Implementation of *'A Vision for Change'* for Mental Health Services

Report
to Amnesty International Ireland

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Introduction

This independent report, commissioned by Amnesty International Ireland and Mental Health Reform, [1] aims to provide an economic assessment of the progress on *A Vision for Change* (AVFC), which set out a programme of radical reform of the provision of mental health services in Ireland. It also aims to provide information to support further implementation of the reforms. The difficulty in accessing the necessary data on services made this task very difficult. Therefore this report uses what limited data was available to assess mental health service reform.

We are conscious that AVFC envisaged a radical transformation of how mental health services are planned and delivered. It set out the importance of empowerment, advocacy, peer support, offering a range of therapies, supporting carers and having an outcomes focus centred on recovery. It proposed improved mental health promotion and prevention. This report is focussed on the degree to which the recommended transition from hospital-centred to primarily community-based services has progressed in terms of resource allocation.

The report also provides a distillation of the main World Health Organisation and other international guidance for how services should be delivered and financed.

Following international best practice in terms of shifting most services from institutional to community-based provision and recognising the community as a valuable resource in dealing with mental health problems, AVFC aims to build a comprehensive mental health system. Within this system, all mental health activities – from community support groups, to voluntary groups, to primary care, to specialist mental health services – are expected, to work in an integrated and coordinated way for the benefit of all people with mental health difficulties.

The starting point in the study was to draw on all the available secondary data on mental health service provision from a range of bodies in Ireland, including the Health Research Board (HRB), the Mental Health Commission (MHC), Health Service Executive (HSE) and data collected for the Independent Monitoring Group (IMG).

Data from these sources were used to review the extent to which progress has been made on implementing the reforms in AVFC. The review focused on the overall levels of funding, the investment in new facilities, human resources and services, and on the implementation of the shift from hospital and residential care towards community based services.

To supplement the secondary sources attempts were made to access primary data on levels of activities and costs from a range of local service providers. Despite support from the HSE the process was largely unsuccessful. Nevertheless lessons were learnt

[1] As an independent report, it does not represent the views of either organisation.

about the limited data available for service planning and delivery, and the urgent needs to improve the available data.

The report draws attention to where data limitations hinder reviews such as this one and identifies areas where improvements in data will make future monitoring of progress more feasible. Input from relevant sources was received throughout the preparation of this report, including Mental Health Reform and the Assistant National Director for Mental Health at the HSE.

Prior to a review of mental health in Ireland a brief summary of mental health services internationally provides a context, with a particular focus on Europe. This broader perspective highlighted common problems across all EU countries, in particular the challenges of the availability and reliability of data. While all European countries systematically collect hospital information data, data on community mental health services are less comprehensively collected. European countries also struggled to demonstrate how the mental health budget is distributed across mental health services, mental health promotion, mental disorder prevention or other areas.

This lack of data seems to be a common and major obstacle, yet the governance of health systems relies on a valid data set to monitor trends, especially during reform implementation when input, process, output and outcome measures shows the successes or failures and a need for intervention at the policy level[2].

Mental health: general review

Mental health falls under the scope of the World Health Organisation (WHO)'s definition of health as *"a state of complete physical, mental and social well-being, and not merely the absence of disease"*. Therefore mental health is not just the absence of mental disorder, but it is a state of health in which an individual is able to realise his or her potential, to cope with the normal life stressors, to work productively and fruitfully, and to make a contribution to his or her community.

Like in many other scientific fields, mental health poses a terminology issue. In the literature relating to mental health, it is common to find a wide variety of terms and definitions and there is no international consistency in the use of those terms. Moreover, the use of the terminology is constantly evolving. Terms like "mental health", "mental disorder" and "psychiatric disorder" are often used interchangeably, even though it is recognised that mental health needs do not equate to psychiatric needs. On the other hand, there is no standard by which to measure, diagnose and study the presence of mental health: science portrays mental health by default as the absence of psychopathology.

[2]Health statistics.Key data on health 2002.Luxembourg, Office for Official Publications of the European Communities, 2002.

Some of the issues in defining and measuring mental health are discussed in a recent article in *The Guardian.*[3] It reported that the approach to mental health presented in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association is flawed and encourages a rigid, normative vision of human behaviour. According to the article, the threshold of what is deemed a disorder is lowered with each successive edition of the manual, with nearly all forms of human behaviour now becoming pathologised. Of the approximately 180 disorders one person could have suffered from in the mid 1980s, there are now approaching 400. This following report will not enter the terminology debate. Data will clearly specify what they include and what they do not.

In recent years, mental health has featured increasingly highly on the global and European health policy agendas. For example, the World Health report 2001[4] was entirely devoted to mental health and the World Bank emphasised mental health as an important component of its strategy to improve disadvantaged economies[5]. The WHO proposition that there can be "no health without mental health"[6] has been endorsed by the Pan American Health Organisation, the EU Council of Ministers, the World Federation of Mental Health, Mental Health Europe NGO and the UK Royal College of Psychiatrists[7]. "No health without mental health" has also been adopted by the Irish organisation Mental Health Ireland, Supporting Positive Mental Health.

Burden of Mental Disorders

Mental disorders have been found to be common, with over a third of people worldwide reporting sufficient criteria to be diagnosed at some point in their life. The World Health Organisation (WHO) reported in 2001 that approximately 450 million people worldwide suffer from some form of mental disorder or brain condition. This section discusses the impact of mental health on society in terms of what is called 'burden of disease'. The terminology used is drawn from the World Health Organisation's reports on 'burden of disease'.

According to the World Health Report 2004 (WHO), neuropsychiatric disorders in 2002 accounted for 13% of the global burden of disease, and this figure remained unchanged in 2004 (WHO, Global Health Observatory). The Disability-Adjusted Life Year (DALY) estimates for the WHO Member States, related to the neuropsychiatric disorders are presented in Table 1 for 2002 and 2004; for both years they represent approximately 13% of the total number of DALYs lost.

[3]Leader D. (2012, November 6). Nail biting doesn't belong in psychiatry's list of OCD symptoms, The Guardian

[4]The world health report 2001 - Mental Health: New Understanding, New Hope

[5]The World Bank (2000), Entering the 21stCenturyWorld Development Report 1999/2000, Oxford University Press, New York

[6]WHO Mental health: facing the challenges, building solutions. Report from the WHO European Ministerial Conference. Copenhagen, Denmark: WHO Regional Office for Europe, 2005

[7] Prince M. et al. (2007), No health without mental health, *The Lancet*, 370: 859–77

Table 1: Global burden of neuropsychiatric disorders

WHO Burden of disease in Age-standardised DALYs per 100,000 by cause	2002 World Population (000) 6,224,985 Total DALYs (All Causes) (000) 1,490,126	2004 World Population (000) 6,425,275 Total DALYs (All Causes) (000) 1,521,022
	DALYs (000) by Cause	DALYs (000) by Cause
Unipolar depressive disorders	67,295	65,363
Bipolar disorder	13,952	14,398
Schizophrenia	16,149	16,735
Epilepsy	7,328	7,834
Alcohol use disorders	20,331	23,731
Alzheimer and other dementias	10,397	11,135
Parkinson disease	1,570	1,708
Multiple sclerosis	1,477	1,525
Drug use disorders	7,388	8,345
Post-traumatic stress disorder	3,335	3,463
Obsessive-compulsive disorder	4,923	5,091
Panic disorder	6,758	6,979
Insomnia	3,477	3,616
Migraine	7,666	7,751
Mental retardation	9,956	Not available
Other neuropsychiatric disorders	11,277	21,243*
Neuropsychiatric Disorders	**193,278**	**198,917**
% of Neuropsychiatric Dis. On Total DALYs All Causes	**12.97%**	**13%**

*The 2004 figures reported by the WHO did not include "mental retardation" and "other neuropsychiatric disorders". 21,243 DALYs in the total figure were unaccounted for and so were included in the table under the category "other neuropsychiatric disorders".

Source: Adapted from WHO, The World Health Report 2004, Statistical Annex Table 3 and from WHO, Department of Measurement and Health Information, Global Burden of Disease

The neuropsychiatric conditions that contribute the most disability-adjusted life-years lost are mental disorders, especially unipolar and bipolar affective disorders, substance-use and alcohol-use disorders, schizophrenia, and dementia. Neurological disorders (such as migraine, epilepsy, Parkinson's disease, and multiple sclerosis) make a smaller but still significant contribution.

When the DALYs lost are disaggregated by region, the proportion of neuropsychiatric DALYs is much higher in Europe than for the total WHO member states (Table 2). This is even more pronounced when the proportion of neuropsychiatric DALYs is examined exclusively for Ireland.

Table 2: Burden of neuropsychiatric disorders in Europe and in Ireland

WHO Burden of disease in Age-standardised DALYs per 100,000 by cause	EU 2002 Total DALYs (All Causes) 150,321,605	Ireland 2004 Total DALYs (All Causes) 475,581
Neuropsychiatric Disorders	**29,348,996**	**133,650**
% of Neuropsychiatric Dis. On Total DALYs All Causes	**19.5%**	**28%**

Source: Adapted from WHO, Data and Statistics (2002 and 2004)

However, it should be noted that the burden of neuropsychiatric disorder reported for Ireland is similar to the level observed across high income countries, as shown in Table 3.

Table 3: Burden of neuropsychiatric disorders in world, high-income countries and middle-income countries in 2005

	2005		
	DALYs as proportion of total DALYs		
	World	High-income countries	Middle-income countries
I. Communicable, maternal, perinatal, and nutritional conditions	38.6%	5.6%	20.2%
II. Non-communicable diseases	48.9%	85.7%	64.7%
Neuropsychiatric Conditions	**13.5%**	**27.4%**	**17.7%**
Neuropsychiatric Conditions*	27.5%	32.0%	27.5%
III. Injuries	12.5%	8.7%	15.1%

*Proportion of Non-communicable disease DALYs lost caused by neuropsychiatric conditions

Source: Adapted from No health without mental health, Lancet 2007; 370: 859–77

The Global Burden of Disease (GBD 2010) is the most comprehensive effort to date to measure current levels and recent trends in all major diseases, injuries, and risk factors.[8] There have been changes in terminology and classification from previous GBD studies. GBD 2010 introduced a new classification of mental health disorders and two categories have been distinguished: neurological disorders and mental and behavioural disorders. Some of the 2002 and 2004 disorders (reported in the Table 1 above) are now encompassed in other disorders. In particular, post-traumatic stress disorder, obsessive compulsive disorder and panic disorder are all encompassed in anxiety disorders; what had formerly been termed 'mental retardation' is now encompassed in idiopathic intellectual disability; and insomnia is encompassed in other mental and behavioural disorders.

The following table (Table 4) shows the mean DALYs values for 2010 for the mental and behavioural disorders.

Table 4: 2010 DALYs for mental and behavioural disorders.

Global Burden of Disease in Age-standardised DALYs per 100,000 by cause	2010 Mean DALYs
Mental and behavioural disorders	**2,682.8**
Schizophrenia	201.8
Alcohol use disorders	258.8
Drug use disorders	287.7
Unipolar depressive disorders	1,087.7
Bipolar affective disorder	188.3
Anxiety disorders	390.8
Eating disorders	31.3
Pervasive development disorders	111.1
Childhood behavioural disorders	88.5
Idiopathic intellectual disability	14.9
Other mental and behavioural disorders	21.9

Source: Institute for Health Metrics and Evaluation, University of Washington (2013)

[8] GBD 2010 is led by the Institute for Health Metrics and Evaluation (IHME) at the University of Washington and a consortium of several other institutions including: Harvard University, Imperial College London, Johns Hopkins University, University of Queensland, University of Tokyo and the WHO.

It is important to note that due to changes in the disorder classification and in the basis for calculations, values showed in Table 4 are not comparable with values presented in Table 1.

