Building Political Will on Mental Health

Evaluation of the One Foundation's support of advocacy in mental health.

The **One** Foundation

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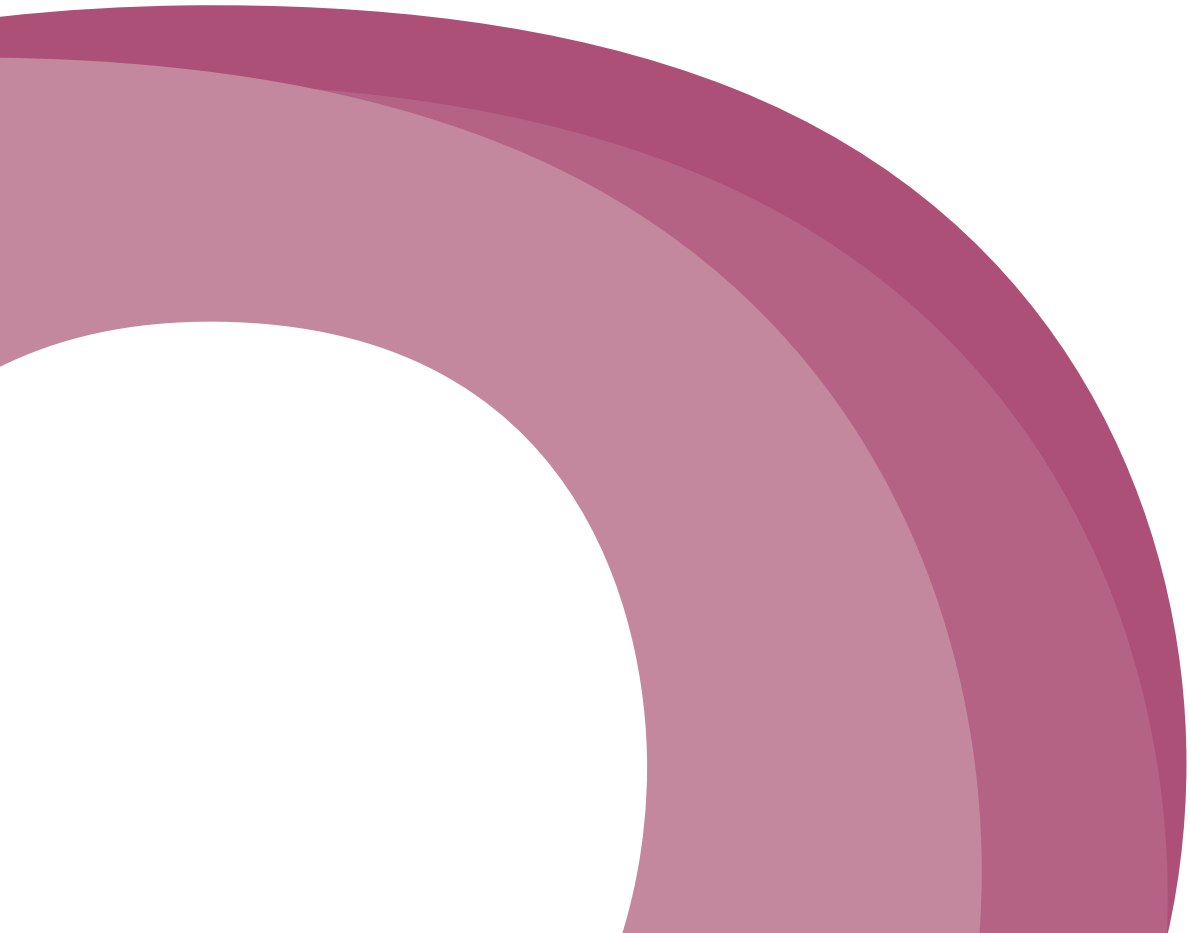

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Introduction

The One Foundation was co-founded in 2004 by Declan Ryan and Deirdre Mortell to improve the lives of disadvantaged children in Ireland and Vietnam. The foundation will have invested €75 million, mostly in non-profit organisations over a ten-year period between 2004 and 2013, in part via co-investments with another limited life foundation operating in Ireland, The Atlantic Philanthropies.

In June 2012, the foundation commissioned an external evaluation of its advocacy investments focusing specifically on three advocacy goals named in mid-2008:

1) To make children's rights real
2) To make immigrant rights real
3) To build political will on mental health

The following is the review of the foundation's advocacy on 'building political will on mental health and a blended case study of three organisations: Amnesty International Ireland, Mental Health Reform and Headstrong.

The full report "Evaluation of The One Foundation's (2004-2013) Support of Advocacy on Children's Rights, Immigrant Rights and Mental Health Reform, Ireland," including methodology and context is available on www.onefoundation.ie

Building political will on Mental Health

The following is an overview of the mental health social policy context and what OF sought to achieve. Analysis of advocacy performance and impact follows in a blended case study of three organisations: Amnesty International Ireland, Mental Health Reform and Headstrong.

Mental Health, Ireland

When OF became active in the field of mental health in 2006, quality services were unevenly available for those who needed them, including children, young people and their families. With no comprehensive national information on mental health problems, OF estimated from available data that one in four of all people in Ireland were affected by mental ill health either directly or through a family member. Depression accounted for almost 70% of mental health illness and for almost 50% of hospital admissions relating to mental health. Recorded suicide (one of few mental health indicators tracked), had doubled in 30 years, and was reported to be the biggest killer of young men aged 15-24. In 2004 alone, there were 400 deaths by suicide.[1] Children's mental health services lacked dedicated staff and waiting lists were long. For example, the Health Services Executive's 2007 review (the main agency responsible) found 3,598 children waiting for assessments, 1,000 of whom had been waiting more than a year.[2]

This assessment was substantiated by findings of the Inspector of Mental Health Services (2006) that mental health provision was ad hoc, with deficiencies in community mental health teams.[3] Successive governments had failed to develop community-based services, which resulted in over-reliance on in-patient units. Also, children continued to be treated (inappropriately) in adult facilities.

