

Schizophrenia Ireland
Lucia Foundation



Occasional Paper No. 1

**Public Policy, Poverty
and Mental Illness:**

*Opportunities for
Improving the Future*

Kahlil Thompson Coyle, ed.

Schizophrenia Ireland

Lucia Foundation

Schizophrenia Ireland 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.

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FOREWORD

In November 2004, Schizophrenia Ireland held a seminar discussing public policy, poverty and mental illness. The seminar was funded through the Combat Poverty Agency as part of its Working Against Poverty Grants Scheme.

The seminar brought together some of the key policy makers from government, statutory and non-governmental bodies concerned with the issues. It explored the relationship between policy, poverty and mental illness within the context of considering possible policy gaps, and solutions aimed at improving the status quo in Ireland.

Key contributions were made by: David McDaid, London School of Economics (LSE) and Consultant to the World Health Organization (WHO); Bairbre Nic Aongusa, Principal with the Department of Health & Children; Brian Hartnett, Irish Advocacy Network (IAN); and Bjørg Njaa, President of the Norwegian National Association for Relatives of the Mentally Ill.

What follows is a discussion of the issues presented at the seminar, copies of the presentations, and the policy recommendations made on the day by the seminar participants. It is the hope of Schizophrenia Ireland that the poverty dimension of mental illness becomes firmly set on the Irish policy agenda, gaining the prioritisation that it urgently deserves.

by John Saunders

Director, Schizophrenia Ireland

PUBLIC POLICY, POVERTY AND MENTAL ILLNESS: AN OVERVIEW OF THE ISSUES

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 39,000 people with schizophrenia in Ireland alone.

For people with self-experience of a severe mental illness, poverty greatly adds to their distress.¹ 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 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.²

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.³

Footnote:

1. For further information in this regard, please see SI's *Social Inclusion & Mental Illness Report, 2000*.
2. Source: WHO Regional Committee for Europe, Fifty-third session, Vienna, 8–11 September 2003 (<http://www.euro.who.int/document/rc53/edoc07.pdf>).
3. Abstracted from Rethink, Rethink Policy Statement 57, "Poverty and Severe Mental Illness", 2003.

Assessment of the Irish Context

Within the Irish context, the following areas are of particular concern:

Mental Health Needs to be Recognised as a Priority issue

In Ireland, mental healthcare as a proportion of the overall healthcare budget has dropped from 10.6% in 1990, to just 6.8% in 2003.⁴

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.

Employment

While no accurate data exists for Ireland, figures in England would suggest that upwards of 76% of people with enduring schizophrenia are unemployed.⁵

Research

Better information about the prevalence of illness, assessment of needs for treatment and rehabilitation, and processes and outcomes of treatment/rehabilitation are essential. Without urgent action to address information gaps on the relationship between poverty and mental illness, the development of responses will continue to be piecemeal, inconsistent and inadequate to need.

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.⁶ 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.

Footnote:

4. Mental Health Commission Annual Report, (2002), p. 22.

5. Office of the Deputy Prime Minister, U.K. *Mental Health and Social exclusion: Social Exclusion Unit Report*, p.51.

6. Fernandez, J, "The Homeless Mentally Ill: Aspects of Violence", *The Care of the Disturbed Mentally Ill*, Dublin 1996.

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

- ***Mental Health needs to be prioritised on the national agenda.***
- ***A cross-departmental approach on government policy on poverty and mental illness is needed.***
- ***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.***
- ***National research on the relationship between poverty and mental health must be carried out.***
- ***A re-assessing of the appropriate interfaces between health authorities and social services, and determining whether changes are required, needs to take place.***
- ***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.***
- ***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.***
- ***A tailored anti-poverty and mental health promotion programme needs to be established.***
- ***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.***
- ***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.***
- ***Mental health "proofing" should be instituted for all government policies, in line with the WHO's recent Mental Health Action Plan for Europe.***

Conclusions

It is evident that inter-departmental coordination at the government level is absolutely fundamental in tackling these concerns. Not surprisingly, both 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 poverty considerations specifically within the context of mental illness.