Political framework: mental health policies

During the recent Sixty-fifth session of the World Health Assembly held in Geneva in May 2012, a number of public health issues were discussed and some resolutions were adopted. Among these was resolution WHA65.4 on the global burden of mental disorders which asks Member States to take 5 main actions:

1. According to national priorities and within their specific contexts, to develop and to strengthen comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, and early identification, care, support, treatment and recovery of persons with mental disorders;
2. To include in policy and strategy development the need to promote human rights, tackle stigma, empower service users, families and communities, address poverty and homelessness, tackle major modifiable risks, and as appropriate, promote public awareness, create opportunities for generating income, provide housing and education, provide health-care services and community-based interventions, including de-institutionalised care;
3. to develop, as appropriate, surveillance frameworks that include risk factors as well as social determinants of health to analyse and to evaluate trends regarding mental disorders;
4. to give appropriate priority to and to streamline mental health, including the promotion of mental health, the prevention of mental disorders, and the provision of care, support and treatment in programmes addressing health and development, and to allocate appropriate resources in this regard;
5. to collaborate with the Secretariat in the development of a comprehensive mental health action plan.

The WHA65.4 resolution highlights once again the need for a stronger commitment to mental health and the requirement for action. However, this has previously been recognised by the majority of European countries, who have emphasised mental health as a priority area in recent years. The Mental Health Declaration was signed in Helsinki in 2005 and governments committed to addressing the challenges in the mental health sector. This included the implementation of a wide range of activities in a number of areas, such as mental health promotion, mental disorder prevention, preventing stigma, service provision, human rights and the empowerment of service users, families and carers. Internationally, most policy, planning documents and legislation have been developed or updated since 2005.

The WHO Mental Health Atlas Project, launched in 2001, was an attempt to map mental health resources in the world. It was updated in 2005 and the 2011 version of the Atlas represents the latest global picture of resources dedicated to the mental health sector. The project involved a survey of all Member States with data being obtained from 184 of 193

Member states, covering 95% of WHO Member States and 98% of the world's population.

The presence of a national policy on mental health is widely viewed as fundamental in raising awareness and securing resources, therefore developing and strengthening policy for mental health remains a key concern. Most countries now have national or regional mental health policies in place; the Mental Health Atlas 2011 (WHO) report indicated that 60% of countries have a dedicated mental health policy covering roughly 72% of the World's population (Table 5).

In addition to dedicated mental health policies, the majority of the countries report that mental health is mentioned in their general health policy: the majority of Member States (54%) have both a dedicated mental health policy and specifically mention mental health in their general health policy. Twenty three per cent of countries only include mental health in their general health policy with no separate dedicated mental health policy.

As recommended in the "Mental Health Policy, Plans and Programmes" (WHO, 2004), mental health plans should outline the tangible details that will allow the implementation of the policy. They should also specify other crucial elements such as the budget and timeframe for implementing strategies and clarify the roles of different stakeholders involved in the implementation of activities defined within the mental health plan.
Mental Health Atlas 2011 (WHO) report indicated that a mental health plan is present in almost three-quarters (72%) of responding Member States again with notable differences by WHO region. Among countries with mental health plans, 82% approved or revised their mental health plan in 2005 or later, while only 6% continued with plans created or adapted before 2000.

Table 5 illustrates the proportion of countries with a mental health policy and the proportion of the population covered by these policies, for the world and for Europe. Of the countries with mental health policies, the majority have a corresponding mental health implementation plan; the percentage of the population covered by the implementation plans is also presented in Table 5.

Table 5: The proportion of countries in the world and Europe with a mental health policy and implementation plan, and the corresponding population coverage

	% Countries with Mental Health POLICY	Population Coverage (%)	% of the Countries with Mental Health PLAN (of those with a mental health policy)	Population Coverage (%)
World	59.8%	71.5%	71.2%	94.8%
Europe	73.1%	90.8%	81.0%	95.2%

Source: adapted from Mental Health Atlas 2011 (WHO)

Economic aspects of mental health

Another indicator of the priority given to mental health within the health sector is the proportion of total health expenditures directed towards mental health. In terms of overall mental health expenditure, the global median percentage of government health budget expenditures dedicated to mental health is 2.8% as indicated by Mental Health Atlas 2011. The median percentage of health expenditures dedicated to mental health is 0.5% in low income countries and 5.1% in high income countries, with graduated values in lower- and upper-middle income countries.

Mental Health Atlas 2011 (WHO) reports that the global median mental health expenditure per capita is US$ 1.63 per year (€1.25 at the current exchange rates). Data were obtained converting local currency figures of the interviewed Countries to USD (May 1, 2011) in order to compare mental health spending across States. Not surprisingly, mental health expenditures per capita are more than 200 times greater in high income countries (USD44.84 mental health expenditures per capita; €34.5 at the current exchange rates) compared with low income countries (USD0.20 mental health expenditures per capita; €0.15 at the current exchange rates).

Despite the diversity between countries in relation to their economies, investment and stage of development of mental health reforms and policies, there is clear evidence to suggest that all countries are supporting deinstitutionalisation, establishing services close to where people live and integrating those with mental health problems in the community.[9] There has been an intense debate between those in favour of the provision of mental health treatment and care within hospitals and those who prefer treatment and care in community settings. Solid research has established that movement from institutions to community life has beneficial developmental outcomes when compared with that of people living in institutions.[10]There is a strong consensus to move towards deinstitutionalisation that reflects the acknowledgement of the failure of the system of care based on old-fashioned and remote institutions and the higher quality of service provided in community-based mental health services.

The findings of a study[11] performed by WHO Regional Office for Europe's Health Evidence Network (2003) shows that there is no scientific evidence that community service alone can provide satisfactory comprehensive care. Nor are there persuasive arguments or data to support a hospital-only approach. The results of the study support balanced care which means that mental health services should be provided in community settings close to the population, with hospital stays arranged promptly when necessary.
Modern community-based and modern hospital-based care should be working together as integrated parts of a comprehensive mental health system, to be able, for example, to

[9] Martin Knapp et al. (2007), *Mental health policy and practice across Europe*, European Observatory on Health System and Policies Series.
[10] European Commission (2008), *Mental Health in the EU: key Facts and Figures*. EU Health and Consumer Protection Directorate.
[11]Graham Thornicroft and Michele Tansella, (2003), *What are the arguments for community-based mental health care?* WHO Regional Office for Europe's Health Evidence Network, Copenhagen.

respond quickly to the need to communicate or transfer patients between different services. The major risk is to consider the two components as mutually exclusive and to fall into a false dichotomy between hospital and community services.[12] The different services and interfaces among them all play an important role. Such interfaces should exist between the whole range of statutory, voluntary and community organisations.

In three studies involving costs and outcomes (Jones et al., 1984; Knobbe et al., 1995; Stancliffe and Lakin 1998; 2005, this latter for people with intellectual disabilities), costs of community services ranged from 5% to 27% less than institutional services. While the results of these studies support a shift towards community based mental health care, caution is needed in considering and interpreting these results. In terms of costs these comparisons can be misleading as institutional and community services differ in many important aspects, such as the characteristics of the populations served, staff wage rates and condition of employment and the array of services provided.

The WHO Regional Office for Europe's Health Evidence Network study (2003) mentioned above, found little difference overall between hospital and community costs, suggesting that community care is more cost-effective than long-stay hospital care due to improve effectiveness in terms of patients outcomes rather than lower costs. It is important to understand the economic impact of shifting care institutions to the community and the transitional period has to be carefully planned and monitored. Several economic studies (Knapp et all, 1997, 2005, 2007, McDaid et all, 2009, 2010) emphasise the importance of understanding the economic consequences of deinstitutionalisation as a key step for the success of the operation. These studies highlight the fact that from a practical point of view, the first patients to be transferred are usually those with fewer clinical needs, while the patients with more complex or higher needs and whose care costs more, remain in the hospital. Consequently, during this transitional phase, there is a risk of transferring too much funding out of hospitals in the early stages when low dependency patients are moving, and underfunding for the new community placements in the middle- to long-term when the high-need patients will also be transferred.

At the same time, the shift from an institution-based care towards a community-based arrangement involves multiple life domains like housing, social services, education and employment, especially for people with complex health problems. This implies that also at funding level such a shift should take place, from almost an exclusive reliance on the health system, to a mixed economy of services that draw resources from multiple funding sources. The transitional phase can take several years to implement and community based services have to be operational before hospitals are closed. During this period there is a need to fund both hospitals and community services. Experience shows the need for some bridging finance or the so called "parallel" funding.[13] WHO (Euro Observer, 2007) also highlights that shifting care from institutions to the community means (leads to)

[12]Graham Thornicroft and Michele Tansella, (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence, *British journal of Psychiatry*, 185:283-290.
[13]Mental Health Policy Project Policy and Service Guidance Package, WHO, 2001

rising indirect costs sustained by caregivers, mainly families and voluntary organisations, and society as a whole.

Across all countries, great challenges remain and further work is required. One of the major problems is the substantial gap between the burden caused by mental disorders and the resources available to prevent and treat them[14]. A significant amount of work still remains in order to gather evidence to determine best practice approaches. This is hindered by the fact that data on mental health resources have not been systematically collected in many countries. While most countries collect mental health data on persons treated in psychiatric hospitals, general hospitals, outpatient facilities and day treatment facilities, fewer countries collect data from primary care facilities and community residential facilities. As for any other aspect of health services, accurate and timely information is vital for mental health service planning, implementation and monitoring.

Mental Health Services in Europe

Activity in mental health policy has flourished in recent years. Since 2005, 57% of countries have adopted new mental health policies in Europe. WHO Europe "Policies and practices for mental health in Europe - meeting the challenges" (2008) is an overview of policies and practices for mental health in 42 Member States in the WHO European Region. It reports that most countries have opted for a separate mental health strategy, but many have included mental health within their overall health policy documents. There is open discussion on the merits of the two approaches. The advantages of an integrated strategy include avoiding the fragmentation and isolation of the mental health sector while the advantages of a separate policy are greater flexibility and visibility.

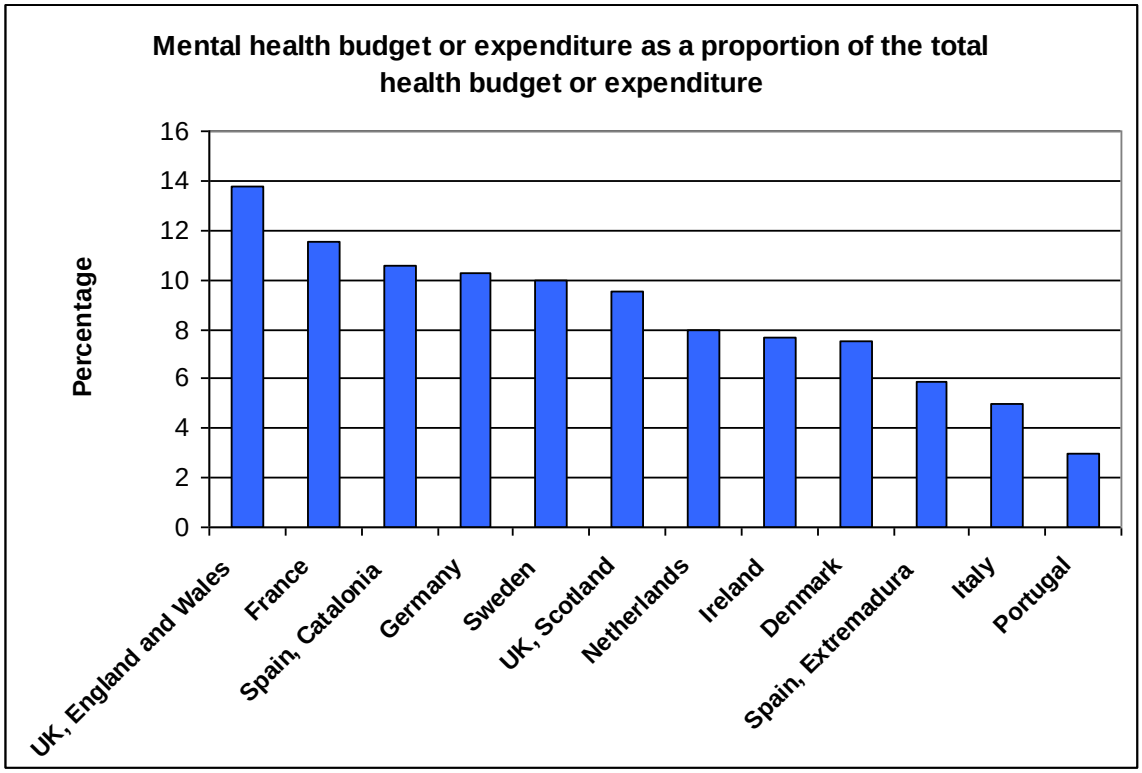
International concern and effort are long overdue since at least one in four people in Europe experience a significant episode of mental illness during their lifetime[15] and there is still a high "treatment gap" between the need for and the receipt of appropriate services. While mental health problems account for approximately 20% of the total disability burden of ill health across Europe (as shown in Table 2), the mental health sector receives a lower proportion of total health expenditure, often below 5%.[16] Figure 1 focuses on the EU-15 countries and illustrates the mental health budget or expenditure as a proportion of the total health budget or expenditure. The most recent data available are presented, predominantly from 2004 to 2006. Data were unavailable for Austria, Belgium, Finland, Luxemburg and Greece and were only available for certain regions of the UK and Spain.