Poor and inadequate services and treatments were the result of many factors, not least a decline in the proportion of the state health budget specifically designated for mental health – from 9.1% in 1998[4] to 7.7% in 2008.[5] Responsibility for development of health policy, including mental health lay with the Department of Health, with the HSE (Health Services Executive) the main agency responsible for service delivery.

In 2006, the Irish government published what was seen as a progressive policy, "A Vision For Change" (AVFC). However, the policy had not been implemented or funded. AVFC called for a shift from the (hidden) treatment within Ireland's Victorian institutions of containment to provision of supports in an open community setting, with an emphasis on recovery.

At the time, Amnesty was advocating for reform. It had identified mental health as an area of Irish social policy where its human rights approach could give added value because mental health was, it concluded, a neglected policy area,[6] with 'serious and multiple infringements of human rights.'[7] From 2003 onwards, Amnesty had pioneered public information campaigns framed around the right to mental health.[8]

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1 This overview draws on data contained in The One Foundation's internal documents used during TOC analysis and Amnesty International Ireland's submissions to the foundation.
2 Written reply to parliamentary question, 19 October 2007, Jan O'Sullivan TD, referenced inter alia at http://debates.oireachtas.ie/dail/2008/04/17/00019.asp.
3 Mental Health Commission, Annual Report 2006, including Report of Inspector of Mental Health Services.
4 A Vision for Change p.260
5 See WHO (2008) Policies and Practces for Mental Health in Europe: Meeting the Challenges. www.euro.who.int/-data/assets/pdf
6 Mental Illness: The Neglected Quarter, 2003, AII.
7 Cooke & Montogomery, 2009.
8 The overall aim was to make real Article 12 of the International Covenant on Economic, Social and Cultural Rights that every person has the right to the highest attainable standard of physical and mental health.

Advocacy Goal & Strategy – "build political will on mental health"

In 2008, OF named its mental health advocacy goal "to build political will on mental health." The root problem it identified was that "people with mental health problems in Ireland are subject to significant stigma and lack appropriate, accessible and effective services and supports." Some barriers to change were easy to identify. There was a poorly organised mental health lobby with limited effective campaigning history. Significant social stigma was attached to mental health. These factors contributed to a perceived lack of political will to designate State resources to address reform. Within the State's vast public health system, mental health was relatively neglected, and mental health services perceived as beholden to special interests with large political capital (e.g. drug and insurance companies). With an agreed reform policy, One Foundation decided to support organisations working to ensure implementation and resourcing of AVFC.

Given this analysis, the strategy for change identified in 2005 (during OF's work with McKinsey) required three levers, working together: one to address the campaign, lobbying and evidence deficit; a second to "support an innovative project in a selected region to help it become a centre of excellence;" and a third was to "support mental health NGOs, service users and their families to become public advocates."

The assumption was that all three levers working in synergy would build political will on mental health and thereby change statutory provision to a community-based recovery model, and ultimately ensure a statutory right, enshrined in legislation, to timely and effective mental health supports. Therefore, to achieve its advocacy goal, OF "sought to increase political will on mental health" (as measured by the frequency and content of Oireachtas debates, and via political polling), and crucially, "realise the adoption of a proven solution" as a national programme (funded by the state). The evaluation uses these indicators in its discussion of performance and impact.

Investments

Strategic investments were made in three organisations, each representing one of the three levers to effect change: Amnesty International Ireland (Amnesty, from 2006), Mental Health Reform (formerly the Irish Mental Health Coalition, from 2006), and Headstrong (the foundation established Headstrong in 2006 and

supported development of its Jigsaw model). Other investments were made in national youth organisations to build youth resilience (for example, BeLonGTo, an LGBT youth support organisation), but these were not direct mental health advocacy investments. In broad terms, the strategy translated into investments in:

Amnesty, based on its advocacy/campaign/lobbying experience and its capacity to build alliances around shared campaigns;

Mental Health Reform (formerly the Irish Mental Health Coalition) in order to build collective capacity in the sector and form a common platform, and finally,

Headstrong (to demonstrate an effective community-based mental health solution, i.e. Jigsaw).

OF invested almost €5 million to achieve its advocacy goal, "to build political will on mental health," as illustrated below.

Table 3. The One Foundation Investments – Mental Health Advocacy Goal

	2004-2008 €	**2009-2013 €**
Amnesty International Ireland	**590,600**	**2,301,190**
Irish Mental Health Coalition/ Mental Health Reform	**211,288**	**800,000**
Headstrong		953,910*
	801,888	4,055,100
OVERALL TOTAL	**4,856,988**	

Note: * This amount represents 12% of a total investment of €8 million in Headstrong for the period 2009 - 13. An investment of €2.25 million in Headstrong, 2004-2008, was not advocacy related.

Amnesty was to catalyse the issue in the Irish context through its lobbying and campaign work while supporting the building of alliances in a sector considered fragmented. Once the sectoral alliance was in place and its advocacy capacity strengthened, Amnesty would revert to its role as human rights watchdog, monitoring and safeguarding rights. Meanwhile, Headstrong's Jigsaw model (of co-ordinated, community-based mental health supports for young people) would be developed with OF early investments, and eventually funded by government.

An outline description of each grantee organisation follows with a brief summary of the outcomes and impact of activities conducted in pursuit of this advocacy goal

Amnesty International Ireland (www.amnesty.ie)

Amnesty International Ireland (Amnesty) has a long track record of success in advocating for reform.[9] OF began supporting Amnesty in 2006 (with a grant of €85,000 and a further €50,000 a year later) to build on the success of its 2003 campaign, and to "raise mental health to the level of a priority campaign" with a general election approaching. Amnesty's next proposal (2008-2011) was granted (€.5 million) to: get into the game quickly with a well-proven campaigning organisation and catalyse the area of mental health (EI/1). Of the total investment of €5 million in mental health advocacy, OF invested €3.2 million in Amnesty making it the main driving force working to achieve OF's mental health goal.

