

# Consultation on preparation of Ireland's National Action Plan against Poverty and Social Exclusion 2006-08

Written submission from:  
Schizophrenia Ireland – Lucia Foundation (SI)

## Introduction

The purpose of this document is to outline the main issues confronting people with schizophrenia and their families in Ireland today, and to make recommendations for Ireland's National Action Plan against Poverty and Social Exclusion 2006-08.

Schizophrenia is a serious mental illness characterised by disturbances in a person's thoughts, perceptions, emotions and behaviour. It affects approximately one in every hundred people worldwide, and there are an estimated 41,000 people with schizophrenia in Ireland.

Schizophrenia Ireland (SI) welcomes this opportunity to engage in promoting a reformed and enhanced National Action Plan against Poverty and Social Exclusion that meets the real needs of the people it serves.

Against this background, it is important to highlight the current trends in mental health and social exclusion<sup>1</sup>:

### ***Holistic approach needed***

At present, there is a groundswell of determination around the country to abandon outdated and inadequate mental healthcare services and increase funding for mental healthcare. Critically, the dominance of the medical model is being questioned, and there is growing recognition that there is limited efficacy if social and economic issues are not also addressed. A person's life must be viewed holistically, as there are many different influences and consequences on a person's life that must be considered (e.g. relationships, work and quality of life).

### ***Social environment and mental health***

People with mental health problems are vulnerable to social exclusion. Socially excluded individuals are vulnerable to stressors that may increase the risk of mental health problems.

### ***High costs***

There are high costs associated with mental health problems. Conversely, costs increase if a person becomes socially excluded.

## **I. Facilitating participation in employment**

Only 22% of people with mental health problems are employed in Ireland.<sup>2</sup> This number represents the lowest employment rate when comparing all disabilities.<sup>3</sup>

---

<sup>1</sup> "Mental Illness and Social Exclusion", David McDaid, London School of Economics, *Public Policy, Poverty and Mental Illness: Opportunities for Improving the Future, Occasional Paper No. 1*, Schizophrenia Ireland, 2005.

<sup>2</sup> Central Statistical Office, 2002.

<sup>3</sup> National Disability Authority's (NDA) 2005 report, *Disability and Work*

However, many studies have shown that 90% of individuals with mental health problems want to work.

According to the National Disability Authority's (NDA) 2005 report, *Disability and Work*:

“Work is an important part of belonging and participating in society. Having a job is good for mental health. Apart from bringing in an income, work is a valuable social outlet, taking people out of the house to become part of a wider community. Work is a place where people meet others and make friends. Absence from the workforce, on the other hand, can contribute to social isolation, and joblessness is associated with a higher incidence of mental health problems. Participating in the workforce also offers people with disabilities the chance to make a positive contribution. In a job, the focus is on ability, not disability. It is on what people are adding to society, not on dependence.”

The occupational needs of people with mental health problems vary greatly from individual to individual and will change for any one individual through the duration of his/her recovery. There is need for a range of meaningful occupational options both work based<sup>4</sup> and non-work based.

Schizophrenia Ireland suggests the following:

**Priorities:**

- Interventions to improve access to employment.
- Rectify social welfare system to ensure that disability benefits do not create barriers to return to future employment.
- Promote the recognition that people with severe and enduring mental health problems are able to work with the right support
- Reduce the misperception by employers that people with mental health problems can't contribute.

**Improvements to the present system:**

- Improved and increased range of meaningful occupational options both work based<sup>5</sup> and non-work based.

**New Measures:**

- Develop a specific, flexible and long-term work experience programme for people with a mental disability, with sufficient places for all eligible applicants.

## **II. Facilitating access by all (to resources, rights, goods and services) and Preventing the risks of exclusion**

### ***Equity***

It continues to be the case that Ireland's mental health services are inequitably distributed, with huge variations in per capita expenditure between regions, and lesser expenditure in areas of greater need. Schizophrenia Ireland recommends adjusting budgets to reflect an equitable level of expenditure per capita across all regions, with a positive loading in favour of regions, which are considered to be socio-economically deprived. A more equitable distribution of resources must be achieved without reduction in service provision in any region.

---

<sup>4</sup> In general, SI supports the recommendations of the NCATE report (1997).

<sup>5</sup> *Ibid.*

### ***Housing***

Housing is a major cause of stress amongst people with self-experience of mental illness. Many people with severe mental illness find themselves having to remain in the family home beyond a time that is of their choosing. Through SI's contact with service users and relatives, housing is often cited as their most serious concern. Increased provisions for accommodation is needed, along with greater flexibility to meet the current needs. It is paramount that there is a coordinated response from a variety of statutory and voluntary agencies to ensure that a good supply of appropriate housing is available.