[14] Kohn et al (2003), *The treatment gap in mental health care*, Bulletin of WHO, 82:858-66

[15] Knapp et al. (2007), *Mental Health Policy and Practice across Europe-The future direction of mental health care,* Open University Press, England

[16] Mental Health Atlas 2011 (WHO)

Figure 1: Mental health budget or expenditure as a proportion of the total health budget or expenditure, EU-15 countries



Source: Adapted from WHO Europe "Policies and practices for mental health in Europe - meeting the challenges" (2008)

The proportion of the health budget dedicated to mental health, ranges from 13.8% in England and Wales to 3% in Portugal.

The report "Policies and practices for mental health in Europe" (WHO, 2008) explains that national budgets often underestimate total expenditure on mental health. The more advanced the community-based and primary care mental health services, and the more decentralised the funding of mental health services- the higher the additional expenditure is likely to be.

Not surprisingly, the European study found that only a proportion of the mental health expenditure comes from the health budget and the move towards community-based services increases the need for decentralised spending. The government departments responsible for social care are often responsible for accommodation and day care. These figures are very hard to identify, since they are rarely ring-fenced, and this hides the real public cost of mental health care. The report explains that in general countries had great difficulty in being precise about the expenditure and funding figures. It was not always specified what services were included and excluded, especially if expenditure was not a central responsibility. Particularly difficult to identify were: mental health services provided in primary care; reimbursement of drugs; private psychiatric practices contracted by health insurance; some outpatient services; mental health care in nursing

homes and expenditure on mental health promotion programmes or mental disorder prevention programmes; expenditure from local authorities; and out-of-pocket expenditure.

Mental health budget figures include different components across countries so cross-country comparisons should be made with caution. This problem is evident also in the report "Mental health policy and practices across Europe" (Knapp et all, 2007) which highlights that the percentage of mental health expenditure to total health budget varies widely across Europe. Therefore any inter-country comparisons may be inappropriate due to differences in the definition of health system and expenditure. There is also great uncertainty about whether the boundaries are drawn consistently around "mental health". Social care, supported housing and secure provision could all variously be included or excluded from mental health budgets calculations. The links between funding, employment of staff and other resources, their combination to deliver services, treatments and support and the achievement of individual and societal mental health goals are not easy to identify. The levels and routes of funding vary from country to country in response to a variety of political, economic and cultural influences. However, in real terms, the implementation of these strategies and reforms require a major reorganisation of the mental health sector, which has proved in practice to be difficult.

Understanding the economic burden of mental ill health and the above mentioned links is fundamental as the effect of mental ill health can touch all aspects of life (relationships, employment etc.) and not least because many mental health disorders are chronic diseases. Total mental health costs to society are estimated at 3-4% of GNP in European Countries[17] and therefore highlight the need for political commitment in both drafting and implementing effective policy.

Even if the many and damaging consequences of poor mental health are well known and despite ample evidence that good mental health underlies all health[18], the level of funding for mental health services has been disappointing across Europe as denounced by the report "Mental health policy and practices across Europe". Figure 1 shows that only a small number of European countries spend at least 10% of their health budgets on mental health (UK, France, Catalonia region in Spain, and Germany).

An effect of the lack of funding is the large unmet need in mental health services. Analysis of data from the WHO World Mental Health Surveys[19] (2008) reported that overall only around one-third of those who could benefit from treatment actually made use of the services, in particular because of the stigma of having a mental health problem. Across France, Germany, Italy, Spain, Belgium and the USA an average of only 53% of people with severe mental disorders received treatment in a one-year period. This under-utilisation of services is reported even where there is no need to make out-of-pocket payments to access services. The surveys (WHO, 2008) state this phenomenon could be

[17] Liimatainen M et al., *Mental Health in the Workplace*, Geneva: ILO, 2000

[18] *No health without public mental health the case for action*, Royal College of Psychiatrists Position statement PS4/2010

[19] WHO World Mental Health Surveys, 2008

explained by the fact that people appear to be fearful of being discriminated against if they are labelled as having a mental health problem. It is clear then that national mental health awareness campaigns are also necessary to overcome this fear of stigmatisation and to increase the number of people with a mental disorder who make use of the services provided. It is only in this way that a fully coordinated mental health reform and policy can be fully realised.

The deinstitutionalisation process in Europe

A broad consensus to move towards deinstitutionalisation has taken place across most of western Europe for more than 20 years and this change is now underway in central and eastern Europe. However, Mental Health Economics European Network[20] (2008) identifies insufficient and unspecified budget allocation for the transitional phase of deinstitutionalisation in the majority of the EU countries. In particular, concern is raised whether the hospital budget should be "ring-fenced" for mental health services when plans are made to close a large institution in order to protect this funding from leaking away into other sectors of the health care system or to other public policy areas. Hence a protection of such funds is recommended to ensure that resources are actually transferred from hospital to community services. Unfortunately few data are available to analyse, from an economic point of view, the transitional phase and the deinstitutionalisation process.

Mental Health Atlas (2011) which investigated the median mental hospital expenditures as a percentage of all mental health expenditures, found a median of 60% for European Countries and a world median of 67%.

Table 6: Median mental hospital expenditures as a percentage of all mental health expenditure

Mental Health Atlas (2011)	World median	European median
Mental hospital expenditure as % of all mental health expenditure	67%	60%

Source: adapted from Mental Health Atlas 2011 (WHO)

The percentage of mental health expenditure on mental hospitals varies considerably across WHO regions with a low of 36% in Eastern Mediterranean Countries to a high of 77% in Africa. However, the same report says these numbers are likely to be biased by the low number of countries reporting total mental hospital expenditure (only 41 of 184 countries).

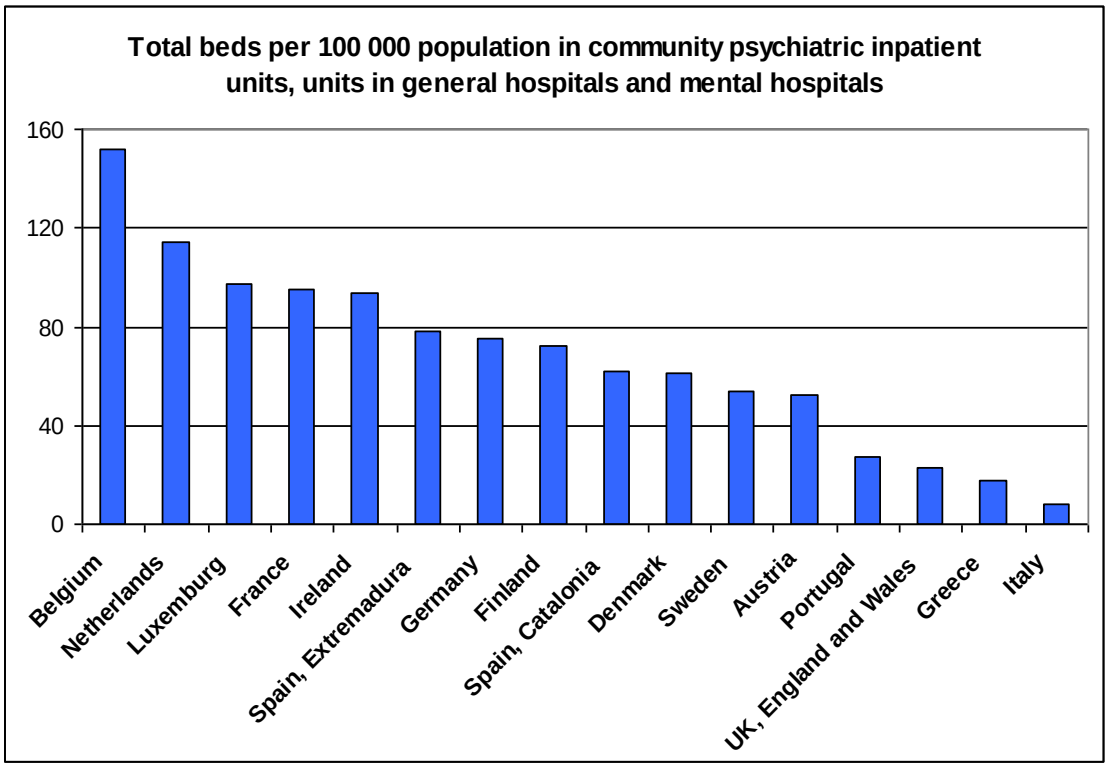
The report "Policies and practices for mental health in Europe" (WHO, 2008) highlights that most countries have had difficulty in providing information on funding allocation for different components. The service component for which information is most frequently

[20]Mental Health Economics European Network, Policy Briefings (1-5), 2008

available is mental hospital beds and very few countries provided meaningful information on the remaining components in particular community-based services and mental health care in primary care services. Some countries appear to allocate a very high proportion of expenditure to beds in hospitals. Few countries were able to specify the spending on community-based services excluding beds. The median spending on community-based services was 9%. However, the report states that data cannot be easily interpreted because of the definitions of funding sources, such that, for example, some of the figures did not include contributions from local governments.

The report "Policies and practices for mental health in Europe" (WHO, 2008) shows a consistent movement towards community-based services. Figure 2 illustrates the total psychiatric beds per 100,000 of the population in community psychiatric inpatient units, units in district general hospitals and in mental hospitals in the EU-15 countries between 2004 and 2006. Rates per 100,000 population range from 152 in Belgium to 8 in Italy, with a median of 72.

Figure 2: Total beds per 100 000 population in community psychiatric inpatient units, units in general hospitals and mental hospitals, EU-15 countries, 2004-2006



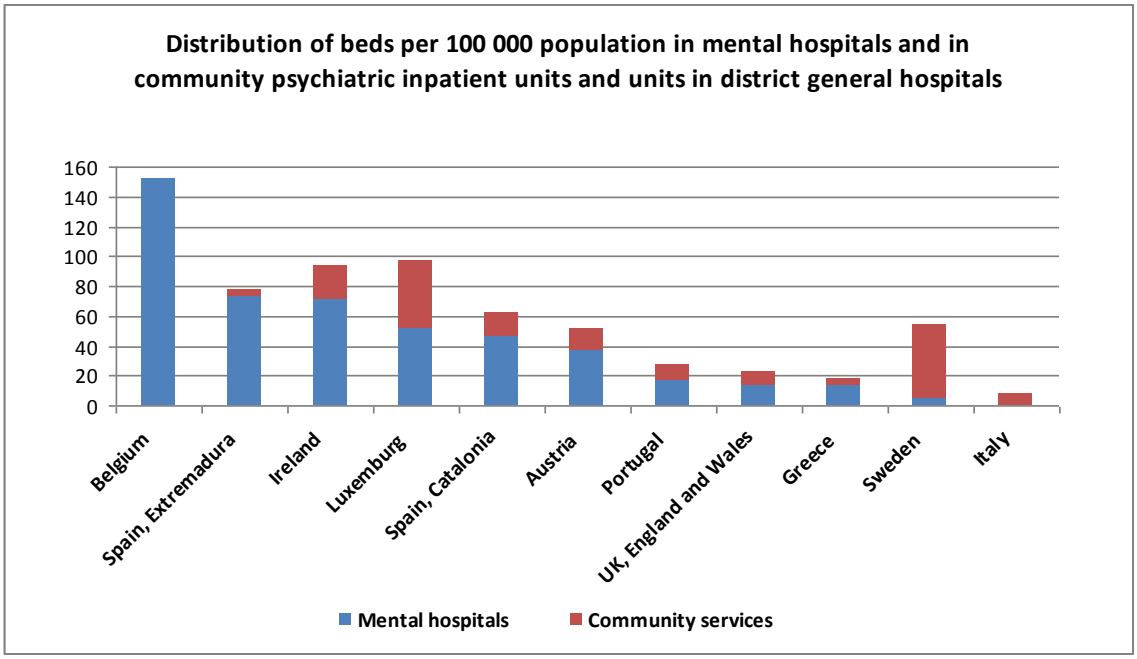
Source: adapted from WHO Europe "Policies and practices for mental health in Europe - meeting the challenges" (2008)

The report explains that variation across countries reflects differences in both the organisation of mental health services and investment. Italy and the United Kingdom (data from England and Wales) for example, have rates similar to those of Albania and

Turkey. In Italy and the United Kingdom (England and Wales), having few beds indicates post-deinstitutionalisation, whereas having few beds in Albania and Turkey indicates low investment and the absence of service infrastructure. Mental hospitals are available in all countries expect Italy because of the Italian Mental Health Act of 1978. *Basaglia Law* 180 contained directives for the closing down of all psychiatric hospitals which signified a large reform of the psychiatric system. The last mental health hospital in Italy was closed more than 30 years after the law, showing that implementation takes time.