Amnesty's dedicated mental health advocacy unit spearheaded a campaign based on three objectives, two of which related to legislation, one to systems change:

i) the Department of Health and Children (DoHC) review the 2001 Mental Health Act against international human rights standards, regarding the Convention on the Rights of Persons with Disabilities (CRPD);
ii) DoHC publish legislation for appropriate community-based services, and
iii) improve inter-departmental practices on mental health. *We had never had such resources for one campaign area before. It was exciting* (EI:19).

Within the advocacy unit, designated posts (four, later five) were tailored to ensuring a strong knowledge base to inform advocacy activities to achieve these objectives: Campaign Coordinator (experienced in campaign strategy development), Legal Officer (national and international law), Policy Officer (mental health service provision), Advocacy Officer (experienced in training groups and individuals in advocacy skills), and Communications Officer (experienced in media and social marketing/public awareness campaigns). An "Experts by Experience Advisory Group" (EEAG) was constituted to inform the rights-based approach of the work and advocacy activities. Where gaps existed, outside specialists were contracted to contribute to the effort. For example, Amnesty commissioned an economics consultancy, Indecon (2010) to research the affordability of reform (i.e. move from institutional to community-based care) including developing a performance assessment framework.[10]

Alongside data-generating activities, Amnesty conducted an anti-discrimination social marketing campaign aimed at the public, and worked to ensure there was a media focus on mental health issues. It was active in building a sectoral alliance

9 Disclosure – the Evaluator has been a lifelong member of Amnesty International.
10 Indecon Report, 2010. Accountability in the Delivery of A Vison for Change: A Peformance Assessment Framework for Mental Health Services. www.amnesty.ie/reports

via its work in co-founding and facilitating the Irish Mental Health Coalition (the precursor of Mental Health Reform) and the Children's Mental Health Coalition. Amnesty's lobbying concentrated in two complementary directions - on training NGOs and individuals to build advocacy capacity, and direct and indirect lobbying of politicians and state agencies. The unit's work largely continued in this direction until 2011, when a policy officer transferred from Amnesty to Mental Health Reform to contribute to its enhanced lobbying and campaign capacity. In 2011, a Policy Officer was recruited specifically on children's mental health, as this was a core focus of Amnesty's work in 2011-2013.

Irish Mental Health Coalition/Mental Health Reform (www.mentalhealthreform.ie)

OF's investment in the Irish Mental Health Coalition (IMHC) was to strengthen coalition-building within the sector and build an advocacy platform. Founded in 2006, IMHC was re-constituted in 2011 as Mental Health Reform (MHR). Members include NGO's in the mental health and allied fields, service user groups, social workers, clinical psychologists and families of people with mental health issues. OF invested €0.3 million in IMHC in 2010 to develop the mental health sectoral alliance over three years – founding members were: Amnesty, Bodywhys (eating disorders), Grow (depression), Irish Advocacy Network and Schizophrenia Ireland. This grant increased to €0.5 million in 2010 to support the newly constituted Mental Health Reform over three years to 2013. In total, the amount invested in MHR was in the region of €1 million.

In addition to building a sectoral alliance, IMHC/MHR's activities were focused on advocating for reform of the mental health system and the right to mental health services. It published and circulated twin documents "Guiding a Vision for Change - Manifesto" in 2011, which set out MHR's position on how to achieve full implementation of AVFC and the "Agenda for Action," which set out 18 "asks" under three key components:
1) Promotion of the Recovery Ethos,
2) Modernisation of the Mental Health Services, and
3) Increased Accountability, Transparency and Governance.

In its re-constituted form as MHR, a "Defend the Spend" campaign in 2011 and a "Don't Drop the Ball on Mental Health" campaign in 2012 both sought to protect the mental health budget from being cut in the recession. MHR engaged in public information campaigns in traditional and social media, and in public protests, most notably, outside Dáil Éireann in June 2012. These activities complemented MHR's lobbying and were conducted in tandem with involvement in an Oireachtas cross-party group on mental health and in the Children's Mental Health Coalition.

Headstrong (www.headstrong.ie)

Headstrong, the National Centre for Youth Mental Health was founded in 2009 by psychologist Tony Bates (with OF support) in response to a number of youth mental health issues: suicide was the leading cause of death, one in four were "going through difficult times and felt there was no one to talk to," a lack of support for families; access to appropriate services. In addition, there was a stigma associated with youth mental health, compounded by myths and misunderstandings. Headstrong aimed to: "give every young person in Ireland

somewhere to turn to and someone to talk to." The organisation has worked with communities and statutory services to empower young people to develop skills and resilience to cope with mental health challenges, and with government, media and communities to change the way Ireland thinks about youth mental health.

With OF's investments, Headstrong developed three strands of work: service development (via Jigsaw, to streamline a range of services and supports); advocacy (with government, media, families and schools in addition to supporting young people to advocate for themselves), and research (e.g. the first national study of youth mental health, "My World Survey," to inform programmes and Jigsaw projects). Therefore, in addition to developing the Jigsaw model of community-based supports for young people, the organisation has lobbied government, commissioned research and hosted conferences on youth mental health.

Based on OF's strategy, the Jigsaw model was to demonstrate a solution to community-based mental health supports in order to advance OF's advocacy goal – to build political will on mental health. In practice, the Jigsaw model joins together the pieces of an existing mental health puzzle to provide a community-based solution. Jigsaw sites are designated, youth-friendly spaces, located in the centre of a town or city. A critical factor in Jigsaw's development has been Headstrong's work with communities to build agreement and secure the cooperation of a wide range of mental health providers, youth and community workers. By 2013, Jigsaw sites had been established in seven counties, four initially (Galway, Kerry, Meath and Roscommon) with additional sites in other places almost established or at an advanced stage of development (Donegal, Offaly, Dublin 15, Tallaght and Clondalkin, Limerick and North Fingal). These sites will enable a coordinated response locally to young people's mental health needs, funded by government.

