 2009 and 2010, expenditure reduced by €70M to €703M, reflecting approximately 1,000 staff losses in the period. In 2011, the mental health services budget lost at least 1.8%, though likely more given probable staff losses in 2011. The year-on-year cuts to recurring expenditure along with the failure to deliver development funding has meant that the mental health budget has not moved forward as a proportion of overall health spending. While the Expert Group for A Vision for Change anticipated that implementation of A Vision for Change would mean the mental health budget being 8.24% of the overall health budget, and while economists Eamon O’Shea and Brendan Kennelly recommended that a target for mental health funding be set at 10% of overall health spending, the latest mental health budget is just 5.3% of the HSE’s overall budget.

Good quality care has also suffered due to the inequitable allocation of resources across the country. The Mental Health Expert Group found that there was a ten-fold variation in per capita funding for mental health across different services around the country, while a 2003 study by the then Irish Psychiatric Association found that areas of greatest socio-economic deprivation receive fewest resources. In the absence of a national Director of Mental Health with budget authority, little has changed with regard to the allocation of resources across the country since A Vision for Change was published.

It is little surprise, then, that the current state of staffing is far from that recommended in A Vision for Change. The 2010 Inspector of Mental Health Services’ reports on adult community mental health team staffing showed that only about half of the required psychologists and occupational therapists and 60% of the required occupational therapists were in place. A similar situation applies in Child and Adolescent Mental Health Services, where as of September 2011, CAMHS community teams had only 42% of the total staffing recommended in A Vision for Change.

A Vision for Change, p.179.
It is also important to acknowledge that current resources applied to mental health services may not be used efficiently. The Value for Money review of long-stay residential care for adults within the mental health services found that about one-quarter of clients were in accommodation that did not suit their needs. Many of those in long-stay hospitals and those in community residences required less support than they were receiving.\(^{34}\) It is clear, then, that there is scope for realising resource savings from within the mental health services that can be used to support the transition from the traditional model of care to the recovery-orientated approach set out in *A Vision for Change*. TCD’s Centre for Health Policy and Management is undertaking a project with Mental Health Reform, Amnesty International Ireland and the HSE to develop an economic model for allocating resources that can be used by mental health services around the country and by HSE central management to better allocate resources in relation to needs across the country.

Government’s allocation, in Budget 2012, of €35M funding for mental health, including €23M set aside for an additional 370 community mental health team staff, is welcome. It will be vital to fast track recruitment of the additional posts so that the holistic, quality community services that can prevent and/or reduce inpatient admissions can be developed quickly. The appointment of a national Director for Mental Health Services who has executive powers, budgetary control and responsibility to publicly report on progress is also essential to ensuring that the funding promised for 2012 is realised in real improvements to services.

Mental Health Reform recommends that:

- In the short term, all service areas should receive at least the national average level of funding (national average level adjusted according to the population covered) within three years. This will assure a geographically equitable and harmonised funding distribution at the service area level.

- In the medium and long term, it is important to make available the resources necessary to meet the objectives in *A Vision for Change* in full.

- Given the lack of capital resources in the near-term, alternatives must be urgently explored for development of community-based facilities including sharing primary care facilities and renting premises.

- A resource allocation model should be developed and used by the HSE to allocate resources equitably based on need.

- The HSE should report regularly on how resources are being used towards policy objectives and should take early corrective action where resources used are not in line with policy.

- Government should provide both parallel funding and safeguarded funding to develop community resources during the transition from institutional provision to services in the community.

- The HSE should ensure coordination between primary care and mental health services in the planning and commissioning of services.

- Some developments in mental health services are constrained by or contingent upon resources in other departments. For example, moving people from HSE supported accommodation into independent living is dependent to some extent on local authority housing resources. The HSE and other public service agencies, as well as relevant government departments, should coordinate budgeting and planning in order to progress relevant recommendations in *A Vision for Change*.

In summary, in order to increase accountability, transparency and governance, Mental Health Reform seeks:

- Establishment of an executive office within the HSE which is responsible for implementing A Vision for Change. This must be led by a Director for Mental Health Services who has executive powers, budgetary control and responsibility to publicly report on progress.