Conversely, it is imperative that people with self-experience of mental illness and their families be partners in planning and policy development at all levels. Without their voices, any efforts would lack the true and fundamental concerns of those affected by policies on a daily basis.

The challenge for a focused approach to the issues is the lack of a cohesive and inclusive strategy and the undercutting of resources. 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, mental health policy can and should build upon the increasingly shared conviction that anti-poverty measures must be at the cornerstone of any new policies.

PRESENTATIONS

Mental Illness and Social Exclusion

David McDaid, London School of Economics (LSE) and
Consultant to the World Health Organization (WHO)

The Norwegian Experience

Bjørg Njaa, President of the National Association for
Relatives of the Mentally Ill

(Please note: informal presentation, no handouts provided)

Irish Mental Health Policy

Bairbre Nic Aongusa, Principal with Ireland's Department of
Health & Children

Service Users' Experiences

Brian Hartnett, Irish Advocacy Network (IAN)

(Please note: informal presentation, no handouts provided)

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**PUBLIC POLICY,
POVERTY &
MENTAL ILLNESS
SEMINAR**



Schizophrenia Ireland
Lucia Foundation
14th Biennial Conference

WELCOME ADDRESS

Kevin Jones

Seminar Chairperson

& Council Member

Schizophrenia Ireland



Schizophrenia Ireland
Lucia Foundation
14th Biennial Conference

MENTAL ILLNESS AND SOCIAL EXCLUSION

David Mc Daid
London School of
Economics



Mental Health and Social Exclusion: An Overview

David McDaid
London School of Economics and Political Science

Clontarf Castle, Dublin

November 2004

Structure

- Background
- Consequences and costs of exclusion
 - Focus on employment issues
- Actions to tackle social exclusion
 - England
 - European level developments

Context

- Undertaking systematic review of links between social exclusion & mental health for Gatsby Trust
- MHEEN network collecting data on trends in labour market