Key Achievements - Portfolio

There was substantial evidence of success in relation to the two main indicators of success for the advocacy goal:

a) an increase in political will on mental health (as measured by the number and content of Oireachtas debates and political polling data), and

b) adoption of a proven soluion as a national programme (funded by the state).

The following achievements resulted from the combined activities of grantees and demonstrate a number of incremental wins towards achievement of the advocacy goal: Increase in Oireachtas (parliamentary) questions and debates (from 10 in 2009 for Feb./April, to 117 written answers and 3 Dáil debates in 2011), and evidence of a positive shift in political commitment. Establishment in 2009 and operation of a cross-party Oireachtas group,[11] dedicated to Mental Health (20+ members of the Dáil and Seanad). This was the first cross-party group of its nature formed in the Oireachtas. Increase in number of Jigsaw projects supported by government. By 2013, Jigsaw sites in seven counties. Increase in the number of political 'champions' (and inclusion of mental health in general election and Presidential election manifestos in 2011) with acceptance of the benefits of closing institutions in favour of community-based services. Public declaration of personal struggles with mental health by politicians – former Prime Minister of Norway, Kjell Magne Bondevick's Dublin declaration prompted Minister John Moloney to

11 The cross-party Oireachtas group on mental health was established in 2009 during the 30th Dáil as a forum for discussion and to increase political focus on the issue.

acknowledge his own struggles with mental health, a major step for a serving minister in Irish politics. Growing awareness and political interest in mental health. Poll data (MBL) shows changes in politicians' attitudes: by 2012, three quarters of TDs reported the issue had increased in importance, and the budget needed to be increased. Discussion of poll findings hosted at cross-party Oireachtas group.[12] Three of Amnesty's four objectives for mental health were included in the Programme for Government, 2011-2016. Increase in media coverage of mental health (tracked by grantees). Work by AI and MHR has had an impact on public perception of the issue and shifted debate away from mental illness to mental health. Minister of State portfolio includes mental health and Office for Disability and Mental Health established within the Department of Health and Children to support cross-department policy development and implementation on mental health. New Directorate of Mental Health services established in 2013.

12 Millward Brown Landsdowne (MBL) political opinion poll was commissioned by the foundation in 2009, 2011 and 2012 . See www.onefoundation.ie

Mental Health Advocacy – Activities, Milestones and Impact 2006-2013

2003 – Amnesty's Mental Health campaign;
2006 – A Vision for Change published, IMHC founded
– Headstrong established
– Amnesty and IMHC funded;
2008 – Amnesty's Advocacy Unit,
2009 – All party Oireacthas Group on mental health
– Amnesty spearheads public campaign; 2010: MHR established, Indecon report;
2011 – Closure of institutions; Programme for Government commitments;
Presidential election priority.
2013 – investment of €70 million and appointment of 383 staff, HSE MH Directorate formed.

Foundation Inputs/Supports	Advocacy Activities X Target	Law: Referendum Passes
€€€ & Supports e.g. Business Plans **A Amnesty:** **B IMHC/MHR** **C Headstrong/Jigsaw**	**A Amnesty:** 'Drive' lobby and campaign in MH; build sectoral coalition; push rights-based case; include Services users' advocates; data and research; facilitate Oireachtas group; drill down on law; public anti-discrimination campaign. **B IMHC/MHR** MWs issues (CMS data, Case Work, DIC, Action Groups, Research) & interpretation (Policy G & Board) **C Headstrong/Jigsaw** Provide 'workable'model that is a solution to community-based supports.	**Raised political and public awareness;** **Impact** **Structural and Systems change.**

Blended Case Study in Advocacy Effectiveness

The following discussion provides a brief analysis of the advocacy performance and impact of the work conducted by the three organisations in OF's mental health portfolio. While investments were staggered from 2006 onwards, only Amnesty had prior experience of mental health advocacy. In addition, the OF advocacy goal was only named in 2008 when mental health advocacy was at an early stage of development.

A Strong high capacity coalitions – "A challenging birth"

When OF became involved in mental health advocacy there was no unified national mental health network, although there was a service-users' group and several national organisations represented people with particular mental health issues. Not only were there multiple players, each with their own issues, most were more

concerned with services than advocacy. Therefore, the challenge was to bring unity to a fragmented sector by developing collective capacity to ensure a strong sectoral voice common issues, a coalition-building process that proved to be: *a challenging birth. We almost lost the baby on several occasions* (EI:3).

Amnesty was a founder member and coordinator of the Irish Mental Health Coalition (IMHC), established in 2006. While some NGOs may have resented a human rights organisation facilitating the development of this coalition, the impact of Amnesty's campaign and lobbying (since 2003) could not be denied: it was widely recognised that Amnesty had put mental health issues into the public domain and onto the political agenda. *Mental health was entirely operated by the State. People didn't agitate. Invisibility was a factor in the past. There was social stigma. Their success [Amnesty] has been the disappearance of all that* (EI:18).

Over time, the original five member organisations in the IMHC became more engaged. Building a strong coalition was a developmental process because some organisations didn't get the policy work [or] were naive, resistant and defensive, even fearful about taking on government (EI/19), with others unconvinced of the need to put time and energy into advocacy. They see *government as a source of their ongoing services budge*t (EI:17). In 2010/2011, IMHC *was essentially disbanded and renamed as part of the board and organisational development process* (EI:16) that included recruitment of a new Director and strategic planning. OF's grant of almost €1 million enabled transformation of IMHC into an organisation whose very name communicated its mission: Mental Health Reform (MHR).

> **Mental health was entirely operated by the State. People didn't agitate. Invisibility was a factor in the past. There was social stigma. Their success [Amnesty] has been the disappearance of all that.**

Increased collaboration between Amnesty and Mental Health Reform ensured best *possible outcomes, under the circumstances* (EI:19), and did result in building the capacity of the mental health coalition. By 2012, MHR was comprised of 35 member organisations (up from 5 under IMHC). Its reach had extended to organisations working with homeless people, immigrant groups etc. MHR had also become an active member of a new alliance, the Children's Mental Health Coalition (developed by Amnesty with funding from OF). Government invited MHR to participate on several policy committees such as the National Disability Strategy Monitoring Group and the National Housing Standards Monitoring Group. By 2012, MHR was active in campaigns (e.g. MHR's 'Defend the Spend'), its Director was engaging in media work and the organisation had an increased media presence to promote its reform message.