- Provision of adequate funding to ensure equitable services across the country.

- Provision of adequate funding to allow for the transition from institutions to community services without jeopardising quality of services.

- A detailed, costed implementation plan.

- Transparent, reliable financial and performance monitoring systems aligned to AVFC that systematically capture the voice of the service user.

- Legislation to underpin implementation of AVFC.

- Establishment of a statutory complaints mechanism which can be accessed directly and is independent of the service provider.
What do we mean by Mental Health?

“We all have mental health issues.” (Mental Health Reform consultation)

A Vision for Change recognises that mental health is more than just an absence of a mental health problem. The World Health Organisation defines mental health as

“a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”

This definition of mental health as well-being is not focussed on the absence of symptoms. Rather it is about being able to cope with life’s daily challenges as well as having the internal resources to handle stressful situations such as grief, loss and change. Some people can cope well with life’s challenges even while continuing to have symptoms. Others find that symptoms interfere with their ability to cope and may seek treatment to reduce their symptoms.

“You get a manual with a car. How do we navigate and manage our own mental wellbeing?” (Mental Health Reform consultation)

Many social and economic factors can impact on mental health. The World Health Organisation describes how poverty and deprivation, with related conditions such as unemployment, low education and homelessness, can increase one’s risk of having poor mental health. Other social and economic risk factors include: low social status, basic needs not being met, violence or abuse, substance abuse and childhood neglect, among others.

What do we mean by a Mental Health Condition?

“It’s the difference between seeing mental health in a holistic, total existential, living your life way and early intervention being a clinical, symptomatology of the mind approach.” (Participant in focus group with Headstrong’s Youth Advisory Panel)

Understandings of mental health conditions are diverse. From a psychiatric perspective, mental disorders concern problems in the functioning of the mind resulting in abnormal thoughts, emotions and behaviours. Poor mental health can also be understood as a reaction to ‘abnormal’ life events. Poor mental health impacts negatively on one’s life, including relationships, work and general quality of life. Experiences like hearing voices, feeling depressed or feeling anxious can be distressing. However, some people describe mental health conditions as positive, extra capacities that should be nurtured and experiences like having hallucinations are not as exceptional as one might think: one study found that 10% of men and 15% of women experienced a hallucination at some point in their lifetime. Thus what we commonly describe as ‘mental illness’ can be understood from a variety of perspectives.

78 The World Health Organization defines ‘mental or behavioural disorders’ as the collection of disorders set out in the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Generally speaking, they refer to "a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. See WHO (2001) at http://www.who.int/topics/mental_disorders/en/ retrieved 20/9/11
80 The Icarus Project describes itself as a network of individuals diagnosed with mental health conditions who “believe these experiences are mad gifts needing cultivation and care, rather than diseases or disorders.” (available at http://theicarusproject.net/about-us)
Also, a person’s mental health condition is likely to be influenced by a unique constellation of factors including their biological make-up, psychological condition and social and economic circumstances through a complex web of interactions. Ultimately, it is important to respect the individual’s perspective on their own experience, as each individual case is unique.

“All these words and labels are dehumanising.” (Mental Health Reform consultation)

Some people find that receiving a mental health diagnosis helps them to understand their experience better. However, others have found that this medical conception of their condition has failed to reflect their experience and limited their own ability to learn how to cope with their thoughts, emotions and behaviour. When treatment is limited to reducing symptoms, individuals may not receive the support they need to learn how to manage their emotions, thoughts and behaviour. Having a label of a mental health diagnosis often results in being more socially excluded as it can lead to a person experiencing discrimination by others and a degree of self-stigmatisation and withdrawal from social interaction.

A Vision for Change states that “poor mental health affects our ability to cope with and manage our lives, particularly during personal change and through key life events, and decreases our ability to participate fully in life” (A Vision for Change, p.16). Mental Health Reform believes that this way of thinking about mental health conditions is the most helpful for understanding the supports people need in order to recover from poor mental health. If poor mental health is about having difficulty coping with life, then mental health supports should focus on what each individual needs to improve their ability to cope with life, whether that be medication, talking therapy and other means of self-awareness, peer support, help with their housing, benefits, employment, support with life skills or help with getting connected to their local community.