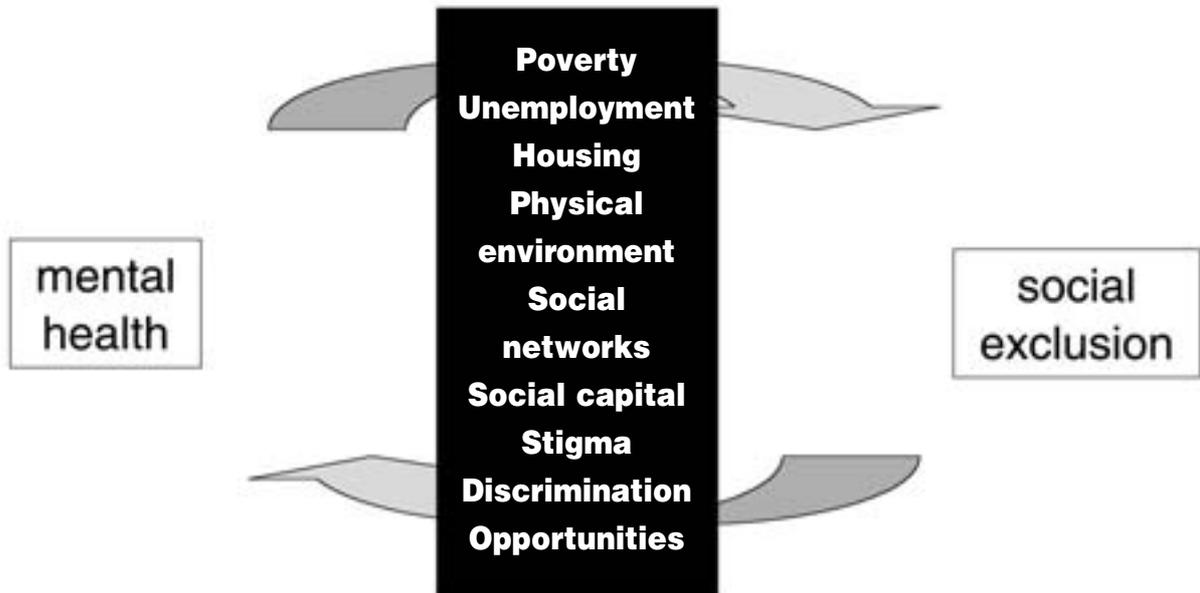
Definition of social exclusion

- Social Exclusion
 - Participation - A function of deprivation and participation functioning over four dimensions: consumption, productivity, social participation and political participation (CASE 2002)
 - Eg, reduced opportunities to access employment
 - Rights - The deprivation of right to be a member or a citizen of a particular community or country and the deprivation of human rights
 - Eg, Mistreatment of vulnerable individuals

Trends in mental health and social exclusion

- Questioning the dominance of a medical model
 - Limited efficacy if social and economic issues not addressed
 - Too narrow a view - many different influences and consequences on a person's life: relationships, work and quality of life
- Inter-relationship between social environment and mental health
 - People with mental health problems vulnerable to social exclusion
 - Socially excluded individuals are vulnerable to and, exposed to, stressors that increase the risk of mental health problems.
- High costs
 - Associated with mental health problems
 - Increase if a person becomes socially excluded

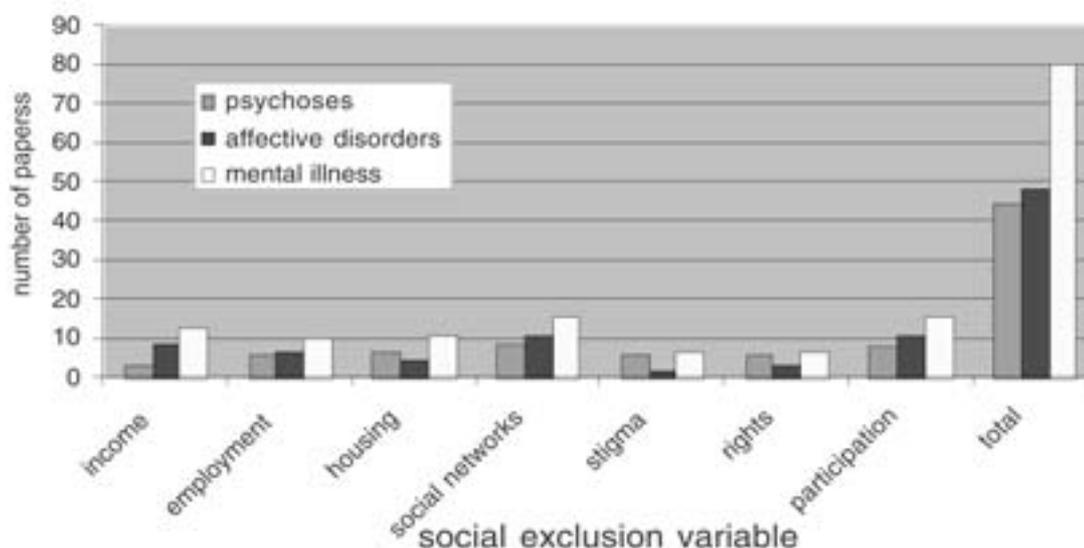
What is the relationship between mental health and social exclusion



A systematic review of the evidence

- What *empirical* evidence is there of a link between mental health and social exclusion? How does this impact on different severities of mental health problem, different age groups, and the transitions between them?
- A systematic review
 - Summarise evidence
 - Assess quality
 - Incorporates scientific methodology - minimise errors and bias
 - Produces balanced inferences not 'expert views'