Therefore, the sectoral mental health coalition not only had a difficult birth, it took time and support to develop, and was really only gathering steam in 2012,

a year before the funding commitment ended. Also, MHR's fundraising has been challenging, due in part to the direct advocacy nature of its work, though it has secured funding commitments that should see it through to 2016. Some commentators blamed the confusion caused by the emergence of the Children's Mental Health Coalition (led by Amnesty, with funding from OF), and questioned if it was a duplication of effort.[13] However, the main advocacy lesson emerging is that facilitation by an outside player (Amnesty), skilled in lobbying and campaign work, can aid the development of sectoral capacity and coalitions, because its focus is on advocacy and it is not a competitor for resources within a given sector. However, there is a point when the coalition's strength must ensure its own sustainability.

B Strong national grassroots coordination.

The government's mental health policy document "A Vision for Change" (2006) called for a shift to community-based mental health services and supports. Grantees involved in advocacy required information to stimulate local action and reaction, i.e. action on what was happening in communities and reaction to emerging policy. This two-way link was considered necessary to address gaps in data and to stimulate mobilisation. National-local links also provided information on political risks in advocating for change and allowed advocates to apply pressure on public representatives via local constituency offices. The sweeping reforms in AVFC would have a major impact on local areas. One policy-maker explained: *You have to understand …mental health is an industry in remote places. It contributes to the local economy and provides jobs. A hospital needs beef and a local butcher gets the business. Several people from the same family might be employed in one hospital. People have to have a credible alternative [employment] and communities need to be involved [in reforms]*(EI: 18).

Amnesty and Mental Health Reform took different approaches to establishing and maintaining national grassroots links. Amnesty's nationwide social marketing anti-discrimination campaign was valuable because it took its message to communities. Also, its "Experts by Experience Advisory Group" met on a regular basis in Dublin and provided valuable information on local processes and developments. For example, research documented the reported experiences of unfair treatment by people experiencing mental health problems and this data formed the backbone of the anti-discrimination campaign.

MHR focused on developing a national network through consultation, linking with member organisations, professionals and the general public. MHR has facilitated four public consultations a year in different parts of Ireland; meet with local groups and engage lead mental health professionals at an area level etc. These links have been maintained and sustained by a strong social media presence. Therefore, MHR has created its own nation-wide connections, and has sought to "capture a different constituency" using an education and awareness raising approach with a focus on the link between professionals, service users/family members and service providers.

While Dublin was the main site of Amnesty's lobbying and campaign work, and the location of national parliament, members and supporters throughout Ireland (from college campuses to local groups) were given online support to mobilse locally

13 The Children's Mental Health Coalition established by Amnesty and the Children's Rights Alliance in Dec. 2009, with 38 NGOs, including Headstrong. See www.childrensmentalhealth.ie

(Lobbying Network, Monthly Action, Tools, Tips etc.). From 2011, Mental Health Reform built on this work through widespread consultative activity holding eighteen public meetings 2011-2013, engaging with the mental health community across the country from service users and their families to Executive Clinical Directors of Mental Health Services. *The [MHR] CEO understands the system and has the contacts* (EI:11).

Unlike Amnesty and MHR, where work to maintain and sustain national grassroots links was only one aspect of advocacy, it was at the core of Headstrong's Jigsaw approach. Each local Jigsaw project involved the development, coordination and support of local providers from Headstrong's national base. *Headstrong is a very valuable tool. Jigsaw demonstrates success and therefore people are convinced. They want it in their towns. They [Headstrong] can't keep up with demand* (EI:18). However, Jigsaw was not a one-size-fits-all project model. It was negotiated and tailored to suit local needs and available supports. In that sense, it demonstrated the value of a commitment to facilitating and coordinating local community-based solutions. By 2013, there were nine Jigsaw hubs providing synergy between mental health providers and youth supports, funded by the State, and used by young people in at seven counties with further hubs in development.

C Disciplined and focused messages with effective communications

Amnesty's anti-discrimination social marketing campaign (2010-2011 repeated in 2012-2013) was an excellent example of effective communications that contributed to advocacy effectiveness. Research conducted by Dublin City University into the experiences of unfair treatment reported by over 300 people with experience of mental health problems[14] informed the focus of Amnesty's anti-discrimination social marketing campaign.

> **I can't get a job. I've tried and tried. They'll say well where have you been? And I'll say I was in a psychiatric hospital and you can see it's all downhill afterward and you never hear from them again.**
>
> **(Amnesty, "Hear my Voice")**

Amnesty demonstrated its campaign experience by using the words of mental health service users to highlight issues and multiple media sources to ensure

14 Published in a 2010 report entitled 'Hear my Voice' http://www.amnesty.ie/theresearch.

maximum message penetration via billboards, bus shelters, newspaper and radio advertisements. It brought into the open an issue previously hidden and raised awareness of prejudice. Advice from a PR company informed the strategies used. In addition, the social marketing campaign empowered people with mental health problems who witnessed their words displayed in places of prominence. Amnesty focused on mental health service users' experiences to inform the messaging activities. It also engaged with media, activists, and other organisations to create public demand for change. The campaign created an environment where prejudices among the public were challenged and people were made aware of the need for reform.

