<u>Submission to the Independent Monitoring Group on A Vision for Change</u>

Introduction

Amnesty International Ireland (AI) again welcomes this opportunity to make this submission to the Independent Monitoring Group (IMG) for *A Vision for Change* (AVFC). AI is most concerned about the fulfilment of individuals' human rights in the context of mental health.

AI is disappointed at the lack of implementation of AVFC on two key fronts:

- The failure to deliver on the vision of comprehensive and community-based care
- The failure to deliver social inclusion for people who have experienced a mental health problem

The right to the highest attainable standard of mental health cannot be fulfilled without both of these issues being addressed (see Annex 1 for a detailed explanation of human rights in relation to mental health). Access to a full package of comprehensive and community-based mental health care and support services conducive to health, dignity and inclusion is a key component of the human right to the highest attainable standard of mental health. And without measures that promote social inclusion by addressing barriers to the social determinants of mental health, individuals cannot achieve recovery and equal enjoyment of their socio-economic rights. The following submission will show why the IMG should recommend that:

1. **Government publishes legislation to underpin implementation of comprehensive and community-based mental health services, and**
2. **All Government Departments with responsibility under AVFC set out what they will do specifically with reference to people affected or at risk of mental health problems in order to deliver AVFC.**[1]

1. The need for legislation to underpin delivery of comprehensive and community-based services

The Indecon report[2], the HSE's own implementation plan and successive Inspector's and IMG reports have shown that Government is failing to provide the comprehensive community-based services set out in AVFC. Even before the economic downturn, there was a lack of progress. While the appointment of an Assistant National Director for Mental Health is a positive step, the role does not have control over the mental health budget and so cannot ensure expenditure fits policy goals. So too, the Minister for Disability and Mental Health has not had adequate powers to ensure delivery of Government policy. While AI recognises that

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[1] In this submission the following abbreviations will be used for Government Departments: Department of Social and Family Affairs (DSFA); Department of Enterprise, Trade and Employment (DETE), Department of Environment, Heritage and Local Government (DEHLG), Department of Justice, Equality and Law Reform (DJELR) and Department of Education and Science (DES).

[2] Indecon (2008) *Review of Government Spending on Mental Health and Assessment of Progress on Implementation of A Vision for Change.* Dublin: Amnesty International Ireland.

there are a range of temporary factors militating against effective implementation, **a fundamental hindrance to effective implementation is the lack of a statutory obligation on the HSE to implement comprehensive and community-based mental health services**.

The WHO observes that mental health laws can help to achieve the goals set out in mental health policy by providing a legal framework for implementation and enforcement. It does not prescribe a particular legislative model for countries, but rather highlights some of the key issues and principles to be incorporated into legislation. For instance, it says, legislation can ensure that appropriate services and treatments are provided by health services and other social welfare services, when and where necessary; and it can help make mental health services more accessible, acceptable and of adequate quality.[3] Ireland does not currently have a statutory framework for comprehensive and community-based services despite the fact that both the 1992 *Green Paper on Mental Health* and the 1995 *White Paper: A New Mental Health Act* called for such legislation. *A Vision for Change* acknowledges that mental health legislation is essential to underpin the right to respect for the dignity of individuals and the protection of their human rights.[4] The IMG itself has recommended that the Office for Disability and Mental Health (ODMH) consider the role legislation might play in accelerating implementation.[5] Moreover at a recent conference hosted by the Irish Mental Health Coalition (IMHC) there was broad-based support for the idea that legislation might act as a viable catalyst for reform of the mental health services.[6] A number of distinguished speakers, including the UN Special Rapporteur on the Right to Health, called for a consideration of how legislation could lead to Ireland's mental health services being available, accessible, acceptable, and of appropriate quality.

For these reasons, AI calls on the IMG to recommend that:

- **Government publishes legislation to underpin implementation of comprehensive and community-based mental health services.**

2. The need for action beyond the Department of Health and Children
Government has largely failed to implement the social inclusion recommendations of *A Vision for Change*. The consequence is that people with mental health problems continue to be socially excluded. It is not acceptable that people disabled by a mental health problem continue to have the highest rate of unemployment of any disabled group, that they are the most stigmatised amongst disabled people, that they are not being provided adequate housing and housing supports, that welfare, education and training services are failing to effectively promote mental health and support recovery, leaving people with long-term mental health problems socially isolated and poor. These consequences arise from the facts that:

- Government Departments are not taking ownership of their responsibilities under AVFC. For example, DSFA claims that responsibility for AVFC lies solely with the Office for Disability and Mental Health.[7]

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[3] WHO Resource Book on Mental Health, Human Rights and Legislation: Stop exclusion, dare to care (WHO Geneva 2005) para 3.5.
[4] First core value/principle of *A Vision for Change* Annex 1.2.
[5] IMG Report 2008, published April 2009, p22.
[6] IMHC conference 'Mental Health: Human Rights and Legislation, What's possible in Ireland' 18 May 2009, Radisson Hotel, Golden Lane, Dublin 8. For more information see: www.AVisionofRights.ie. For example, of those delegates who responded to a survey (50), 96% (48) agreed that legislation could play a role in demanding progress on mental health policies and plans.
[7] The Secretary General at DSFA wrote to an AI member in June 2009 stating that "implementation of the recommendations of 'A Vision for Change' is a matter for the Office for Disability and Mental Health …" though she expressed support for the Office.

- No Department other than Health has provided evidence of any specific mental health initiative arising from *A Vision for Change.*
- Departments have failed to evaluate the effectiveness of their existing mainstream programmes for people with mental health problems.
- Departments have failed to report to the IMG on all of the recommendations relevant to them. For example, DJELR have never reported on Recommendation 4.1 which concerns equality, though it is directly responsible for the relevant legislation.
- There is inadequate and un-transparent coordination between relevant Departments, with DSFA not covered under the ODMH's remit.

The DEHLG has already taken positive action in its housing strategy for people with disabilities by establishing a dedicated strand on mental health. This sub-group has provided a forum for developing specific actions that will address individuals with mental health-related housing needs.

AI asks the IMG to recommend that each Department set out the following:

- **What it will do under the National Disability Strategy (NDS) that will have a specific focus on mental health (for those Departments that have a Sectoral Plan)[8]**
- **What it will do beyond the NDS to implement *A Vision for Change*.**

AI's recommendations for non-health Departmental actions are further specified in Annex 3.

AI also calls on the IMG to ensure that each Government Department reports on the specific effectiveness of its programmes for people with mental health problems in order to demonstrate achievement of the recommendations of AVFC.

Conclusion

Both comprehensive community-based services and social inclusion must be delivered in order to fulfil the vision of Government's mental health policy. AI asks the IMG to adopt AI's recommendations and thereby support the realization of the right to the highest attainable standard of mental health in Ireland. AI is available at any time to provide further information in relation to these recommendations.

[8] DSFA, DETE and DEHLG are required to prepare a Sectoral Plan under the National Disability Strategy that explains what they will do for people with disabilities including people disabled by reason of a mental health problem. DES and DJELR are not required to prepare a Sectoral Plan.

Annex 1 – Mental Health and Human Rights

Article 12 of the International Covenant on Economic, Social and Cultural Rights states that every person has the right to the highest attainable standard of physical and mental health. This is not a right to be healthy. Instead it is a right to the **facilities, goods, services and conditions that are conducive to the realisation of the highest attainable standard of health**, both mental and physical. Thus, unsurprisingly, the right to health includes an entitlement to mental health services. It is also closely related to and dependent on the realisation of other rights such as the rights to food, housing, work, education, and is underpinned by the key principles of **non-discrimination, equality and participation**.

Human rights law and standards do not demand that the State be overburdened financially. Instead the right to health imposes an obligation on States to ensure the satisfaction of, at the very least, core minimum essential levels of services required under the right to health. It then requires that such core minimum services be improved and expanded over time in accordance with the **principle of progressive realization**. Progressive realization requires the State to take steps (which must be deliberate, concrete and targeted) to the maximum of its available resources with a view to progressively realizing the right to health over time.

The right to health and mental health services

Human rights law requires that health services be:

- **Available** – there must be adequate numbers of mental health-related facilities and support services and adequate numbers of medical and other professionals trained to provide these services throughout the State.

- **Accessible** – services must be accessible physically and geographically, they must also be economically accessible, i.e. affordable and information on such services must also be readily accessible to persons with mental health problems.

- **Acceptable** – they must be respectful of medical ethics as well as cultures and traditions. Of course, services must also be provided in a way that respects the human rights of the individual service user.

- **Of good quality** – they must be scientifically and medically appropriate, staff must be properly skilled and interventions must be evidence-based and scientifically approved.