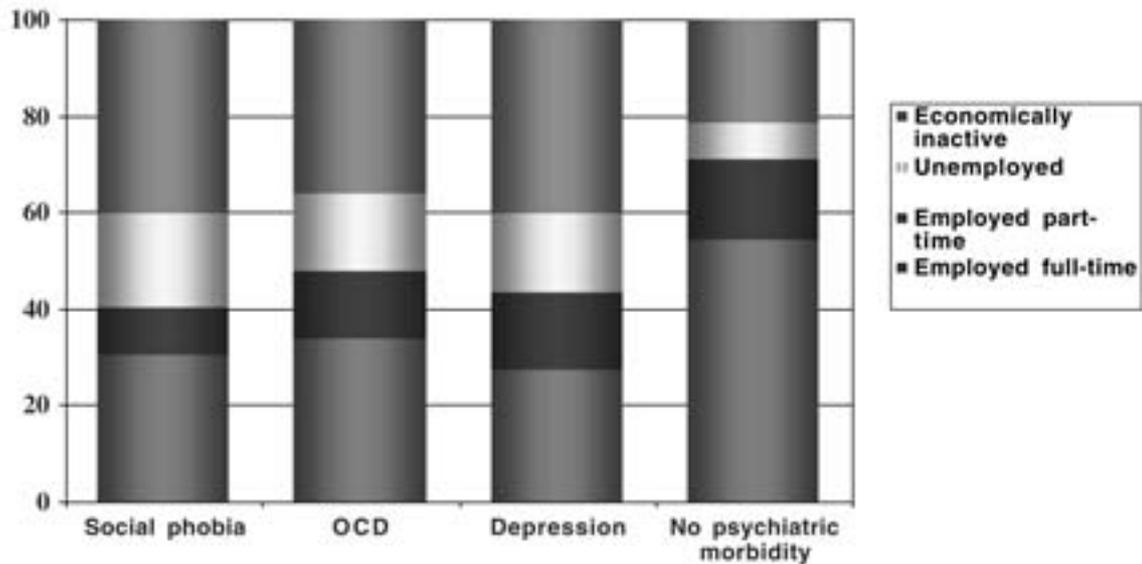
Distribution of social exclusion topics discussed in papers from 3 mental health categories



Broad consequences

- Between 60 – 80% of all costs associated with mental health problems occur outside the healthcare system.
 - Lost employment;
 - Lost career opportunities
 - 3 times more likely to be in debt
 - Impact on family relationships – lower rate of co-habitation
 - Criminal justice system
 - Homelessness (30-50% have a mental health problem – SEU 1998)
 - Long term impacts, good evidence for children

Employment: common mental health problems, UK 1993-4



Patel et al, 2002a,b,c

Employment rates for people with more mental health problems

- Employment rates for more severe problems lowest
- People counted as economically inactive rather than unemployed

Employment and mental health

- 90% of individuals report wanting to work
- Up to 58% in one US study of people with severe and enduring mental health problems are able to work with the right support
- For people with schizophrenia in one English study employment rates had decreased from 12.0% in 1990 to 4.4% in 1999 (Perkins and Rinaldi 2002).
- Six site European study reported that only 17.1% were employed or students (Thornicroft et al 2004)

Employment rates for people with mental health problems

Ireland

22% employed

3% unemployed

75% economically inactive

(Source: Central Statistical Office, 2002)