### ***Homelessness***

It has been well documented that a significant percentage of the homeless in Ireland have severe mental illness. Current reports suggest that up to 30% of the homeless population have some form of mental illness.<sup>6</sup> In the Inspector of Mental Hospitals 2002 report, Dr. Walsh noted, "[o]ne of the most central difficulties facing the mentally ill, and those tasked with providing for them, is the fact that many are or become homeless."

### ***Income Supports***

Given the high level of unemployment amongst people with enduring mental illness, the provision of adequate and appropriate income supports is particularly important. A diagnosis of mental illness should not be a prescription for poverty.

### **Recommendations:**

Against this backdrop, Schizophrenia Ireland (SI) considers that examining the relationship between mental illness and social exclusion is fundamental in addressing the needs of people with severe mental illness. Specifically, Schizophrenia Ireland recommends the following actions:

#### **Priorities:**

- Mental Health needs to be prioritised on the national agenda.
- A cross-departmental approach on government policy, poverty, social inclusion and mental illness is needed.
- Budgets need to be readjusted to reflect an equitable level of expenditure per capita across all regions, with a positive loading in favour of regions, which are considered to be socio-economically deprived. A more equitable distribution of resources must be achieved without reduction in service provision in any region.
- Stigma is perhaps the single biggest issue for people with mental illness, and evidence shows it is a significant hindrance to recovery. Stronger efforts to promote mental health and to combat the stigma of mental illness are necessary.
- Prioritise funding housing provision for single homeless people with a history of mental illness.
- Ensure that rent allowance supplement reflects rises in the costs of rent.

#### **New Measures:**

- There needs to be a coordinated response from a variety of statutory and voluntary agencies to ensure that a good supply of appropriate housing is available.

---

<sup>6</sup> Fernandez, J, "The Homeless Mentally Ill: Aspects of Violence", The Care of the Disturbed Mentally Ill, Dublin 1996.

- National research on the relationship between social inclusion and mental health must be carried out.
- A partial incapacity benefit should be implemented, as recommended by the Department of Social Welfare's 2003 *Report of the Working Group on the Review of the Illness and Disability Payment Schemes*.
- A tailored social inclusion and mental health promotion programme needs to be established.

**Improvement to present system:**

- A re-assessing of the appropriate interfaces between health authorities and social services, and determining whether changes are required, needs to take place.
- The "Back-to-Work" Scheme should be reviewed in consultation with people with a mental disability in order to improve incentives for people to return to work.
- The medical card scheme should be extended to all people who require on-going mental healthcare.
- Mental health "proofing" should be instituted for all government policies, in line with the WHO's recent Mental Health Action Plan for Europe.
- There is a need for a range of social housing to facilitate people who no longer require supported housing.
- Adequate levels of accommodation are needed which should be community based and supported at an appropriate level for the individual.
- Supports need to include community based life skills training and development (as apposed to centre based training).
- It should be acknowledged that some people might always require some degree of supported accommodation.

**III. Helping the most vulnerable groups such as people with disabilities, the unemployed, people discharged from institutions**

***Poverty and Mental Health Problems***

For people with self-experience of a severe mental illness, poverty greatly adds to their distress and social exclusion.<sup>7</sup> In light of this, government policies can greatly impact people's experiences.

Critically, the World Health Organization (WHO) has cited that it will address the issues of poverty and mental illness in 2005. At a WHO Regional Committee for Europe meeting, the following was highlighted:

"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. Widening disparities in society or economic changes in individuals' life courses seem to be of particular importance here. Whether defined by income, socioeconomic status, living conditions or educational level, poverty is an important determinant of mental disability and is associated with lower life expectancy and increased prevalence of alcohol and drug abuse, depression, suicide, antisocial behaviour and violence. As a cause of poverty, loss of status and mental distress, unemployment is a major issue in all European Member States. Raising awareness about the impact of political decisions and policy

<sup>7</sup> For further information in this regard, please see SI's *Social Inclusion & Mental Illness Report*, 2000.

changes on the mental health of a population, especially with regard to unemployment and poverty and its association with depression, suicides and substance abuse, is one of the priorities for WHO's Mental Health programme in Europe.”<sup>8</sup>

Contributing to social exclusion, poverty affects the lives of people who experience severe mental illness in a variety of ways, including:

- Becoming severely depressed, anxious, frustrated or suicidal
- Not being able to afford appropriate accommodation or living in poor accommodation
- Lacking self esteem
- Having a poor diet and lacking exercise
- Struggling to make it through each day
- Not being able to afford a social life or holidays
- Not being able to engage in creative opportunities due to financial constraints
- Not being able to progress towards paid work because they cannot afford suitable clothing, child care, etc
- Not being able to provide for themselves for the future because they cannot afford to save money
- Not being able to afford insurance
- Relying on others, including their families, to subsidise them
- Being stigmatised because of their mental illness and/or poverty problems
- Being socially isolated
- Lacking motivation.<sup>9</sup>

### ***People discharged from mental health institutions***

Once a person has successfully engaged with the mental health services, the process towards a resumption of independent or supported living must be actively considered. At all times, service providers, whether in a hospital or community setting need to be alert to the ongoing whole life concerns and needs of the individual.

Leaving acute care services can be a particularly vulnerable time for people, and evidence suggests that at this time they are at a higher risk for suicide. In light of this, it is fundamental that everyone should have a comprehensive discharge plan that has been agreed on in consultation with the person themselves, family members and all other relevant individuals. Community services and the GP should receive a copy of the discharge plan. Appropriate accommodation must be part of the discharge plan, and it is unacceptable to place people in temporary, short-term emergency accommodation.<sup>10</sup>

According to the New Zealand Ministry of Health,

Discharge planning is a formal process that leads to the development of an ongoing, individualised programme of care and support which meets the objectively assessed needs of a patient/consumer on leaving hospital. It addresses the social, cultural, therapeutic and educational interventions

---

<sup>8</sup> Source: WHO Regional Committee for Europe, Fifty-third session, Vienna, 8–11 September 2003 (<http://www.euro.who.int/document/rc53/edoc07.pdf>).

<sup>9</sup> Abstracted from Rethink, Rethink Policy Statement 57, “Poverty and Severe Mental Illness”, 2003.

<sup>10</sup> Such as bed and breakfasts, emergency shelters and homeless shelters.

necessary to safeguard and enhance that person's health and well being in the community. Discharge planning involves the patient, family...the treatment team, and other service providers. It is required when a patient leaves any inpatient facility, and it is particularly important in the case of patients with mental health disorders (including substance abuse) who have been in hospitals suffering from chronic mental illnesses with residual psychiatric disability.<sup>11</sup>

While the phrase "Discharge planning" has its merits, it also serves to heighten the dislocation and disruption that has occurred. The reasons why a person is deemed to be in need of hospitalisation may not have disappeared just because their "symptoms" have been reduced or eliminated. Appropriate housing, meaningful occupation, access to money and supports will not necessarily have resolved themselves while the person has been withdrawn from daily coping. Without taking a comprehensive account of a person's whole circumstances, the opportunity for improved health and living in the community will be at serious risk of failure. Discharge planning must be viewed as a fundamental right of each person upon leaving hospital – and a cornerstone in the process of his or her recovery.

### **Recommendations**

#### **Priorities:**

- Service providers, whether in a hospital or community setting need to be alert to the ongoing whole life concerns and needs of the individual.
- Discharge planning must be viewed as a fundamental right of each person upon leaving hospital – and a cornerstone in the process of his or her recovery.

## **IV. Mobilising all relevant bodies in fighting poverty and social exclusion**

### ***Inter-departmental coordination***

It is evident that inter-departmental coordination at the government level is absolutely fundamental in tackling these concerns. Not surprisingly, social exclusion, poverty and mental illness related issues are influenced by different government departments, notably the Department of Health and Children, Department of Finance, Department of Social and Family Affairs, and the Department of the Environment, Heritage and Local Government. While there is significant cross-departmental coordination and cooperation on the National Anti Poverty Strategy (NAPS), there is, however, little evidence to suggest that the various government agencies discuss and evaluate social exclusion and poverty considerations specifically within the context of mental illness.

### ***Inclusive Policy Development***

Equally, it is imperative that people with self-experience of mental illness and their families be partners in planning and policy development at all levels, including the National Action Plan against Poverty and Social Exclusion 2006-08. Without their

---

<sup>11</sup> New Zealand Ministry of Health, "Guidelines for Discharge Planning for People with Mental Illness", 1993,  
[http://www.moh.govt.nz/moh.nsf/0/9e473fa9e37439e6cc256d5c0076c80f/\\$FILE/GuidelinesforDischargePlanningforPeoplewith.pdf](http://www.moh.govt.nz/moh.nsf/0/9e473fa9e37439e6cc256d5c0076c80f/$FILE/GuidelinesforDischargePlanningforPeoplewith.pdf)

voices, any efforts would lack the true and fundamental concerns of those affected by policies on a daily basis.