States must take steps to ensure a **full package of comprehensive and community-based mental health care and support services** conducive to health, dignity and inclusion. The recently adopted Convention on the Rights of Persons with Disabilities (CRPD)[9], which reiterates the right to health (Article 25), recognises the right of persons with disabilities to independent living and community inclusion (Article 19). This demands a shift in Government policies away from institutions toward in-home, residential and other community support services, where appropriate. The importance of community-based treatment, care and support is also stressed in the MI Principles, which encompass the right 'to be treated and cared for, as far as possible, in the community in which he or she lives', and the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate (MI Principles 7(1) and 9(1) respectively).

[9] Ireland has signed but not yet ratified the CRPD.

Underlying determinants of health

The human right to the highest attainable standard of mental health is not limited to mental health services but extends to what are known as the underlying determinants of health, such as housing, employment (including access to employment and safe and healthy working conditions), social security and education, which must also be available, accessible, acceptable and of good quality. All of these rights should be **enjoyed equally and without discrimination** by all persons, including persons with mental health problems. The CRPD expressly defines discrimination on the basis of a disability as including the denial of reasonable accommodation (Article 2) and calls on States to take appropriate steps to safeguard and promote the realization of this right.

Housing

The human right to adequate housing, which is derived from the right to an adequate standard of living (Article 11 ICESCR, Article 28 CRPD), is of central importance in the enjoyment of all socio-economic rights, including the right to health. It means more than a right to a roof over one's head; rather it is the right to live somewhere in security, peace and dignity. The Committee on Economic, Social and Cultural Rights has expressly stated that disadvantaged groups, including persons with mental health problems, should be ensured some degree of priority consideration in the housing sphere in order to ensure that they can enjoy their right to housing. Accordingly, both housing law and policy must take the special housing needs of this group fully into account.

Employment

The right to work is a fundamental right recognized in numerous international conventions to which Ireland is a party, including Articles 6 and 7 of the ICESCR and Article 27 CRPD.[10] The right to work requires States to have specialized services to assist and support individuals in order to enable them to identify and find available work. Importantly in the context of people with mental health problems, discrimination in access to and maintenance to employment is prohibited and States must pursue national policies designed to promote equality of opportunity and treatment in respect of employment and occupation, with a view to eliminating any discrimination in those areas. The right to work also requires States to implement technical and vocational education plans to facilitate access to employment. Even in times of severe resource constraints, disadvantaged and marginalized individuals and groups such as people with mental health problems must be protected by the adoption of relatively low-cost targeted programmes. In essence the human rights framework recognizes the important role of employment in ensuring integration into society and in combating social exclusion.

Social Security

The right to social security encompasses the right to access and maintain benefits, whether in cash or in kind, without discrimination, in order to secure protection *inter alia* from lack of work-related income, unaffordable access to healthcare and insufficient family support, particularly for children and adult dependents. Social security with its re-distributive character, plays an important role in poverty reduction and alleviation and promoting social inclusion. Denial of or lack of access to adequate social security can undermine the realisation

[10] The right to work is not an absolute and unconditional right to obtain employment, Rather it comprises the right to the opportunity to gain a living by work that is freely chosen, as well as the right to just and favourable conditions of work, fair wages and equal remuneration for work of equal value, a decent living, safe and healthy working conditions, and an equal opportunity for promotion in work

of other rights, such as the right to health. In the case of persons with disabilities, including mental health problems, income support must be provided in a dignified manner and must reflect the special needs for assistance and expenses associated with disability. That social security be provided without discrimination is especially important for people with mental health problems.

Education

The right to education is both a human right in itself and an indispensable means of realising other human rights. As an empowerment right, the right to education is the primary vehicle by which economically and socially marginalized adults and children can participate fully in their communities. In reiterating the right to education in Article 24, the CRPD clarifies some of the steps States must take to ensure that persons with disabilities can enjoy the right to education on an equal basis with others. States must ensure an inclusive education system at all levels directed to: (a) the full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity; (b) the development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential; and (c) enabling persons with disabilities to participate effectively in a free society. In realizing this right, States must ensure that: (a) persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live; (b) reasonable accommodation of the individual's requirements is provided; (c) persons with disabilities receive the support required, within the general education system, to facilitate their effective education; and (d) effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion. States Parties must also ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination.