UK

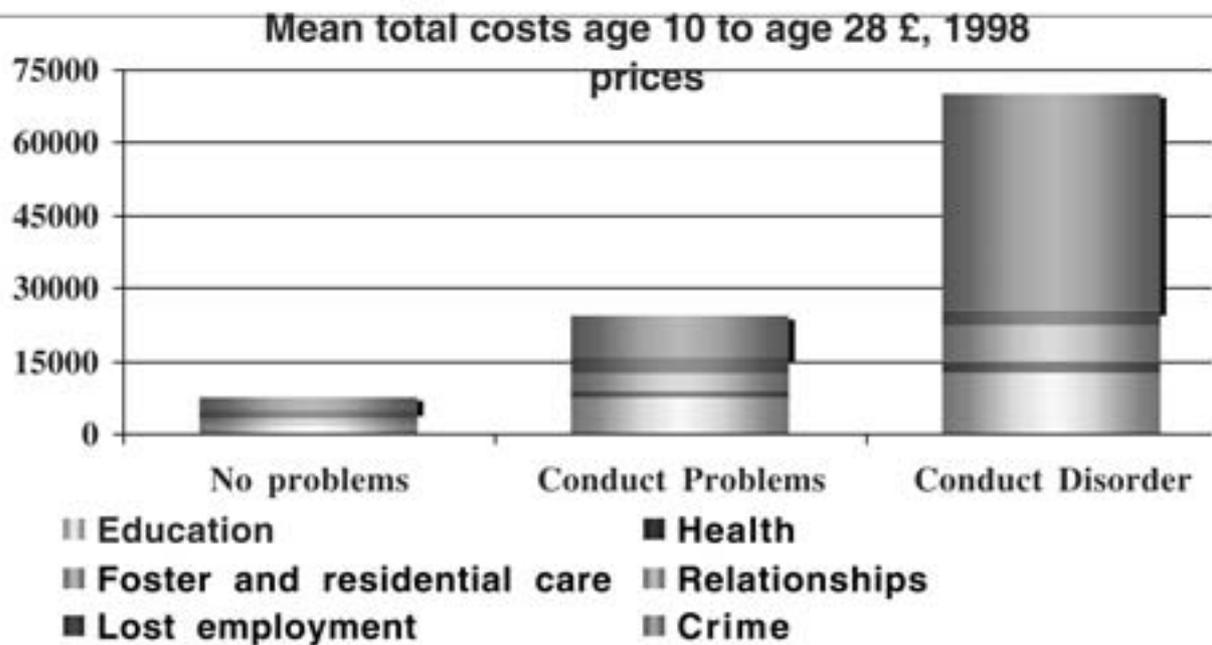
more than half those considered 'disabled' are economically inactive compared with 15% of non disabled (Smith & Twomey 2002)

Some Contributory Factors

- Risk factors in the workplace
- Job Insecurity
- Misperception by employers that people with mental health problems can't contribute
- Poor Enforcement of Legislation
- Anomalies in Social Welfare Systems
 - Disability benefits may be higher than unemployment benefits – but then constitute barrier to return to future employment
 - Significant rise in numbers of people on disability benefits

Long term impacts

Financial costs of social exclusion: long term follow up of antisocial children



Scott et al BMJ 2002

Study Implications

1. Anti-social behaviour in children often leads to lifelong social exclusion
2. Considerable costs in childhood; high public expenditure and personal distress in adulthood (10 times higher for CD compared with NCD)
3. However cost effective interventions exist: Parent training programmes; school based initiatives; Surestart (currently being evaluated)

ODPM report June 2004

- Major report on social exclusion and mental health published by the Social Exclusion Unit in England (Office of the Deputy Prime Minister)
- www.socialexclusionunit.gov.uk

Causes and reinforcers of social exclusion (ODPM 2004)

- Widespread stigma and discrimination
- Professionals have low expectations of what people with MH problems can achieve – employment not seen as key objective
- Lack of clear responsibility for promoting social and vocational outcomes
- Lack of ongoing support to enable people to work
- Barriers to engagement in the community

Vision for the future (ODPM 2004)

- Communities accepting that people with mental health problems are equal
- Receive support *before* they need it
- Genuine choice and empowerment
- Retaining jobs longer, returning to employment faster, career progression
- Recognition of fundamental importance of family relationships and social participation
- Partnership between health, social care, employment and community services

Actions in England (1)