The following figure (Figure 3) coming from the same report "Policies and practices for mental health in Europe" (WHO, 2008) shows the distribution of beds by type of service: the traditional model with mental hospitals and the modern community oriented model that involves community psychiatric inpatient units and units in general hospitals. In countries where information is available, most beds are still in mental hospitals, except for Italy where there are no mental hospitals and Sweden where the community model is predominant.

Figure 3: Distribution of beds per 100,000 population in mental hospitals and in community psychiatric inpatient units and units in general hospitals in EU countries, 2004-2006



Source: WHO Europe "Policies and practices for mental health in Europe - meeting the challenges" (2008)

According to the WHO report (2008), a community-based psychiatric inpatient unit is a psychiatric unit that provides inpatient care for the management of mental disorders within a community-based facility. These types of units are usually located within general hospitals, but sometimes some beds are provided as part of a community centre. Community-based beds mostly provide care to users with acute problems, and the period of stay is usually short (weeks to months). This category(in the WHO report and in the

figure above), includes both public and private facilities. This category excludes: mental hospitals; community residential facilities; and facilities that solely treat people with alcohol and substance abuse disorder or mental retardation or developmental disability. The figure above (Figure 3) is based on 2004 and 2006 data. Since then, community mental health care has been further developed in the European countries through substantial additional investment in specialised teams such as assertive outreach and early intervention.

In spite of the further development of the mental health community services in many European countries, a new era of re-institutionalisation has begun to be evident in the last few years. R-institutionalisation arises from rising numbers of forensic beds, involuntary hospital admissions, and places in supported housing. The precise reasons for the phenomenon remain unclear and more investigation should be done in order to understand the phenomenon, potential correlations and key factors.
A study undertaken in six European countries (England, Germany, Italy, the Netherlands, Spain, and Sweden) measured the changes in the number of forensic hospital beds, involuntary hospital admissions, places in supported housing, general psychiatric hospital beds, and general prison population between 1990-1 and 2002-3.[21] The results were a reduction in the number of psychiatric beds and an increase in the number of forensic beds and places in supported housing in all countries. Involuntary admissions have risen in England, the Netherlands, and, especially, in Germany, but have fallen slightly in Italy, Spain, and Sweden. In England, Spain, and Sweden, the number of psychiatric beds that have been closed is greater than the total number of additional forensic beds and places in supported housing that have been established in the same period of time. In Italy and the Netherlands, the increase in forensic beds and supported housing has been much greater than any decrease in conventional psychiatric bed numbers, whereas in Germany the balance is approximately equal.

The general prison population has grown in all countries by between 16% and 104%, and the two countries with the highest imprisonment rate (England and Spain) have the lowest rate of forensic beds. Although the number of psychiatric hospital beds has further decreased in five of the six studied countries since 1990, this was partly or more than compensated for by additional places in other forms of institutionalised care. While most of the data are consistent with the assumption that deinstitutionalisation and the process of mental healthcare reforms since the 1950s, has come to an end, evidence indicates that a degree of new institutionalisation does exist. The study leaves open the debate whether this process should be described as re-institutionalisation or only as trans-institutionalisation that is, a mere shifting of placements from one structure to another.

The transition from hospital to community based services implies a shift, not only for the patients, but also for the employees of the mental health services. Human resources are the main asset in the health sector; human resources management can help or hinder reforms, depending on how people are involved in and supported through the process.

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[21]Priebe et al.,*Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries*, BMJ. 2005 January 15; 330(7483): 123–126

Traditionally the mental health workforce was comprised of psychiatrists and nurses working in institutional settings. Following the shift to community-based services, the roles and competencies of staff have changed considerably: psychologists, social workers and occupational therapists have entered the workforce, adding diversity, offering skills that cover identification of problems, diagnosis, treatment, care, functional assessment, psychological therapy, psychosocial support, liaison with other agencies and rehabilitation.

According to the "Policies and practices for mental health in Europe - meeting the challenges" (2008) the presence of a national workforce strategy, addressing the numbers and competencies of mental health staff to deal with the challenges of mental health development, indicates the state of reform. Fewer than half the countries surveyed (18 of 42 countries) have such a national workforce strategy. However, there are many programmes for training and higher education courses available for the variety of professionals comprising the mental health workforce, although these are not coordinated at a national level. Therefore it is difficult to measure the benefits of these courses and evaluations have only been conducted at a local or regional level.

A recent example comes from the United Kingdom (England and Wales) where the development of a mental health workforce was supported across health and social care in different forms. Primarily the focus has been on developing the "New Ways of Working" programme[22]where responsibility is distributed among members of the mental health team. This programme aims to ensure that the most advanced skills are deployed to deal with the most complex cases and the provision of supervision or support to the rest of the team; the introduction of new roles to help meet specific needs of service users and carers and to help expand the workforce. Another intervention was the introduction of the "Creating Capable Teams Approach (CCTA), best practice guidance to support the implementation of New Ways of Working and New Roles" published by the Department of Health (UK)[23] that helps mental health teams focus on the needs of service users and carers and of the capabilities that exist within the team.

The rapid changes in services delivery and understanding of mental illness mean that it is important to appropriately adjust training and skill development for mental health staff. "Policies and practices for mental health in Europe" (WHO 2008) while expecting that content of training would be regulated and accredited, states the information available on the proportion of mental health staff receiving such training is very limited. When data were provided, they were mostly estimated. As previously mentioned, many countries indicate that although training courses do take place, the number of staff attending them is not available because the data are not recorded.

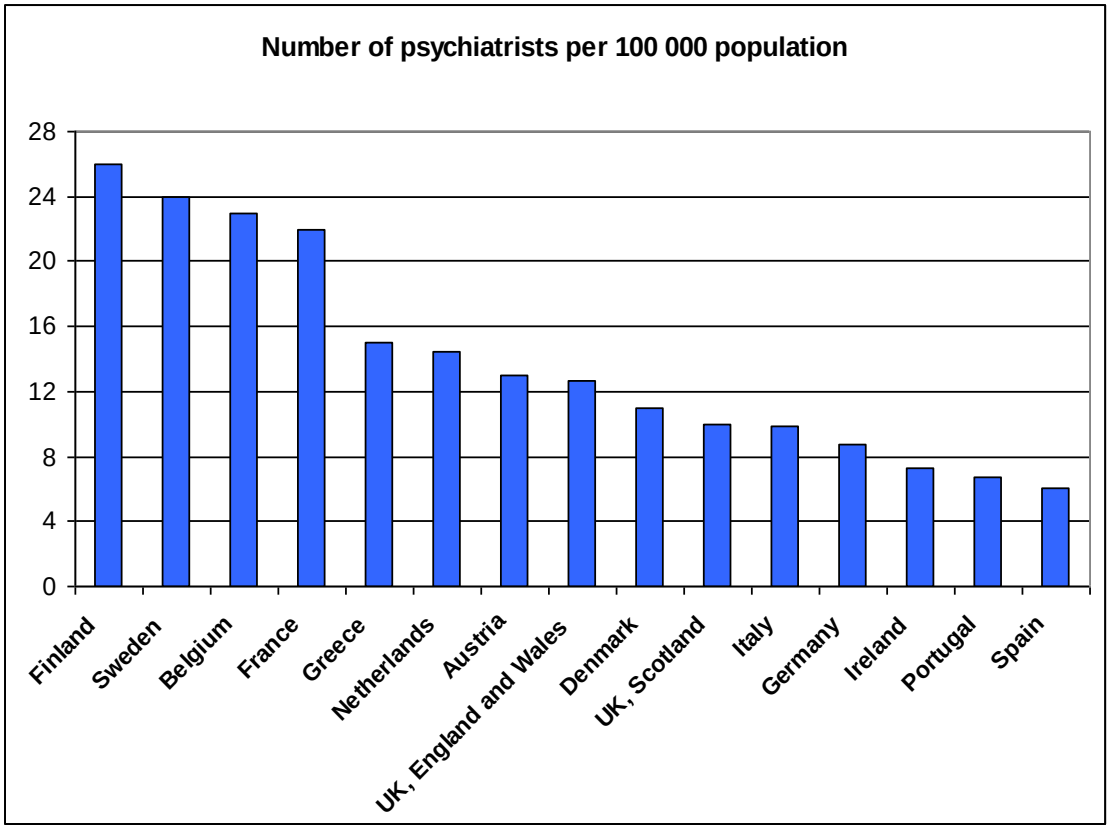
[22]*New Ways of Working for Everyone, a best practice implementation guide*, Care Services Improvement partnership (CSIP) National Institute for Mental Health in England (NIMHE), National Workforce Programme, 2007

[23]*Creating Capable Teams Approach (CCTA) Best practice guidance to support the implementation of New Ways of Working (NWW) and New Roles*, Department of Health, 2007

Surprisingly, at a time of reform and rapid change in the numbers, composition and competencies of the workforce, in combination with ubiquitous concern about recruiting adequate numbers of staff members, fewer than half the countries in this survey have produced a mental health workforce strategy. Of the 43 countries, 15 (35%) report that some training programmes for staff members are organised and conducted in partnership with service users and carers. The information collected does not establish whether this is common practice in any of these countries and whether they are organised in the framework of mainstream training for mental health staff or in the context of pilot initiatives coordinated by nongovernmental organisations.

"Policies and practices for mental health in Europe" (WHO 2008) states that in many surveyed countries clinical leadership and the delivery of mental health care still relies heavily on the presence of psychiatrists. The number of psychiatrists per 100,000 population varies widely and the median rate of psychiatrists per 100,000 in the 41 countries that provided information is 9.Focusing on the EU-15 countries (Figure4) the number of psychiatrists per 100,000 population ranges from 26 in Finland to 6.1 in Spain. While we are also conscious that community-based services rely on the availability of community mental health teams that fully comprise the various disciplines AVFC states they should - occupational therapy, social work, etc. - we use international standard measures that rely on assessing the more internationally comparable statistics on numbers of psychiatrists and mental health nurses per capita. This is not to suggest that services should exclusively rely on such posts in the future.