Sources:

Committee on Economic, Social and Cultural Rights General Comments: No 4 (right to adequate housing) UN Doc E/1992/23; No 13 (right to education) UN Doc E/C.12/1999/10; No 18 (right to work) UN Doc. E/C.12/GC/18; and No. 19 (right to social security)_ UN Doc E/C.12/GC/19.

Irish Human Rights Commission Discussion Paper *Making Economic, Social and Cultural Rights Effective* (2005)

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt UN Doc.E/CN.4/2005/51 (11 February 2005)

Annex 2

How legislation can realise the ambitions of *A Vision for Change* and provide a framework for the provision of specialist community-based mental health services

Under **international human rights law** Ireland is bound to take steps to progressively realize the right to the highest attainable standard of physical and mental health[11]. Simply put this means that each year we must demonstrate that we are improving. This right requires that mental health services be available, accessible, acceptable and of good quality. Ireland must 'use all appropriate means, including particularly the adoption of legislative measures'[12], to fulfil its obligations to respect, protect and fulfil the full spectrum of rights for people with mental health difficulties.

Successive Government policies on mental health (*Planning for the Future* in 1984 and *A Vision for Change*, in 2006) have called for a shift from a system of over-reliance on in-patient care, to a system of comprehensive and community-based care to be provided by multi-disciplinary mental health teams. However the legislative framework has not been updated to reflect these policy objectives. While some modest progress has been made in improving mental health services since the introduction of *A Vision for Change*, on the whole implementation of its recommendations has been inadequate. This is evidenced all too clearly in successive reports of the Inspector of Mental Health Services and the Independent Monitoring Group.

The **World Health Organisation (WHO)** has said that legislation can play a major role in promoting community-based care for people with mental health problems and reducing involuntary admissions, thereby putting into practice the principle of 'least restrictive alternative'.[13] In its Resource Book *Mental Health, Human Rights and Legislation* (2005) the WHO observes that mental health laws can help to achieve the goals set out in mental health policy by providing a legal framework for implementation and enforcement. It does not prescribe a particular legislative model for countries, but rather highlights some of the key issues and principles to be incorporated into legislation. For instance, it says, legislation can ensure that appropriate services and treatments are provided by health services and other social welfare services, when and where necessary; and it can help make mental health services more accessible, acceptable and of adequate quality.[14]

To date, Ireland's approach to legislation in the area of mental health has been piecemeal. The Mental Treatment Act 1945 previously provided the framework for the provision of mental health services. Both the ***Green Paper on Mental Health*** published by the Department of Health in June 1992 and the Government's ***White Paper: A New Mental Health Act*** (Department of Health July 1995) called for the new Mental Health Act to address the obligations of Health Boards (since replaced by the HSE) to provide access to comprehensive community-based services. In commenting on the Health (Mental Services) Act 1981 (which was never implemented), the Green Paper went so far as to say that 'one of the main drawbacks of the 1981 Act is that it does not provide a legal framework for the developing community psychiatric services'.[15] However, because the Mental Health Act was eventually introduced in response to the threat of a finding against the State by the European Court of Human Rights[16], it focused on the issues of involuntary detention and treatment. While it also

[11] Article 12 International Covenant on Economic, Social and Cultural Rights (ICESCR).
[12] Article 2 ICESCR.
[13] WHO *Mental Health: New Understanding, New Hope* World Health Report 2001, pp 89-91.
[14] WHO Resource Book on Mental Health, Human Rights and Legislation: Stop exclusion, dare to care (WHO Geneva 2005) para 3.5.
[15] Green Paper, page 70.
[16] *Croke v Smith* (unreported) High Court 31 July 1995; *Croke v Smith (No. 2)* [1998] IR 101.

established the Mental Health Commission and the Inspectorate of mental health services, the 2001 Act does not contain a framework for the delivery of mental health services needed to reflect a community-based, comprehensive and integrated service as recommended in successive mental health policy documents and as contemplated by the Green and White Papers. Unsurprisingly, the narrow scope of the 2001 Act and its failure to address the recommendations of the Green and White Papers was heavily criticised by opposition parties in the Dáil and Seanad debates.[17]

A Vision for Change acknowledges that mental health **legislation** is essential to underpin the right to respect for the dignity of individuals and the protection of their human rights.[18] In its Third Annual Report (2008) on Implementation of *A Vision for* Change, the Independent Monitoring Group recommended that '[t]he Office for Disability and Mental Health should consider the role legislation might play in accelerating implementation of *A Vision for Change*'.[19] Moreover at a recent conference hosted by the Irish Mental Health Coalition (IMHC) there was a broad base of support for the idea that legislation might act as a viable catalyst for implementation of the much-needed reforms recommended in *A Vision for Change*.[20] A number of distinguished speakers, including the UN Special Rapporteur on the Right to Health, called for a consideration of how legislation could lead to Ireland's mental health services being available, accessible, acceptable, and of appropriate quality, thereby realizing the ambitions of *A Vision for Change* while also respecting the inherent dignity and human rights of each individual.