Mental Health Conditions and Suicide

“We need a 24 hour 7-day a week helpline for families. With the rise in unemployment and in the number of people in financial distress, there may be increased need for counselling by people who cannot afford it.” (Mental Health Reform consultation)

Not everyone who engages in suicidal behaviour will have poor mental health, though having poor mental health increases one’s risk of suicide. The WHO states that: “the most common mental disorder leading to suicide is depression, although the rates are also high for schizophrenia. In addition, suicide is often related to substance use – either in the person who commits [sic] it or within the family.”

Suicide has been defined as “a conscious or deliberate act that ends one’s life when an individual is attempting to solve a problem that is perceived as unsolvable by any other means”. This definition of suicide as relating to difficulty in solving a problem is comparable to the conception of poor mental health as being a difficulty in coping with life, described in the previous section.

There are many risk factors for suicide. To summarise from a 2008 review of the evidence, living in an area of socio-economic disadvantage and being unemployed are each risk factors. So too, having a diagnosis of some mental disorders including depression, schizophrenia, a personality disorder or a childhood disorder can increase one’s risk of completing suicide. Substance misuse, both of alcohol and drugs, is a known risk factor as is having previously self-harmed. Adolescents who have experienced sexual abuse are at higher risk.

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Conclusion

The change set out in Mental Health Reform’s Manifesto Guiding – A Vision for Change is both wide-reaching and fundamental. Putting the recovery ethos into practice will entail a deep shift in the mindset of many mental health professionals, a move from paternalism to partnership, from a focus on risk to a determination to empower, and from an illness to a mental diversity perspective.

Such a fundamental shift in the way that mental health services work will not be easy. It will demand change in many experienced practitioners. It will also require people with a mental health condition to take much greater ownership of and responsibility for their recovery. And it will require family members and other carers to support their loved one’s empowerment. It will require everyone in the community to be open to mental diversity and supportive of emotional health.

In Guiding A Vision for Change, Mental Health Reform has sought to provide guidance on how the mental health services can put the recovery ethos into practice. We have sought to paint a picture of what a recovery-orientated service looks like from the perspective of people seeking support. We have set out the structural conditions for recovery services in terms of staffing, coordination, finance and legislation. Ancient wisdom tells us that “a goal without a plan is just a wish.” If A Vision for Change is ever to become reality, there must be a plan for its implementation and someone must be responsible ultimately for its realisation.

A Vision for Change calls for supporting the full citizenship of all people living with a mental health condition. For that vision to succeed, all government departments and public agencies must be prepared to recognise their role in promoting mental health. People living with a mental health condition need adequate housing and income; they need opportunities to fulfil their aspirations for education and employment; they need affordable transport to overcome isolation; they need support as parents and opportunities to express their creativity. Only when A Vision for Change fulfils these wider goals will it become a means of helping people recover not only their mental health, but their lives.

About Mental Health Reform

Mental Health Reform believes in the empowerment of individuals and mobilisation of local communities to develop public and political will in support of a good quality mental health system.

Reform also requires wider social change (political will, public support, budgetary priority, appropriate legislation, collective action by service users, families and NGOs, etc.) Successful reform of the mental health services requires change in society’s understanding of mental health and greater community support for people recovering from poor mental health. It requires collective advocacy and building the capacity of the reform movement to provide a power base that can influence decision-making in the political sphere. It requires coordinated, strategic action to influence Government drawing on public support.

Mental Health Reform is the national coalition of organisations working to improve mental health services and achieve implementation of the Government’s mental health policy A Vision for Change in Ireland. Mental Health Reform works with its members through education, campaigning and support to help bring about structural and cultural changes in mental health services.
Mental Health Reform has a key role to play in generating political support for improved mental health services:

- Mental Health Reform will help to build the capacity of mental health NGOs, service users and family members/significant others to advocate for improved mental health services.
- Mental Health Reform will develop evidence-based policy positions to support its strategic action and provide quality advice to Government departments.
- Mental Health Reform will coordinate and support a broad base of mental health interest groups to provide a coherent, strategic voice to Government.

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