Figure 4: Number of psychiatrists per 100 000 population, EU-15 countries, 2004-2006

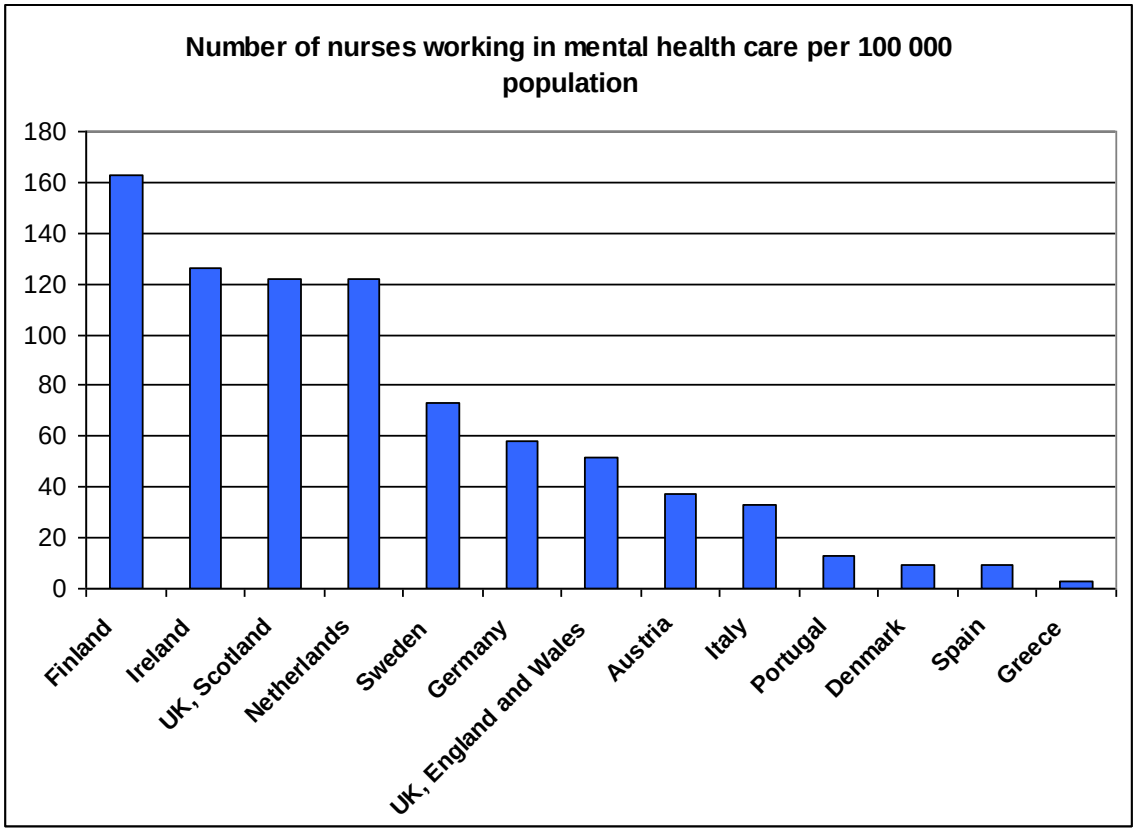


Source: adapted from WHO Europe "Policies and practices for mental health in Europe - meeting the challenges" (2008)

"Policies and practices for mental health in Europe" (WHO 2008) recommend attention to these data as the number of psychiatrists could hide differences in functions. For example, while in some countries most psychiatrists are publicly employed and work in national mental health services, in other countries psychiatrists work predominantly in a private capacity, often as psychotherapists, providing services directly to the public or to hospitals and are mostly reimbursed by insurance schemes.

Caution is also required in deciphering data on the number of nurses working in mental health care per 100,000 population. The following figure, with figures for the EU-15 countries, shows that a few countries have a large number, whereas many have few employed mental health nurses. The rate of nurses working in mental health care varies from 163 in Finland to 3 in Greece. The median rate of nurses per 100,000 population is 21.7, more than twice the median rate of psychiatrists.

Figure 5: Number of nurses working in mental health care per 100 000 population, EU-15 countries, 2004-2006



Source: adapted from WHO Europe "Policies and practices for mental health in Europe - meeting the challenges" (2008)

Important differences have to be taken into account to understand these numbers correctly. Some countries offer and require a period of special training to qualify as mental health nurses, whereas others employ general nurses to work in mental health care and offer on-the-job training. These differences in approach mean it is difficult to draw conclusions from comparative data between countries. Nevertheless, it is interesting to see in the position of Ireland relative to the other 15 EU countries shown in the previous Figures (based on data from 2004 and 2006).

WHO has embraced and developed the principle of deinstitutionalisation since the 1970s when a long term programme of the WHO Regional Office for Europe was approved. Since then, the Regional Office is monitoring changes in the psychiatric services in Europe while emphasising the importance of developing community care under the umbrella of public health principles (WHO, 2008). Recommendations concern the establishment of explicit mental health policies endorsed at the highest level of government so that higher priority is given to mental health. Guiding principles should include: community participation in mental health services; deinstitutionalisation and community care; integration into primary care; partnership with families; continuity of care and a wide range of services to respond to the different needs of the population.

Although more than forty years has passed, WHO (2008) highlights that in some countries there has been a big effort in drafting and reviewing mental health policies but they still not have been implemented. Even countries with genuine and strong commitment to the implementation of modern community based mental health services face challenges in implementation such as the absence of skilled leaders, a competent workforce, infrastructure, partnerships and funding.

Mental Health Services in Ireland

In Ireland, the policy for transformation of mental health services *A Vision for Change* (AVFC) was launched in 2006. AVFC details a comprehensive model of mental health service provision, describing a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.[24] As recommended in AVFC, an Independent Monitoring Group (IMG) has been appointed by the Minister for Health and Children to oversee the implementation of the mental health policy. Six annual reports on AVFC implementation have been published so far.

The HSE Mental Health Implementation Plan was prepared three years after publication of AVFC. While it is important to take time to ensure well planned implementation, this time delay had the effect that the early implementation took place without a clear road map and much of the momentum for change was lost. While the implementation plan provides more concrete plans and actions to deliver AVFC, it is also not sufficiently detailed to provide a blue print for implementation.[25] Moreover, the detailed planning of mental health service development coincided with the financial crisis. An updated Implementation Plan is to be published in the near future.

As shown in Figure 1, 7.7% of the total health budget in Ireland was dedicated to mental health in the years 2004 to 2006 (WHO, 2008). Looking at the historical trend of mental health expenditure in Ireland, Table 6 shows that despite nominal expenditure having increased significantly until 2008, the proportion of the health care budget spent on mental health services fell by more than 60% from 1984. The rapid growth in overall health spending was not reflected in the growth in spending on mental health services meaning that during the period of the implementation of AVFC the proportion of spending on mental health services has remained largely static.

O'Shea and Kennelly's report (2008) makes a rational economic argument for greater investment in mental health in Ireland. The report states that additional investment is required to address the range of costs associated with mental health problems as well as personal, social and economic problems. The central message of the report is that the economic potential of the economy has been affected by a failure to invest in mental health care services.

[24] *A Vision for Change, Report of the Expert group on mental health policy*, Government of Ireland, 2006
[25] Accountability in the Delivery of A Vision for Change-A Performance Assessment Framework for Mental Health Services (2010), Amnesty International, Indecon International Economics Consultants

In 2006, when AVFC was published, a progressive increase in the proportion of funding given to mental health services over the next seven to ten years was recommended. According to the recommendations of the policy, the percentage of total health funding spent on mental health should increase to 8.24% (based on 2005 figures), resulting in an additional €21.6M each year for the next seven years. Department of Health and Children (DOHC) Annual Output Statements and HSE National Service Plans report spending much lower than this.

Table 7: Trend of the public current mental health expenditure in Ireland

Year	Total Public Health Expenditure (€mil)	Public Mental Health Current Exp. (€mil)	Public Mental Health Current Exp. as % of Total Health Exp.
1984	1,413	184	13.0%
1988	1,564	196	12.5%
1992	1,830	197	10.8%
1996	2,354	232	9.8%
2000	5,354	433	8.1%
2004	9,766	717	7.3%
2006	13,056	937	7.2%
2007	14,997	990	6.6%
2008	16,144	1,011	6.3%
2009	15,993	978	6.1%
2010	15,324	949	6.2%
2011	14,189	737	5.2%
2012	14,041	731	5.2%

Source: Adapted from AVFC, Department of Health and Children (DOHC) Annual Output Statements and HSE National Service Plans

In interpreting the health care expenditure figures it is important to take account of the two measures that have effectively reduced the wages of employees. Firstly there was a levy on all staff entitled to state guaranteed occupational pensions in 2009 ("The Pension Levy"), ranging from 5% to 9.6%, and averaging around 8% for health service staff. Secondly, a series of pay cuts were implemented in 2010, ranging from 5-15%, with the average for health services staff being between 7% and 8%. Although the details of these two measures are different, in effect they both reduce the cost to Government of employing staff in the health sector. Pay represents around 60% of health care expenditure, often more in mental health services, so these reductions in pay costs together would allow the same volume of services at a cost that is around 10% lower by the end of 2010 compared to 2008. In other words, budget cuts of 10% could be

accommodated with no loss of volume of services even if there was no improvement in efficiency. This assumes that non pay costs remain constant. The funding changes in 2009 and 2010 have exhausted the scope to make savings from the lower pay costs.

It is well known that immediately after the publication of AVFC, Ireland significantly cut all public spending due to the current financial crisis. The timing of the policy implementation is unfortunate given the overall shortage of public resources and the requirement to reduce overall numbers employed in the public service. The total quantifiable cost reduction target of €750m for the 2012 health budget follows two unprecedented years in the history of the health service in which the HSE saw total budget reductions of €1.75 billion.

The HSE is taking steps to tackle this situation, by closing inappropriate institutions and inpatient beds and by transferring resources to the community. It is also evident that there is the will to provide services in more appropriate care settings. It has not been easy to support these changes, deinstitutionalisation in particular, with significant transitional funding. Since savings cannot always be realised immediately, as previously mentioned, it is often necessary to have bridging funds to allow for the parallel operation of older and newer services (WHO Euro Observer, 2009). However, while mental health budgets have enjoyed some protection, there is concern that expenditure and staffing within the mental health services are reducing at a rate that is disproportionate to overall expenditure and numbers employed.

Although AVFC estimated in 2006 that approximately 1,800 new professionals were needed in order to implement reform of mental health service provision, there has instead been a reduction in staff levels (10.9% between 2009-2012).[26] Mental health policy and reform have been constrained by the HSE embargo and the present Public Service Moratorium on recruitment. Understaffed community mental health teams are a major obstacle to the full implementation of the reform. However, the commitment in budget 2012 of additional funds for the deployment of mental health services (€23 million for 370 new community mental health team posts) demonstrates an effort to make exceptions to the moratorium on recruitments in the public service in order to adequately staff the multidisciplinary teams. Another positive sign can be found in the IMG's 6th annual report which acknowledges that the 1.8% reduction applied to mental health expenditure in 2011 represented a specific exception to the overall health expenditure reduction which reached 5%.

These efforts to limit the impact of budget reduction on mental health services appear to be even more justified in the light of a recent increase in the demand for mental health services. Concerning the child and adolescent population, between October 2011 and September 2012, 8,671 new cases were seen by community CAMHS teams compared with 7,849 in the previous 12 months, which is an increase of 10%. In the same period, there were 9,973 referrals accepted by CAMHS teams, which is a 17% increase on the previous 12 months.

[26] The HSE started to collect and report data on mental health staff in March 2009.

Also, the MHC annual report 2010 highlighted an increased number of referrals to the mental health services, which appear to be directly related to the economic recession. A similar pattern comes from the recent HRB publication "Activities of Irish Psychiatric Units and Hospitals 2011" (2012) showing that 41% of all admissions in 2011 were returned as unemployed, compared with 26% of employed and 11% of retired. These figures have not changed significantly over the last few years. While a direct link between unemployment and inpatient admission due to mental health problems can clearly not be made, the data indicates a high unemployment rate among people who are hospitalised.

In the current situation, the economic crisis is at the same time the cause of an increased need of mental health services and of a reduction of the budget devoted to those services. While it will be difficult to avoid an impact on the delivery of frontline services, the imperative of accelerating the implementation of the mental health reform is equally clear.

Nevertheless, it is also important to look beyond the absolute figures and examine how the funds are spent. During 2006 and 2007 for example, the Minister of State with responsibility for Mental Health allocated additional resources of €26.2 million in 2006 and €25 million in 2007. In 2008, the Minister of State announced that he could not allocate additional resources until he was assured that the resources already allocated had been appropriately utilised. Unfortunately reports submitted by Freedom of Information confirmed that the majority of the additional funding allocated in 2006 and 2007 was either not spent or was simply reallocated to other health programmes.