Therefore, the anti-discrimination social marketing campaign resulted in a communications' hit. In the initial burst 2010-2011, posters were carried on roadside billboards (50), at bus shelters (140), in print media sources (12). Campaign advertisements (354) were carried on national and local radio stations. The impact was estimated by external consultants as follows: up to 2.4 million people had seen the print advertisements, over 600,000 people saw the billboards, and approximately 410,000 adults heard the radio advertisement.[15]

According to several interviewees, the campaign had a major positive impact because it put mental health into the public domain. It stimulated debate in public and political circles, framed the discussion around discrimination and rights and prioritised the experiences of users as an evidence base to show inadequacies in the system. It had massive coverage nationally. *It widened the views on mental health, even if it had edginess.* (EI:18). Once the campaign established advocacy traction, politicians were lobbied, inputs made to the Oireachtas Group on Mental Health, and polling data used to demonstrate support for reform.

While Amnesty excelled in bringing the anti-discrimination message to the public, it was Mental Health Reform (MHR) that leveraged the public's political capital. The "Defend the Spend" campaign in 2011 gathered 6,000 signatures. This was followed by a "Don't Drop the Ball on Mental Health" campaign in 2012 that gathered over 10,000 signatories (4,000 online), with canvassing in over 30 locations. In addition, MHR's vox pop "Because it's time" (with the voices of service users, and family members from the Grassroots Forum, Gateway Project and Basin Club) was widely aired on local and national radio. As a result of these activities, MHR was invited to present a Pre-Budget Submission to the Oireachtas Health Committee and to the Oireachtas Finance Committee.

Headstrong, OF's third grantee in the portfolio, also contributed to the communications effort. Through his column in The Irish Times, radio and TV inputs, Tony Bates, the CEO, was a highly regarded commentator advocating reform. While his message was often focused on youth mental health, he also supported reforms common to all portfolio organisations. *He [Tony Bates] has been very convincing. I notice that he is a regularly cited by ministers and is viewed very favourably in the political world and among the general public.* (EI:18)

However, a senior government official found Amnesty's use of rights-based language offensive. *They were preaching human rights at us. It was extremely irritating and a bit precious* (EI:11). Therefore, not all advocacy targets responded positively to the human rights message. The lesson suggests that advocates need

15 These data are drawn from Amnesty's records and an assessment by Wilson Hartnell PR (Ogilvy), 2011. Wilson Hartnell worked with Amnesty on a number of advocacy-related reviews and consultations.

to be flexible enough to re-frame the message in language that suits the audience. It also illustrates the value of multiple approaches towards achievement of the advocacy goal, in particular, Mental Health Reform's strategy of consultation, education and awareness-raising to build public and political support for reform. Media coverage was a priority for all three organisations (tracked across all media) to keep alive the message of reform and to communicate evidence of public and political commitment to reform (emerging from polls), and workable solutions for locally based supports (as demonstrated by Jigsaw).

> **The lesson suggests that advocates need to be flexible enough to re-frame the message in language that suits the audience.**

D Solid research and knowledge base

As a result of work conducted by grantees, there has been some improvement in research and knowledge in mental health, which has supported reform and contributed to building political will. Prior to OF engagement in the area, data were limited and received minimal media coverage. One interviewee explained: *The Commissioner's Report was the government's main data source on mental health. It informed decisions about services. Even though it was published annually, there wasn't much fanfare in the media* (EI:3). Data were required to substantiate claims for change, while providing evidence of workable solutions. *The HSE is seen as failing and it is failing. We all needed to admit to that and to see some green shoots.* (EI:18)

Two grantees (Amnesty and Headstrong) addressed the research and knowledge gaps by commissioning research or by gathering data. For example, in a creative move in an economic recession, Amnesty commissioned an independent economics consultancy, Indecon (2010), to conduct a cost-benefit analysis of the shift from the institutional model of mental health care to a community-based approach. The findings provided evidence of significant cost savings in the longer term and were widely reported as such. However, the approach did not find favour with certain quarters in government because Amnesty did not involve the department in the research process. *That really got up the nose of the department* (EI:19). While Amnesty had submitted an advance copy of the final draft to the department for comment, it was clear that relevant officials were displeased at not being included earlier in the research design and drafting. This lack of government involvement in the research process had the unintended effect of alienating certain civil servants. Therefore, the data did not have the traction anticipated.

The experience offered an advocacy lesson: key stakeholders need to be consulted and if at all possible, included in research processes, to maximise the likelihood of findings being translated into advocacy wins. There will be times when involvement is not appropriate, because of a need to highlight poor practice. However, if the research is conducted to advance claims for change, the relevant departments should not only be given the opportunity to view findings prior to a public launch but where possible/appropriate to be involved at an earlier stage.

Indecon's research provided several nuggets that informed the advocacy strategy, including, for example, *that top heavy reliance on psychiatric nurses in mental health institutions sapped a good proportion of the mental health budget* (EI:19). Closure of the mental health institutions would have a major impact on jobs and a negative impact on the economic life of the towns and communities where they were located. Therefore, reform posed a major political risk to politicians in whose constituencies these were located.

Headstrong's "My World" (2012) survey is another example of commissioned research that addressed a data and knowledge gap. It was one of a number of data gathering activities to inform best practice and quality standards in mental health delivery via Jigsaw sites. The survey, conducted by the UCD School of Psychology, captured the views of 14,500 young people and provided one of the largest national data sets on youth mental health in the world. The main finding was that the most important factor in supporting and promoting positive mental health outcomes for young people was the consistent presence of one adult in their lives, "someone who knows and understands them." This was a finding the Irish public could actually embrace with some degree of hope in the face of mounting levels of despair about youth suicide and increased mental health pressures. "My World" survey findings have already translated into government policy.[16] These examples demonstrate the contribution research and knowledge made to advocacy for mental health reform.

E Timely, opportunistic lobbying and engagement

Mental health "Champions" across various governments were vital targets in the lobbying strategy, none more so than Fianna Fáil's John Moloney, TD, Minister for State (2008-2011), a politician, publican and undertaker, who witnessed first hand the rise in suicides in his constituency. His role as Minister for State and his relationship with the then Taoiseach (his constituency colleague, Brian Cowen) coincided with grantee lobbying and offered a direct line to Cabinet.