Legislation can serve as a useful tool together with policy, plans, standards and values, which together can deliver a progressive mental health service that accords with international best practice and the human rights framework. The Government needs to consider the adoption of framework legislation that effectively promotes comprehensive community-based care and support services for people with mental health problems, thereby realising some of the ambitions of *A Vision for Change*.

[17] See, for example, Dáil Eireann Volume 517 (6 April 2000) Mental Health Bill 1999, Second Stage, Deputy Alan Shatter, 1008 and Deputy McManus, 1013 (available at: http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/1999/7099/default.htm).
[18] First core value/principle of *A Vision for Change* Annex 1.2.
[19] IMG Report 2008, published April 2009, p22.
[20] IMHC conference 'Mental Health: Human Rights and Legislation, What's possible in Ireland' 18 May 2009, Radisson Hotel, Golden Lane, Dublin 8. For more information see: www.AVisionofRights.ie. For example, of those delegates who responded to a survey (50), 96% (48) agreed that legislation could play a role in demanding progress on mental health policies and plans.

Annex 3

Actions for Non-Health Departments under *A Vision for Change*

A Vision for Change contains a number of important recommendations that fall outside the remit of the Department of Health & Children and the HSE. These recommendations are vital both to ensure the social inclusion of people who experience a mental health problem and to prevent such problems arising. All of the Departments mentioned in *A Vision for Change* have a role to play in recovery and therefore, without their involvement in delivering the mental health policy, its vision cannot be achieved. This cross-departmental approach is an essential hallmark of a national mental health policy that meets international good practice standards.[21] It is also required under the International Covenant on Economic, Social and Cultural Rights.[22]

As part of its mental health campaign, **Amnesty International Ireland (AI) wants each of the Government Departments who have direct responsibilities under *A Vision for Change*, in addition to the Department of Health & Children, to set out the specific actions it will take to implement recommendations and the timeframe within which the actions will be completed.**

AI asks each Department to set out:

- The senior official with responsibility for driving implementation within the Department and reporting on progress to the IMG.
- The recommendations for which it takes primary responsibility. For example, the Department of Education & Science (DES) should set out the education recommendations for which it has lead responsibility.
- How it will implement each recommendation.

  It will not be adequate simply to restate *A Vision for Change* recommendations. Some of these recommendations were widely drawn and unspecific. In order to provide a basis for action, **where necessary, Departments should further specify the recommendations in consultation with mental health stakeholders.** All recommendations should be broken down into targets, annual milestones and Key Performance Indicators. Wherever resources will be required, these should be estimated in terms of human and financial resources.
- Any dedicated programmes for people with mental health problems that will be developed to implement the AVFC recommendations.

  These should include the scope and aim of the programme, an overall, measurable target, timeframe, annual milestones, performance indicators and resources to be applied.
- Where a mainstream programme will be used to implement an AVFC recommendation, the same requirement for a specific, measurable target in relation to people with mental health problems is required.

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[21] World Health Organisation (2007) *Monitoring and evaluation of mental health policies and plans.* Geneva: World Health Organization (Mental Health Policies and Service Guidance Package).

[22] The right to the highest attainable standard of mental health is not confined to the right to mental health services. It embraces a wide range of socio-economic duties on Government to promote conditions in which people can lead a healthy life. As such the right to mental health extends duties of States to fulfill the underlying determinants of mental health, such as housing, adequate income, safe and healthy working conditions, and a healthy environment.

Each Department must set out how it will evaluate the impact of its mainstream programmes on people with mental health problems to ensure it is achieving the stated objective.

- How the Department will coordinate with the Office for Disability & Mental Health.