The current situation is very far from the original ambitions set out in AVFC in 2006, and represents a fundamental challenge in terms of the ability to maximise services through more efficient ways of using reduced resources. The whole health service, not only the mental health sector, must find efficiency savings to cope with lower budgets. The current crisis involves the obligation, but also the opportunity, to reconfigure services for achieving greater efficiency. There is a pressing need to treat patients at the lowest level of complexity and provide services at the least possible unit cost. This represents an opportunity for the mental health sector to treat patients at the lowest level of complexity through increased involvement of GPs in the provision of services. This is in line with AVFC which strongly recommends that mental health services be provided in the primary care setting. Overall efficiency in the provision of health services could be evaluated and improved through the collection of high-quality and timely information and data about costs and outcomes. Moreover, reporting of more and more accurate data leads to greater transparency and accountability and also provides the opportunity to make comparisons and exchange best practices with other countries.

With respect to capital funding and infrastructure, AVFC recognised that within the mental health services capital funding had traditionally been very low and that much of the service activity was taking place in unsuitable and sometimes stigmatised structures. AVFC claimed that, apart from acute units in general hospitals and approximately 50% of current staffed community residences, the other existing facilities were unsuitable for the

new services recommended. The capital cost of providing and equipping the new mental health service infrastructure was then estimated to be €796 million. While AVFC stated that the value of the existing assets should significantly counterbalance the capital cost of the new mental health infrastructure requirement, the reality showed a different situation.

Since the launch of AVFC, the HSE has spent €190 million on mental health capital and has further contracted commitments of €57 million. The multi annual capital plan also shows non-contracted but planned spend of a further €170 million. That means that since AVFC was published, a total of €417 million of capital commitment has been made which represents 52% of the estimated total capital cost (€796 million).

Table 8: Capital funding in mental health services

AVFC Estimated Total Capital cost in 2006	HSE Capital Commitment up to 2012
€796 million	€190 million Capital spent
	€57 million Capital commitment
	€170 million Capital planned
	Total €417 million

Source: Adapted from AVFC and HSE National Service Plans

Sale of lands accounted for €37million; that represents less than 9% of the total capital commitment provided by the HSE (€417 million). Thus while in principle there are resources available for capital development, in practice it is not easy to sell land and buildings for reasonable value in a short time scale, especially in a weak market.

Capital investments progress has been made in the area of general adult mental health services, child and adolescent mental health services and forensic mental health services as reported in the last two annual reports from the IMG, in the HSE National Service Plans and in the Annual Child & Adolescent Mental Health Service reports.

Experiences in many European countries[27] demonstrate that closing an institution does not necessarily generate automatically additional resources to be ploughed into the community services. Many of today's facilities have low market value because the buildings are old or in disrepair, and because the land on which they are located is not in high demand for redevelopment.

Turning to mental health expenditure per capita in Ireland, 2011 data reports on average €167 as per budget per capita in 13 Super Catchment Areas (SCAs), ranging from €116 in the S. Lee, West Cork and Kerry SCA to €248 in Carlow, Kilkenny, South Tipperary SCA.

[27] Euro Observer (2009), Mental health policies in Europe, Volume 11, Number 3

Table 9: Total budget and Budget per capita in Ireland (per region) for the years 2010 and 2011

Super Catchment Area	Population (based on 2006 Census)	Budget 2010	Budget per Capita 2010	Budget 2011	Budget Per Capita 2011
WEST HSE Region					
1. Limerick, North Tipperary, Clare	361,028	€ 59,931,304	€ 166.00	€ 58,399,973	€ 161.76
2. Donegal, Sligo, Leitrim, West Cavan	238,317	€ 51,999,908	€ 218.19	€ 48,668,952	€ 204.21
3. Galway, Mayo, Roscommon	414,277	€ 91,003,973	€ 219.66	€ 89,071,724	€ 215.00
SOUTH HSE Region					
4. North Lee, North Cork	248,470	€ 55,023,000	€ 221.44	€ 54,697,000	€ 220.13
5. South Lee, West Cork, Kerry	372,660	€ 49,458,000	€ 132.71	€ 43,042,000	€ 115.50
6. Wexford, Waterford	256,986	€ 37,417,000	€ 145.60	€ 35,421,000	€ 137.83
7. Carlow, Kilkenny, South Tipperary	203,852	€ 54,549,000	€ 267.60	€ 50,696,000	€ 248.69
Dub North East HSE Region					
8. North Dublin	222,049	€ 30,998,260	€ 139.60	€ 30,342,783	€ 136.65
9. Louth, Meath, Cavan, Monaghan	390,636	€ 49,596,159	€ 126.96	€ 46,543,791	€ 119.14
10. North West Dublin, Dublin North Central	312,472	€ 70,258,422	€ 224.85	€ 68,353,363	€ 218.75
Dublin Mid-Leinster HSE Region					
11. Dun Laoghaire, Dublin South East and Wicklow	372,107	€ 54,865,000	€ 147.45	€ 33,239,000	€ 150.00
12. Dublin West, Dublin South West, Dublin South City[28]	389,750	€ 50,487,000	€ 129.53	€ 69,817,000	€ 179.13
13. Laois, Offaly, Longford, Westmeath, Kildare, West Wicklow	457,244	€ 60,578,000	€ 132.48	€ 59,861,000	€ 130.91
National provided in Dublin Mid-Leinster HSE Region					
14. Forensic National	4,239,848	€ 20,528,000	€ 4.84	€ 19,910,000	€ 4.69

Source: HSE, Assistant National Director for Mental Health, 2012

[28] The Budget for the Dublin South City Integrated Service Area includes the budget for the Cluain Mhuire and Lucena Mental Health Services delivered in the South Dublin-Wicklow Integrated Service Area for reporting reasons.

A decline in the total budget is observed among the SCAs from 2010 to 2011. The budget decreased by approximately 4%, from €736.7 million in 2010 to €708.1 million in 2011.

Table 10: The variation in Budget and Budget per capita 2010/2011

Super Catchment Area	% Variation Budget per capita 2010/2011
WEST HSE Region	
1. Limerick, North Tipperary, Clare	-2.6%
2. Donegal, Sligo, Leitrim, West Cavan	-6.4%
3. Galway, Mayo, Roscommon	-2.1%
SOUTH HSE Region	
4. North Lee, North Cork	-0.6%
5. South Lee, West Cork, Kerry	-13%
6. Wexford, Waterford	-5.3%
7. Carlow, Kilkenny, South Tipperary	-7.1%
Dublin Mid-Leinster HSE Region	
8. North Dublin	-2.1%
9. Louth, Meath, Cavan, Monaghan	-6.2%
10. North WestDublin, Dublin North Central	-2.7%
Dub North East HSE Region	
11. Dun Laoghaire, Dublin South East and Wicklow	+1.7%
12. Dublin West, Dublin South West, Dublin South City	+38%
13. Laois, Offaly, Longford, Westmeath, Kildare, West Wicklow	-1.2%
National provided in Dublin Mid-Leinster HSE Region	
14. Forensic National	-3.1%

Source: HSE, Assistant National Director for Mental Health, 2012

It is important to bear in mind that variations in changes in budget will, to some extent, be due to reconfiguration of the services among the SCAs. The SCAs mental health budgets include all aspects of secondary mental health care including acute community services (Community Mental Health Teams, Child and Adolescent Mental Health services Teams, OPD clinics); low/medium/high support community units; acute inpatient units; continuing care units; supported residential services; specialist mental health services for older persons; most mental health liaisons services and special care or exceptional provision for treatment overseas. Routine maintenance of the infrastructure is

also included in the SCAs budget data. Budgets include pay and non-pay costs as well as grants to NGO partners in mental health. Medications associated with the care are included, while Primary Care Reimbursement Service medications for community based patients and medications in primary care interventions are not included.

As previously mentioned, a key objective in all the mental health policies and reforms as in AVFC for Ireland is the shift of services from residential settings to community settings. Deinstitutionalisation reveals a consistent pattern across states and over time of better outcomes. Evidence suggests good community services cost less than hospital care or at least no more. In three studies involving costs and outcomes (Jones et al., 1984; Knobbe et al., 1995; Stancliffe and Lakin 1998; 2005), costs of community services ranged from 5% to 27% less than institutional services. Another detailed study[29] focusing on people with mental health problems discharged between 1990 and 1992 in England showed that on average, community care was less costly than hospital care. The following table (Table 11) compares the weekly hospital and community costs for people with mental health problems.

Table 11: A comparison of the weekly hospital and community costs for people with mental health problems *(services are anonymised and represented by the letters A to F)*

Year 1990-1992	A	B	C	D	E	F	All
Hospital Cost	£ 378	£ 363	£ 372	£ 447	£ 329	£ 502	£ 419
Community Cost	£ 180	£ 206	£ 303	£ 244	£ 178	£ 226	£ 225

Source: Michael Donnelly et al., *Opening New Doors, An evaluation of community care for people discharged from psychiatric and mental handicap hospitals*, HMSO, 1994

The average cost for each of the six hospitals was greater than the costs for community care; on average hospital costs were 42.8% higher. In two cases (A and F), the cost of hospital care was more than twice the cost of the community care. The study showed considerable variation in the individual costs of community care. Approximately 80% of the total cost of care in community services was accounted for by the accommodation costs, while the contribution to the cost from commonly used support services, such as general practitioners, social workers and community psychiatric nurses, was comparatively small.

A detailed analysis of the quality of the accommodation and client outcomes was also undertaken. The physical quality and social regimes of community accommodation emerged as less institutional and more pleasant than the hospitals. Although comparisons

[29] Michael Donnelly et al., *Opening New Doors, An evaluation of community care for people discharged from psychiatric and mental handicap hospitals*, HMSO, 1994

of client outcomes between different community accommodation revealed significant differences, those interviewed reported an increase in satisfaction with their living environment in the community.

Similarly, in the Irish context, the recent "Value for Money"[30] study suggests that community based services result in better outcomes and greater satisfaction for patients and families than inpatient oriented care. The study also provides evidence that the total cost to run community based services is not higher than the total cost of providing more traditional models of inpatient oriented care. A major goal for Ireland, as described in AVFC, has been to progress the agenda for psychiatric de-institutionalisation by closing aging and inefficient psychiatric hospitals. Historically, significant progress has been made in this regard, moving from a total inpatient census in 1963 of 19,801 to 12,484 persons resident in 1984 (Table 12). There has been a further 17% reduction in the number of patients resident since AVFC was launched: from 3,389 inpatients in 2006, rate of 80 per 100,000 total population to 2,812 inpatients in March 2010 representing a hospitalisation rate of 66.3 per 100,000 total population.[31]

Table 12: Trend of the Irish psychiatric Inpatient numbers

Year	No. of Psychiatric Inpatients in Ireland
1963	19,801
1970	16,403
1977	14,352
1984	12,484
1991	8,207
1998	4,820
2005	3,475
2006	3,389
2007	3,314
2010	2,812

Source: adapted from HRB Statistics Series 15 Activities of Irish Psychiatric Units and Hospitals 2010

[30] P. Gibbons et al., Value for Money, A comparison of cost and quality in two models of Adult Mental Health Service provision, AVCF and HSE, 2012

[31] HRB Statistics Series 15 Activities of Irish Psychiatric Units and Hospitals 2010

Likewise, there is a downward trend in the number of admissions to psychiatric units and hospitals as shown in Table 13. Since the launch of AVFC in 2006 there has been a sharp decrease in these figures. The HRB reported 18,992 admissions to Irish psychiatric units and hospitals in 2011, a rate of 413.9 per 100,000 population. This is a reduction of 627 admissions from 2010 and a decline in rates from 462.7 in 2010 to 413.9.