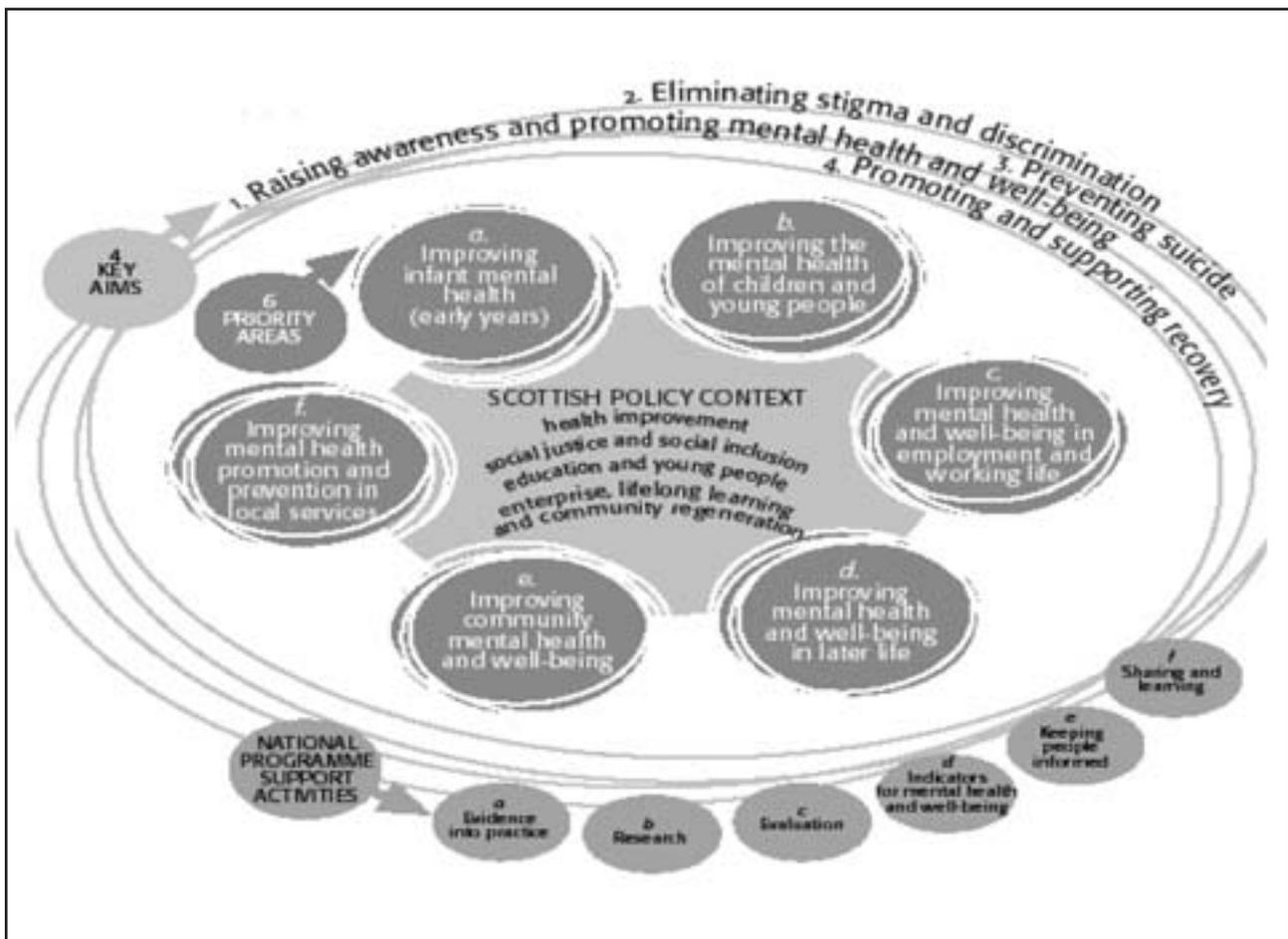
- National Service Framework on Mental Health – emphasis on promotion of mental wellbeing and reintegration as well as treatment
- 27 point action plan on mental health and social exclusion
- Action on Mental Health published 10/2004
- Includes teaching in schools/work with broadcasters; action in the public sector; improved training for Job Centre Staff