Perhaps the greatest indicator of successful political engagement on the issue was the establishment and operation of a cross-party, Oireachtas Group on Mental Health, a first in terms of Irish parliamentary processes. The group was facilitated by Amnesty initially, then jointly with MHR from 2011 until 2013, when MHR assumed responsibility. The Group's purpose is to facilitate debate at regular intervals on structural (institutional to community-based supports) and legislative reform (revised Mental Health Act 2001). Senior civil servants were among those called to present, to inform the debate. Members were given regular updates that enhanced the quality of the debate and external speakers were invited to address the group (e.g. Assistant Director of Mental Health, HSE, Martin Rogan, and former Prime Minister of Norway, Bondevik).

Lobbying impact was also evident in growing support for reform: the issue was raised in parliamentary questions (PQs), Dáil debates (up from 10 in 2009 to 117 written answer and 3 debates in 2011), and in political party policy documents. *The PQs have increased from one year to the next, but there's a saturation point. We've probably reached it [2012]* (EI:27).

16 Minister for Education, R. Quinn, TD cited its influence on new school guidelines - Wellbeing in post-primary schools: Guidelines for mental health promotion and suicide prevention. According to Susan Kenny (NOSP), the research was 'part of the rationale of working on the guidelines for schools.' Irish Times, 31 January 2013.

A lesson learned was the value of a cross-party approach to widen the political base of support for reform beyond individual political champions to all parties. It resulted in the inclusion of mental health as an issue in the 2011 General and Presidential election manifestos and embedded a commitment to reform in the 2011 "Programme for Government" (three of Amnesty's four objectives were included).

F Collaborating funders engaged in strategic funding

The OF strategy was to invest in three organisations, each contributing in its own way to achievement of the desired advocacy goal. However, OF's involvement was more than financial grants to support advocacy work. Grantees reported additional benefits from collaboration including improvements to management and governance, performance monitoring systems, links to wider networks of support, etc.

The most important impact of OF engagement with mental health was to stimulate wider interest and engagement with the idea of mental health reform: *[It] acted as a catalyst to bring serious attention to mental health and push for implementation of the government's stated policy – A Vision for Change* (EI:22). OF established Headstrong (with Tony Bates), elevated mental health to priority status within Amnesty, and helped the Irish Mental Health Coalition transform to Mental Health Reform (a sectoral network). It piloted a strategic advocacy effort by stimulating sectoral development and provided a solution, a project focused on community-based supports. Following regular reviews, the strategy changed, in particular when it became clear that building sectoral capacity took more time than anticipated. *Mental Health Reform were making slow and steady progress by 2011, but we were worried and decided to continue to invest in Amnesty, beyond our original timeframe of investment. That was a really good idea.* (EI:3)

OF collaborated with each of its grantees in the portfolio in different ways. It trusted Amnesty's campaign/lobbying experience to be the public face of this drive to catalyse mental health advocacy. Amnesty knew how to keep the issue alive via campaigns on gaps in provision and the discrimination experienced by people with mental health issues. We had regular reviews and worked with them [foundation team] through several versions of our proposals, to tone down expectations. *They managed the relationship very well from a distance. They had a lot of trust in us. We delivered and were accountable. It was very important to have this interest and to have a dedicated advocacy unit* (EI:19). OF worked closely with MHR until it was on a firm footing in terms of management and governance. *They helped to broker the relationship between Amnesty and Mental Health Reform so that Amnesty was gradually exiting and (MHR) was picking up the advocacy work* (EI:16).

Collaboration with grantees was not always successful. On-going monitoring and performance management resulted in some grantees feeling that the pressure to produce results was relentless. The concept of a limited life foundation brings a heightened urgency to get results, in this case, in less than a decade. Process issues – the time and attention required to build relationships of trust – are central to collaboration. Some grantees were of the view that OF did not sufficiently value process work: *It was all about numbers. How many have you got?* (EI:15). The experience points to a possible pitfall of a push for advocacy impact in a short period. *The pressure was never ending. We were all working flat out. It was never enough.* (EI:15). From this grantee's perspective, OF did not appreciate the time

required to develop working relationships to mainstream innovative programmes. This points to the danger of trying to push projects to scale up (multiply in number), an indicator of success that does not easily translate to performance measurement of outcomes that are highly dependent on social processes. *The pressure was to deliver more … rather than appreciating the quality of what we were doing. That was deeply disappointing* (EI:15).

Conclusion

From 2006 to 2013, OF catalysed and supported advocacy capacity in the area of mental health in Ireland, an area neglected in terms of social policy, where there was previously little political will to champion change, a situation hampered by public stigma. The primary indicator of successful achievement – to build political will on mental health – was the government's support for and resourcing of the Jigsaw model. While there is still a major gap in translating political will into a designated mental health budget, the structural change outlined in the government's policy document has begun: *There's no going back. Like Cortez, we've burnt the ships and must now exist without them (the institutions)* (EI:18).

In December 2012, politicians and the general public were shocked by the tragic death by suicide of the Taoiseach's close political ally, Minister for State, Shane McEntee, TD, that not only brought renewed focus on mental health as an issue, but also highlighted the major stress faced by politicians in key policy-making positions, especially in an economic recession.

The impact of advocacy work conducted by OF grantees was evidenced by the extent of political engagement, with a documented increase in the number of Oireachtas Q&As, the establishment and operation of the cross-party Oireachtas Group on Mental Health (ensuring sustainability of the issue in parliamentary processes), in politicians' increased participation in opinion polls and sessions to debate the research findings.

The Fine Gael/Labour government, 2011, included three of Amnesty's four stated objectives in its Programme for Government. It has committed to:

a) establishing a cross-departmental group on mental health (education, housing, employment);

b) a "full and comprehensive review of The Mental Health Act, 2001" (in progress a the time of writing) and

c) introducing a "Mental Health Capacity Bill" in line with the Convention on the Rights of People with Disabilities. This win demonstrates political support in principle for reform and rights-based arguments.