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

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

The importance of action by Departments outside of Health

The World Health Organisation (WHO) highlights that "mental health is necessarily an intersectoral issue requiring the involvement of the education, employment, housing and social services sectors, as well as the criminal justice system".[23] It recommends that a mental health plan distribute rights and responsibilities between different ministries and specify the role that each related Department will play in each action.[24]

Until now, non-health Departments have reported to the Independent Monitoring Group by and large by citing relevant recommendations and linking these to information on their existing programmes. Much of this information has concerned mainstream, ongoing programmes where the benefit to mental health problems is unspecified, making it impossible to assess improvements to people with mental health problems *per se*. Furthermore, there has been little evidence of any specific mental health initiative arising from *A Vision for Change.* Without mental health-specific evidence it will be impossible to evaluate whether the implementation of *A Vision for Change* itself is resulting in improvements to individuals' lives.

Furthermore, there is a need for all relevant Government Departments to **take ownership** of their responsibilities under the Government's mental health policy. For example, the Department of Social & Family Affairs (DSFA) wrote to an AI member in June 2009 stating that "implementation of the recommendations of '*A Vision for Change'* is a matter for the Office for Disability and Mental Health…" Though DSFA expressed support for the Office, the Department did not accept any responsibility for implementation. This is despite the fact that an entire chapter of *A Vision for Change* is devoted to social inclusion, for which the Department takes lead responsibility within Government.

How cross-sectoral action has worked in other countries

Cross-sectoral action has been recognised as vital to successful mental health service reform in other countries. Reform programmes in both the US and the UK have established frameworks for cross-sectoral planning and implementation.

[23] World Health Organisation (2007) *Monitoring and evaluation of mental health policies and plans.* Geneva: World Health Organization, 2007

[24] World Health Organisation (2005) *Mental health policy, plans and programmes (updated version 2).* Geneva: World Health Organization (Mental Health Policy and Service Guidance Package), p.38.

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

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

In its report after one year, the Substance Abuse and Mental Health Services Administration (SAMHSA) found that significant progress had been achieved in progressing actions. Transformation grants were awarded to nine states to cover a 5-year programme. A number of national-level collaborative programmes were also initiated. These included, amongst others:

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

The report further said that the cross-sectoral approach was essential:

> This level of commitment and collaboration among high-level, senior staff across multiple Federal departments is unprecedented. Yet, it is absolutely essential to support the wholesale changes required to make the mental health system consumer and family driven, culturally and linguistically appropriate, recovery focused, and results oriented.[25]

The UK National Social Inclusion Programme
The National Social Inclusion Programme in the UK was developed in order to further the findings of the UK Government's report *Mental Health & Social Exclusion.* This report set out a twenty-seven point action plan to achieve the vision that people with mental health problems would have the same opportunities to work and participate in their communities as others. It included actions for the Department for Education and Skills, the Department of Work and Pensions, the Department of Environment, Food and Rural Affairs, the Home Office and other agencies. The National Social Inclusion Programme was established to progress this action plan and has involved more than twenty Government Departments as well

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[25] *Transforming Mental Health Care in America: The Federal Action Agenda: A Living Agenda.* DHHS Publication No. (SMA) 08-4060. Revised 2008. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008, p.4.

as other agencies in its implementation to date. Some of the achievements of the inclusion programme so far have been:

- Publishing commissioning guidance for vocational services
- Publishing 'Finding and Keeping Work', a framework document for the development of a mental health and work strategy, and developing a mental health and work strategy (due to be published in 2009)
- Setting a national level indicator on the proportion of adults in contact with secondary mental health services who are in employment
- Established an Employer Engagement Network to share best practice
- Changes to the welfare benefits system
- Incorporating educational outcomes into the Care Programme Approach for individuals who were not educated to Level 2
- Producing mental health briefing documents for housing, health and social care staff on rent arrears management and 'Choice Based Lettings'
- Coordinated revision of the Code of Guidance for local authorities and setting out revised definitions of those in priority need of housing

Conclusion

The bulk of the €3 billion cost per annum of mental health problems in Ireland occurs outside the health sector, in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement as well as in premature mortality.[26] The failure to tackle the social exclusion of people with experience of the mental health services also impoverishes the social, cultural and political life of Ireland. All of the Government Departments named in *A Vision for Change* have a responsibility to set out the specific actions they will take to implement the recommendations, and in such a way that progress can be measured. The IMG can provide a needed impetus to such action by requiring Departments to report as specified in this paper.

[26] O'Shea, E. & B. Kennelly (2008) *The Economics of Mental Health Care in Ireland*, Dublin: Mental Health Commission.