Actions in England (2)

- Sustained anti stigma campaign
- Implementing evidence based practice in vocational services and community reintegration
- Greater employment opportunities
- Supporting families and community participation
- Getting the basic right – access to benefits, decent housing, financial advice
- Clear implementation strategy – actions incorporated into departmental delivery plans – links to public service targets

Changing Attitudes: Frank Bruno

- Headline in Sun ‘Bonkers Bruno Locked Up’
- Sad Bruno in Mental Health Home
 - Accompanying story labelled him a hero
 - Health editor sent on a mental health training course
 - Sun contributed to ‘Fund for Frank’



Actions in Europe

- Athens ministerial conference on stigma and mental health
- Recent European Health Forum Gastein on mental health and social inclusion
- One of the pillars of the Intergovernmental Conference in Helsinki

Conclusions

- Social exclusion is both a major consequence and contributor to mental health problems
- There are also substantial socio-economic impacts
- The evidence base on interventions to effectively address social exclusion growing
- Interventions to improve access to employment are of high importance
- ODPM report in England is a useful tool for considering policy actions

PUBLIC POLICY, POVERTY & MENTAL ILLNESS SEMINAR



Schizophrenia Ireland
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THE NORWEGIAN EXPERIENCE

Bjorg Njaa

President of the National
Association for Relatives of the
Mentally Ill



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IRISH MENTAL HEALTH POLICY

Bairbre Nic Aongusa

Principal with
Department of Health &
Children



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Mental Health Policy

Bairbre Nic Aongusa
Dept. of Health & Children



Poverty & Mental ill-health

- Mental Ill-health can lead to poverty
 - Poverty can lead to mental ill-health
 - Focus on preventing and treating mental ill-health & supporting those with enduring illness
 - Recognising limitations of health focus – requires multi-sectoral approach
- 

National Anti-Poverty Strategy

- NAPS target groups include “people with disabilities”
- Health targets under NAPS do not include mental health specifically
- Policy measures
 - Primary Care Strategy
 - Poverty proofing
 - Health Impact Assessment

Mental Health Issues

- Importance of investment in mental health services
 - Increased visibility in political arena
- Inequity in funding between regions
 - Issue for new HSE?
- Need for quality information & research
- Expert Group

Multi-sectoral approach

- Housing
- Homelessness
- Services for children
- Employment
- Key roles for voluntary sector



RECOMMENDATIONS MADE BY THE SEMINAR PARTICIPANTS

Small Group Work

The participants of the seminar were asked to discuss the following question. Responses were then fed back to the full forum.

1. Please agree on roles of Leader, Timekeeper and Reporter within your group.
2. On the flip chart, please record your responses to the following question:
What are your recommendations for mental health policy in respect to poverty arising out of today's deliberations?
3. The Reporter will highlight the main priority recommendations in a 3 minute report to the full group.

Group Responses:

Group 1

- Holistic Assessment
- Comprehensive Assessment of need
- Role of social inclusion unit
- Cabinet committee on social inclusion
- Absence of Mental Health NAPS review
- Information systems and networking
- Social welfare – extent of mental illness
- Mental health higher on social inclusion agenda
- Mental health – mainstreamed in poverty and equality proofing and health impact assessment
- Scoping of Mental Health policy and provision cross departmentally
- Inequality in access to services
- Pathologising social problems
- Non-stigmatising services at primary care (Primary care strategy should include mental health)
- Importance of occupational needs and pathways to work
- Training budgets in health must include mental illness
- Role of personal Assistants towards integration... (volunteers, professional)
- Need to recognise changing needs and centrality of person using service
- Economic analysis – independent (including analysis of preventative work)
- Educate Mental health professionals on link between mental health, poverty and social exclusion
- Services should be recovery focused