The cumulative effect of grantees' lobbying and campaign activities had been to build public interest and encourage political processes to engage with the project of mental health reform. While there are ongoing issues regarding government resources, the reform argument has largely been won. MHR has received a funding commitment to 2016, in recognition of its success in establishing a unified sectoral voice for reform. However, the sustainability of mental health advocacy beyond 2016 is unclear. Amnesty has now scaled back its mental health focus to a monitoring brief and some low level lobbying on the Mental Health Act review. Ultimately ensuring mental health rights is a long-term project that will require continued advocacy.


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Bibliography

Note: Foundation documents consulted during the evaluation are either available via the website, www.onefoundation.ie, or are not for public view. Records held by OF relating to grantees' plans and progress were also consulted but were, in the main, internal documents, unless otherwise specified in the text. Other reports commissioned by grantees or completed by grantees, are available via the foundation's website list of organisations supported.

CSO (2004-2013)
Reports sourced online *www.cso.ie.*
Central Statistics Office, Ireland.

Combat Poverty Agency (2005)
Ending Childhood Poverty. CPA.

ESRI (2008-2012).
Reports sourced online *www.ersi.ie.* Including Annual Monitoring Report on Integration (Commissioned by The Integration Centre); Understanding Childhood Deprivation in Ireland (Watson, Maitre and Whelan, 2012).

Ferriter, Diarmuid (2004)
The Transformation of Ireland, 1900-2000.
Profile Books, UK.

Finn, Anthony & Hilary Curley (2007)
Missing: Research into Separated Children Gone Missing from State Care. www.onefoundation.ie

Byrne, Elaine A. (2012)
Political Corruption in Ireland, 1922-2010: A Crooked Harp? Manchester Uni. Press, UK.

Children's Rights Alliance (2006)
From Rhetoric to Rights: Second Shadow Report, UN Committee on the Rights of the Child.

Compass (2011)
Evaluation of the Children's Rights Alliance (internal document).

Crosscare, Doras Luimní, NASC (2012)
Person or Number? Barriers Facing Migrants Accessing Social Protection.
www.nascireland.org

Department of Health & Children (1999)
Children First Guidelines.
www.dohc.ie

Department of Children and Youth Affairs (2012)
Report of the Independent Child Death Review Group.
www.dcya.gov.ie

Department of An Taoiseach (2011)
Towards Recovery: Programme for a National Government, 2011-2016. *www.taoiseach.gov.ie*

Donoghue, Freda (1998)
Defining the Nonprofit Sector – Ireland.
The Johns Hopkins Institute for Policy Studies, USA.

Gilmartin, Mary (2012)
The Changing Landscape of Irish Migration, 2000-2012.
National Institute For Regional and Spatial Analysis, Working Paper Series, No. 69.

Hardiman, Niamh, Ed. (2012)
Irish Governance in Crisis. Manchester Uni. Press, UK.

Harvey, Brian
(1994) Combating Exclusion: Lessons from the Third EU Poverty Programme, Combat Poverty Agency, Dublin.

(1998 & 2008) Working for Change: A Guide to Influencing Policy in Ireland, Combat Poverty Agency, Dublin.
www.cpa.ie/publications

(2003) Report on the Implementation of the Government's White Paper, Supporting Community and Voluntary Activity in Ireland.

(2011) A Way Forward for Delivering Children's Services. Barnardos, Dublin.
www.barnardos.ie

(2012) Downsizing the Community Sector: Changes in Employment and Services in Voluntary & Community Sector in Ireland, 2008-2013. ICTU, Dublin.

Hodgett, Alistair and Aoife Sweeney, Wilson Hartnell PR, Olgivy (2009) Advocacy Gap Analysis.
www.onefoundation.ie

Indecon (2010)
Accountability in the Delivery of A Vision for Change: A Performance Assessment Framework for Mental Health Services. *www.amnesty.ie/reports*

Innovation Network (2007), USA.
www.innonet.org

Irish Refugee Council (2012)
State Sanctioned Child Poverty and Exclusion: The Case of Children in Accommodation for Asylum-Seekers. IRC, Dublin.

Mental Health Commission (2006)
Annual Report. Government publications.

McGuiness, Catherine (1993)
Report of the Kilkenny Incest Investigation. Government Publications, Dublin

Millward Brown Landsdowne (2011 and 2012).
Opinion Polls, including Attitudes Towards Immigration and Immigration Policy Among TDs (commissioned by The Integration Centre) are available on the OF website *www.onefoundation.ie.*

MRCI (2006-2013)
publications are available online via *www.mrci.ie*

Murphy Commission (2009)
Commission of Investigation of Dublin Archdiocese and later, The Catholic Diocese of Cloyne. Accessed online *www.dacoi.ie.*

O'Carroll Associates & Hibernian Consulting (2009-2010). Advocacy Evaluation: The Campaign for Marriage Equality, Ireland. *www.marriagequality.ie*

O'Toole Fintan (2003)
After the Ball. New Island, Dublin.

Perold, Helene (2010)
Media, Public Storytelling and Social Justice. FOMACS Forum on

Migration and Communications.
www.ctmp.ie

Prospectus (2008)
Analysis of The New Communities Sector in Ireland. *www.prospectus.ie* also available on *www.onefoundation.ie*

Quinn-Patton, M.
(2008) Utilization-Focused Evaluation. Sage, USA.

(2008) Evaluating the Complex.
www.aidontheedge.files.wordpress.com

(2008) Advocacy Impact Evaluation, Journal of MultiDisciplinary Evaluation.V.5/N9

(2011) Applying Complexity Concepts to Enhance Innovation & Use.Guildford, NY.

Raftery, M. (2013)
Do They Think We're Eejits? The Irish Times.

"Ryan" Commission (2009)
Commission to Inquire into Child Abuse (CICA). *www.childabusecommission.ie*

Simpacta, UK (2009 & 2012)
The One Foundation Theory of Change.

Weiss, Heather (2007)
Harvard Family Research Program. *www.hfrp.org*

WHO (2008)
Policies and Practices for Mental Health in Europe: Meeting the Challenges. *www.euro.who.int/-data/assets/pdf*