Table 13: Trend of Admissions to Irish psychiatric units and hospitals

Year	Admissions to Irish psychiatric units and hospitals	Rate per 100,000 pop.
1965	15,440	535.0
1970	20,342	705.0
1980	27,098	804.4
1990	27,765	784.2
2000	24,282	669.6
2005	21,253	542.6
2006	20,288	478.5
2007	20,769	489.9
2008	20,752	489.5
2009	20,195	476.3
2010	19,619	462.7
2011	18,992	413.9

Source: adapted from HRB Statistics Series 15 Activities of Irish Psychiatric Units and Hospitals 2010 and 2011

Table 14 shows total admissions to psychiatric units and hospitals, further broken down into first and re-admissions, focusing on the years following the launch of AVFC.

Table 14: Trend of total admissions, first admissions and re-admissions to Irish psychiatric units and hospitals

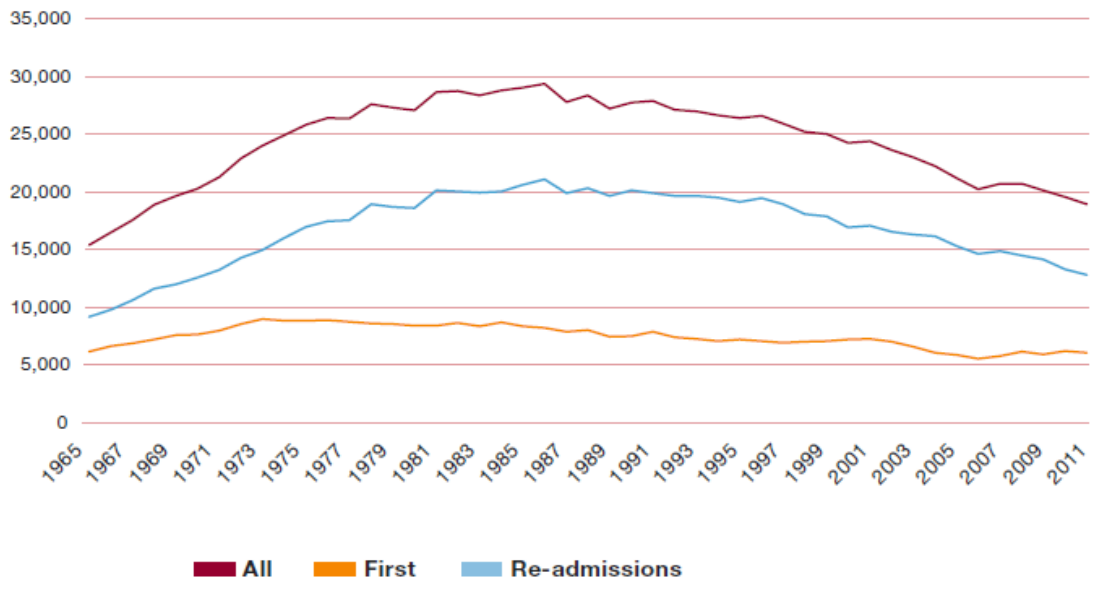
Admissions to Irish psychiatric units and hospitals	2007	2008	2009	2010	2011	% 2007/2011
Total admissions	20,769	20,752	20,195	19,619	18,992	-8.5%
First admissions	5,853	6,194	5,972	6,266	6,129	+4.7%
Re-admissions	14,916	14,558	14,223	13,353	12,863	-13.7%

Source: adapted from HRB Statistics Series 15 Activities of Irish Psychiatric Units and Hospitals 2010 and 2011

The number of the total admissions to Irish psychiatric units and hospitals decreased by 9.4% between 2007 and 2011. While the number of first admissions increased by 4.5% during this period, there was a reduction from 6,266 in 2010 to 6,129 in 2011.
Re-admissions decreased by 16% between 2007 and 2011.

Figure 6 below shows trends in these three variables over a significantly wider timescale (1965-2009).

Figure 6: Total admissions, first and re-admissions to Irish psychiatric units and hospitals 1965-2011



Source: HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2010 and 2011

Admission numbers have been steadily declining since reaching a peak of 29,392 in 1986. Looking at the ten-year period from 2002–2011, re-admissions have shown a constant decline, with a sharp decrease in the last few years (-10.6% from 2009 to 2011). This may suggest that the patients who left hospital had recovered or alternatively were successfully treated in a community service and they did not require readmission to the hospital. In the case of first admissions, although the pattern has remained relatively unchanged and stable over the last 40 years, there was a 13% decline between 2002–2011.

Analysing the geographical distribution, table 15 shows all admissions and first admission are evenly spread across the HSE regions.

Table 15: All and first admissions in Health Service Executive Areas, 2011

HSE Regions	Population (based on 2011 Census)	All admissions	%	First admissions	%
Dub Mid-Leinster	1,351,555	5,383	28%	1,695	28%
Dub North-East	1,018,535	4,035	21%	1,454	24%
South	1,133,858	5,029	27%	1,657	27%
West	1,084,304	4,496	24%	1,291	21%
Non resident	N/A	49	0.2%	32	0.5%
Total	4,588,252	18,992	100%	6,129	100%

Source: adapted from HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2010 and 2011

A gender analysis shows that although there was an equal proportion of total male admissions (50.5%) and total female admissions (49.5%) in 2011, males had a higher rate both all and first admissions. Table 16 shows the figures for male and females.

Table 16: Gender of all and first admissions in to Irish psychiatric units and hospitals in 2011. Numbers and rates per 100,000 total population

2011	Numbers		Rates	
100,000 total population	**All admissions**	**First admissions**	**All admissions**	**First admissions**
Male	9,583	3,281	421.7	144.4
Female	9,409	2,848	406.3	123.0

Source: adapted from HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2010 and 2011

In 2011, depressive disorders were the most common cause of all admissions, accounting for almost 30% of all and 31% of first admissions. Schizophrenia accounted for 20% of all and 12% of first admissions.

For admissions of those under 18 to psychiatric units and hospitals, Table 17 shows an increase of 15.6% between 2009 and 2011.

Table 17: Admission for patients under 18 years old to Irish psychiatric units and hospitals

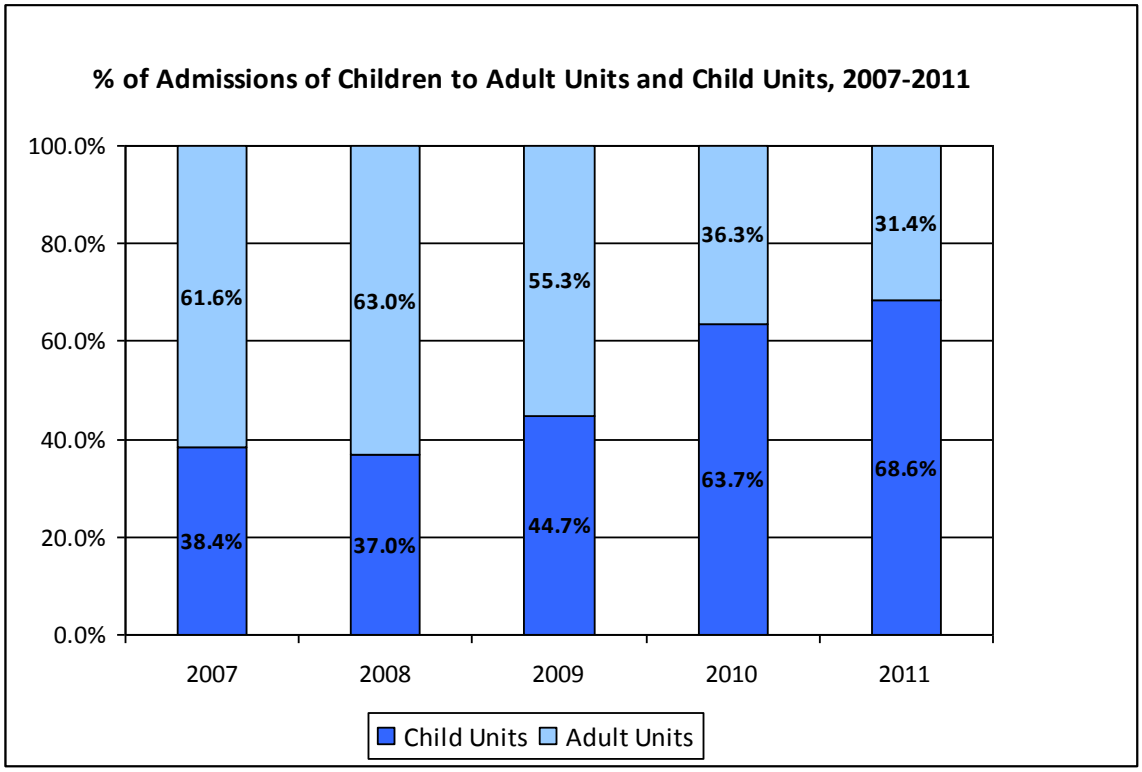
Admissions to Irish psychiatric units and hospitals	2009	2010	2011	% 2009/2011
Admissions under 18 y.	367	435 (272 dedicated to Child &Adolescent services)	435 (303 dedicated to Child &Adolescent services)	+ 18.53%

Source: adapted from HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2010 and 2011

HRB (2011) suggests that the increased number of admissions for patients under18, reflects increased capacity in the Child and Adolescent services for inpatient admission. Figure 7 shows that in 2011 a higher proportion (almost 70%) of these patients were admitted to dedicated Child and Adolescent services while in 2010 the corresponding percentage was lower.

The Mental Health Commission also acknowledges there has been investment in child and adolescent in-patient facilities in recent years. While in 2008 there were only three Child and Adolescent units nationally, with a combined bed capacity of 28 beds, in 2011 there were six Child and Adolescent units, with a combined bed capacity of 70. This trend is reflected in Figure 7 which shows that between 2007 and 2009 the majority of child admissions were to adult units, however, in 2010 and 2011 there was a marked decrease in the percentage of child admissions to adult units.

Figure 7: Trend in the Admissions of Children to Adult Units and Child Units



Source: adapted from Mental Health Commission Annual Report 2011

HRB data (2012) reported 1,806 involuntary admissions out of 18,992 total admissions in 2011.This represents a drop of two percentage points in the proportion of involuntary admissions from 12% of total admissions in 2002 to almost 10% in 2011. According to the Department of Health, an 8% reduction in involuntary admissions occurred between 2007 and 2010 because of the availability of community care. The reduction was also attributed to the full establishment of Mental Health Tribunals under the Mental Health Act, 2001.

The Mental Health Commission holds a database of involuntary admissions in Ireland from the commencement of the Mental Health Act (2001) in 2006. When interpreting the figure it is important to remember that there are a number of patients with multiple involuntary admissions. The Mental Health Commission indicates that a number of patients (n=171) have had multiple involuntary admissions, the majority of them having three or more involuntary episodes in one year.[32] While the number of adult involuntary admissions has reduced by 45% from 2,830 in 2005 to 1,952 in 2010, the number of children involuntary admissions has increased in recent years: Table 18 shows an increase of 61% from 13 in 2010 to 21 in 2011.

[32] Annual Report 2011, Mental Health Commission

Table 18: Trend in involuntary admissions of children and adolescents in Adults Units and Child and Adolescent Units

Year	Adult Units	Child and Adolescent Units	Total
2007	3	/	3
2008	6	2	8
2009	6	3	9
2010	2	11	13
2011	9	12	21

Source: adapted from Mental Health Commission Annual Report 2011

Geographically, the highest rates for involuntary all admissions were for admissions resident in HSE South (Table 19). The admission rate was 49.12 per 100,000 population. HSE Dub Mid-Leinster region has the lowest rate with 28.19 rate per 100,000 population.

Involuntary admissions accounted for 13% of all admissions to public psychiatric hospitals, 11% of admissions to public general hospital psychiatric units and 1.5% of admissions to the private sector.

Table 19: Distribution of 2011 Involuntary admissions in the HSE Regions

HSE Regions	Population (based on 2011 Census)	Total Involuntary Admissions 2011 (Adult)	Involuntary Admission Rate per 100,000 population
Dub Mid-Leinster	1,351,555	381	28.19
Dub North-East	1,018,535	449	44.08
South	1,133,858	557	49.12
West	1,084,304	509	46.94
Private sector	N/A	161	N/A
Total (Exclusive of Private s.)	4,588,252	1,896	41.32
Total (Inclusive of Private s.)	4,588,252	2,057	44.83

Source: adapted from Mental Health Commission Annual Report 2011 and HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2011

While it is perhaps too early to define a trend for involuntary admissions in Ireland, differing trends have been identified in the six European countries included in the study previously discussed (BMJ, 2005).Involuntary admissions between 1990-1 and 2002-3 have risen in England, the Netherlands, and, particularly in Germany. In the same period they have fallen slightly in Italy, Spain, and Sweden.