- Address social welfare disincentives
- Investigation by Equality Authority of effectiveness of existing legislation
- Policies on empowerment
- Disability Bill does not include housing
- Poverty of quality of life
- Dual diagnosis – mental health and substance abuse (need for specialist services)
- State Agencies support by example (employment of people with mental health problems)
- Social Capital survey
- Reflect on how communities are changing and impact on mental health
- Connection between community authorities and health boards
- More conscious attempt to integrate (need to invest in community initiatives – clear linear lines don't work)
- Impact of health reform?
- Need strong voice from NGOs and mental health community

Group 2

- Poverty (income poverty, social poverty, opportunity poverty)
- Physical environment (rural/urban, sense of community, natural networks)
- Urbanization/materialism, deter inclusion
- Define poverty in wider terms – not just income poverty (also includes social poverty) – supports community inclusion (urbanization / materialism), opportunity poverty
- Definition of employment
- Excludes large proportion of those with mental ill health UA and UB
- Resources for employment not applied to the group

Initiatives

1. Employment within mental health services (valuing experience of mental health)
2. Social firms (increase opportunities, retraining, education, subsidy may be good value)
3. Reintegration (Employee assistance programmes, re-integration into workplace, employee retention grant scheme – not being without UB)
4. Normalising the experience of mental ill health (difficulty of employer not understanding complexity/need for support)
5. Benefit trap (decouple medical card from social welfare, young people with no previous engagement in work)
6. Supported employment – current criteria can be restrictive (potential to work 18 Hours)

Group 3

- Employment
- Engage employers, trade unions
- Flexible work Practices

- Effective legislation
- To suit potential employee aim for a win-win situation
- Positive benefits for all
- Recovery of the individual is less cost to society/community
- We need to challenge the notion of defining people by their paid employment
- Challenge the definition of poverty
- Education
- Long-term view
- Today's students are: tomorrow's employers, tomorrow's users of the mental health services
- Training for teachers
- Innovation
- Direct payments (buy your own support system)(choice)
- Pre-employment initiatives
- Change
- Cross-departmental government approach needed
- Lobby on specific issues through an agreed strategic approach

Group 4

- Vision/aspiration
- Revolution/evolution
- Definitions (poverty, social and mental health disability)
- Evidence based (qualitative and quantitative, what do we measure? We currently are excluding experience)
- Plan (quality assured multi-sectoral related to social change agenda, roadmap – ideas, changes, impacts)
- Channels (attitudinal change, mainstreaming, participation, inter-sectoral work, political agenda, using existing policy mechanisms, real work emphasis, training – especially power holders)

Additional comment:

The lived experience of the user needs to be fully taken into account in consideration of returning to and continuing to work. For example, one of the commonest lived experiences of people diagnosed as having schizophrenia is great anxiety and fear, which can be overwhelming and often reach the point of terror, as well as a great degree of social awkwardness and uncomfortableness. This lived experience is very common, particularly in the face of stressors, such as the idea of work, or going about getting involved in work. Experiencing such intense feelings and experiences certainly can cause a person to resist/withdraw from/avoid returning to work initiatives as they are currently structured. Such experiences need to be fully taken into consideration for people returning to work/education/integration within mainstream life. The usual classification of 'positive' and 'negative' symptoms does not seem to capture the intensity of these experiences, which are a major part of withdrawal and avoidance. If pathways to work give appropriate cognisance to these experiences, than returning to work would be a more successful venture for many.

Dr. Terry Lynch

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Martin Naughton, DFI

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Mary Higgins, Homeless Agency

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Deirdre Ryan, NAHB

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Esther Risstubben, (Observer) National Association for Relatives of the Mentally Ill, Norway

Shira Mehlman, FÁS

Fiona Keogh, Mental Health Commission

Patricia Gilheaney, Mental Health Commission

Caroline McGrath, Mental Health Ireland

Liz McManus, Labour Party

Iris Elliott, NDA

Lisa O'Farrell, Centre for Disability Studies, UCD

Liz Sullivan, Combat Poverty Agency

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