## **Recommendations**

### **Priorities:**

- Inter-departmental coordination at the government level is absolutely fundamental in addressing social exclusion, poverty and mental illness related issues.
- People with self-experience of mental illness and their families be partners in planning and policy development at all levels, including the National Action Plan against Poverty and Social Exclusion 2006-08.
- Increased funding to address social exclusion, poverty and mental health related issues.

### **Conclusion**

The challenge for a focused approach to the issues is the lack of a cohesive and inclusive strategy and the undercutting of resources. Financial pressures are currently putting mental health services at risk. Funding, as a proportion of the overall healthcare budget, has dropped from 10.6% in 1990 to 6.8% in 2003.<sup>12</sup> As the funding for mental healthcare dwindles year-by-year, mental health services fall further behind in their ability to meet the needs of service users. It is imperative to acknowledge that mental illness, poverty and social exclusion cost society much more, if adequate services are not delivered. These social costs include lost output in the economy caused by people unable to work; human costs of reduced quality of life amongst those with a mental illness; costs of State support for those unable to work due to mental illness; and the costs for care provided by the State and relatives of those with a mental illness.<sup>13</sup>

As the Mental Health Expert Group, the Mental Health Commission, the Department of Health and Children, mental health voluntary organisations and other NGOs lead the way forward in helping to reshape the mental health landscape, the National Action Plan against Poverty and Social Exclusion can and should build upon the increasingly shared conviction that choice, empowerment, partnership and facilitating recovery must be the cornerstones of any new policies.

---

<sup>12</sup> Mental Health Commission Annual Report, (2002), p. 22.

<sup>13</sup> The Sainsbury Centre for Mental Health, *Economic and Social Costs of Mental Illness*, (2003).

## **About Schizophrenia Ireland - Lucia Foundation**

Schizophrenia Ireland – Lucia Foundation (SI) is the national organisation dedicated to upholding the rights and addressing the needs of all those affected by schizophrenia and related illnesses, through the promotion and provision of high-quality services and working to ensure the continual enhancement of the quality of life of the people it serves.

SI was founded in 1975 and now has offices in the east (Dublin), in the south-east (Kilkenny), the south (Cork), the west (Galway), the midlands (Longford), the mid-west (Limerick) and the north-east (Dundalk).

Organisation's Objectives:

1. To promote the development of parallel mutual self-help groups for people with schizophrenia and their carers.
2. To empower people with schizophrenia and their carers through support, individual advocacy, information and education.
3. To promote the right to appropriate health, accommodation, employment and other services.
4. To advocate for rights and needs and to challenge discrimination against all those affected by schizophrenia.

Schizophrenia Ireland believes that:

- People with schizophrenia should at all times be accorded the rights, entitlements, and opportunities available to any other member of society on an equal basis, and should be empowered to participate in the life of the community to the fullest possible extent.
- Relatives and families, the majority of whom are the primary providers of psychiatric care in the community, should be accorded full recognition and support by the institutions of the State, and be empowered to address their own needs.
- A history of mental illness should never be a cause of discrimination, stigmatisation or prejudice in any form, nor should it inhibit the individual's right of equal access to training education and employment.
- Schizophrenia Ireland lobbies consistently to promote the delivery of quality health care services and to reduce stigma.
- We pursue a partnership and collaborative approach with all relevant agencies.

**Contact us:**

**DUBLIN HEAD OFFICE**

38 Blessington Street, Dublin 7, IRELAND  
T: 01 8601620  
F: 01 8601602  
E: [info@sirl.ie](mailto:info@sirl.ie)

**CORK**

42 Penrose Wharf, Cork, IRELAND  
T: 021 4552044  
F: 021 4553633

**GALWAY**

Unit 6, Town Park Centre,  
Tuam Road, Galway, IRELAND  
T: 091 761746  
F: 091 767389

**KILKENNY**

5 Priory Court,  
Dean Street, Kilkenny, IRELAND  
T: 056 7756210  
F: 056 7756209

**LONGFORD**

55 Dublin Street, Longford, IRELAND  
T: 043 42366  
F: 043 42367

**ENNIS**

Unit 14 A&B,  
Clonroad Business Park,  
Ennis, Co. Clare, IRELAND  
T: 065 6844874  
F: 065 6844964

**DUNDALK**

507 Donovan House,  
Adelphi Court, The Long Walk,  
Dundalk, Co. Louth, IRELAND  
T: 042 9324541  
F: 042 9324541

**BASIN CLUB & JOB CLUB**

39 Blessington Street, Dublin 7, IRELAND  
T: 01 8601610  
F: 01 8601548