The variation between the countries may be explained by the differences in the time periods, the context, mental health reforms or phase of implementation. The Mental Health Act 2001 provides a more modern legislative framework for the admission, detention and treatment of individuals with a mental disorder in compliance with international standards and obligations. While the Mental Health Act is currently under review, it established the Mental Health Commission and put in place mechanisms by which the standards, care and treatment in mental health services can be monitored, inspected and regulated.

One of the most significant changes brought about by the 2001 Act is the establishment of independent Mental Health Tribunals. These review and affirm or revoke detention orders and patients have the right to be heard and to be legally represented at the Tribunal. While the number of tribunal hearings in the independent Mental Health Tribunals has decreased in the last few years, (from 2,096 tribunal hearings in 2008, to 1,882 in 2009 and 1,296 up to September 2010) the general prison population has grown considerably.

Data for committals and persons registered by the Irish Prison Service are reported in Table 20. A similar situation to Ireland was identified in the six European countries study (BMJ, 2005) which found that the general prison population had grown in all countries by between 16% and 104% between 1990-1 and 2002-3.

Table 20: Trend of the committals and persons 2001/2011 in Ireland

Year	Committals		Persons	
2001	12,127		9,539	
2003	11,775	**Var. 2001-2005 -12.1%**	9,814	**Var. 2001-2005 -8.9%**
2005	10,658		8,686	
2006	12,157		9,700	
2007	11,934	**Var. 2006-2011 +42.5%**	9,711	**Var. 2006-2011 +43.8%**
2009	15,425		12,339	
2011	17,318		13,952	

Source: adapted from the Irish Prison Service, Annual Report 2011

Brendan Kelly (2007) studied data from the annual census of psychiatric inpatients and prison statistics in Ireland.[33] He found that between 1963 and 2003 the number of individuals in Irish psychiatric units and hospitals decreased from 19,801 to 3,658 - an 81.5% fall.

During the same period, the daily average number of prisoners in Irish prisons increased from 534 to 3,176, an increase of 494.8%.While the absolute decline in psychiatric

[33]Mental Health in the Criminal Justice System - The deliverables of the Governments 'Vision for Change', Association for Criminal Justice Research & Development, Fourteenth Annual Conference, October 2011

inpatients (a decrease of 16,143 individuals) greatly exceeded the increase in prisoners (increase of 2,642 individuals in prisons), a statistically significant inverse correlation between the number of individuals in Irish psychiatric units and hospitals and the daily average number of prisoners in Irish prisons was found.This is in keeping with Penrose's Law which states that as the number of psychiatric inpatients declines, the number of prisoners increases.[34]

Brendan Kelly's study (2007) examined variables at group rather than individual level. Therefore it is not known whether the individuals who leave psychiatric hospitals are the same individuals who are subsequently imprisoned. There is, however, strong evidence of a high prevalence of mental illness in prisons: Kelly's study recorded data from a systematic review of 62 studies from 12 countries. It found that 3.7% of male prisoners and 4% of female prisoners had psychosis, while 10% of male prisoners and 12% of female prisoners had major depression. In Ireland, according to the Kelly study, the six-month prevalence of psychosis in male prisoners serving a life sentence is 7.1%.

While a direct link between mental health problems and the prison population can clearly not be made, the data in Table 20 indicates a decreasing trend in the prison population up until 2005; however, the trend reverses with a significant increase in the prison population after 2006, when the mental health policy was launched. The inpatient population of public psychiatric hospitals had been falling continuously for almost 50 years (Walsh and Daly, 2004). This suggests that the use of institutional confinement bears as little relationship to rates of mental illness as imprisonment rates bear to levels of crime. It is of note that as of 2002 the public psychiatric hospital population, including voluntary patients, was still higher than the prison population (3,384 vs. 3,165).

Mental health services are provided in many settings including acute inpatient facilities, day hospitals, day care centres, low support and high support community accommodation. In January 2011, the HSE reported 66 centres registered as approved centres for the admission and treatment of acutely ill patients under the Mental Health Act and approximately 800 other centres providing community based services.[35] Unfortunately, data are not currently routinely collected at the national level, as a database, which incorporates for example, information on the community service residents and admissions. Therefore, it is not possible to identify whether the decrease in hospital admissions has been offset by an increase in admissions in community services.

Although progress has been made in Ireland with the de-institutionalisation of old institutions and the establishment of more community services, the balance of expenditure between long stay and community services has remained unchanged between 2008 and 2012.

[34]Hartvig P, Kjelsberg E (2009), Penrose's law revisited: the relationship between mental institution beds, prison population and crime rate, *Nordic Journal of Psychiatry*;63(1):51-6
[35]HSE, Assistant National Director for Mental Health, 2012

Table 21: Mental Health current expenditure 2008/2012

Mental Health Current Exp.	Long Stay Residents	Community Services	Psychiatry of later life	Counselling services	Other services	Total
Outturn 2008	606,614	285,549	10,124	20,248	121,281	1,043,816
Outturn 2009	585,085	275,327	9,765	19,529	116,976	1,006,682
Outturn 2010	559,885	263,469	9,344	18,688	111,938	963,324
Provisional Outturn 2011	413,364	195,294	6,899	13,798	82,645	712,000
Estimated Expenditure 2012	410,463	193,922	6,850	13,701	82,064	707,000

Source: Department of Finance, Revised Estimates Volumes 2011 and 2012

More detailed numerical break-down or explanation has not been provided about the specific composition of each category. Assuming "Long Stay Residents" represents the hospital component, Table 21 shows it remains the highest expenditure component; and Table 22 shows that the proportionate balance of expenditure between categories has remained static.

Table 22: Percentages of the Mental Health current expenditure (components) 2008/2012

Mental Health Current Exp.	Long Stay Res.	Community Services	Psychiatry of later life	Counselling services	Other services
Outturn 2008	58.1%	27.3%	1%	1.9%	11.6%
Outturn 2009	58.1%	27.3%	1%	1.9%	11.6%
Outturn 2010	58.1%	27.3%	1%	1.9%	11.6%
Provisional Outturn 2011	58.1%	27.4%	1%	1.9%	11.6%
Estimated Expenditure 2012	58.1%	27.4%	1%	1.9%	11.6%

The percentage of the long-stay patients out of the total number of hospital inpatients has been slightly decreasing in the last ten years. Data from the Irish psychiatric units and hospital census (HRB) shows that in 2002 55% of patients in hospital were long-stay, with more than one third of these being old long-stay which means having been continuously hospitalised for over five years. In 2006 46% of patients were long-stay and 29% were old long-stay. In 2010 42% of patients in hospital were long stay and 25% were old long-stay.

Regarding the three above mentioned surveys, most of the long-stay patients were aged over 65.

Further data comes from the report entitled "Value for money of efficiency and effectiveness of long-stay residential care for adults within the mental health services" (HSE, 2008). The data suggest that in 2008 59% of long stay residential beds were in the community, accounting for 46.23% of total expenditure on long stay residential care.

While there has been a significant investment in infrastructure through capital projects in the intervening years, the re-orientation of services continues to face the challenges of depleting annual budgets and a dwindling human resource base. A more specific look at staff resourcing within the mental health sector shows a similar imbalance between the community and hospital settings.

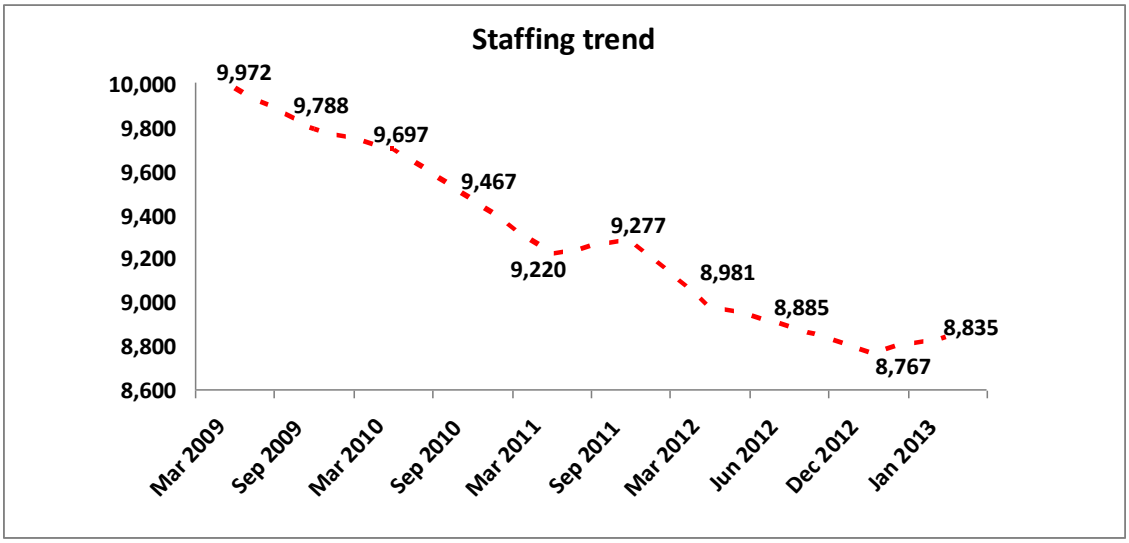
The Irish community-based mental health service recommended by AVFC is coordinated and delivered through multidisciplinary teams: the Community Mental Health Teams (CMHTs). AVFC states that the needs of different groups of service users should determine the precise mix of skills required within their local CMHT and that the precise number of mental health professionals in each of these categories may vary according to the particular requirements of the sector population[36]. Teams should have access to input from psychiatry, nursing, social work, clinical psychology, occupational therapy, and clinicians with specific expertise. Adequate administrative support staffing is also essential.

As mentioned previously, the cumulative impact of staff loss within mental health services continues to challenge the provision of the required mental health services through multidisciplinary teams. Staff levels have constantly reduced since the peak employment levels in 2007, the following figure shows a decreasing staffing trend from March 2009 to June 2012 which means that the gap has increased between current staffing levels and those recommended in the AVFC.

The recommended staffing level in AVFC was 11,530, before taking account of general support staff. The current figures suggest that the mental health staffing level is now approximately 23% below the level recommended by AVFC.

[36] *A Vision for Change, Report of the Expert group on mental health policy*, Government of Ireland, 2006

Figure 8: WTE Mental Health Staff trend in Ireland Mar 2009/Jan 2013



Source: HSE, Employment Reports 2009-2013

Figure 8 shows that between March 2009 and January 2013 there has been a total reduction of more than 11% in the WTE mental health staff.

The IMG highlights in its sixth annual report that the existing community mental health teams are poorly populated with an estimated 1,500 - 1,800 vacant posts. In addition, the IMG notes that staffing of the 56 existing teams is only at 63.8% of the recommended level. IMG acknowledges the positive contribution that came from the 2010 Employment Control Framework for the health service. It provided an exemption from the moratorium and allowed for the filling of 100 psychiatric nursing posts. In addition to that, 90 psychiatric nursing posts were reconfigured within the HSE and targeted towards priority areas.

The recently agreed 2011 Employment Control Framework also provides an exemption from the moratorium in respect of 100 psychiatric nursing posts where they are required to support the implementation of AVFC. Despite exemptions to the recruitment moratorium for some types of staff, it appears that the number of new staff is falling far short of the number of staff losses. In 2009/10 mental health services lost 1,000 posts with almost 600 nurses having retired in 2009 alone and only 54 nurses were recruited from 2010 to March 2011.

The IMG's sixth annual report claims that despite the HSE's supposed ability to hire staff for key posts (notwithstanding the moratorium), the environment of cuts within the HSE has meant that these replacement posts have not materialised to anywhere near the extent of the losses. However, it is not expected that this will deliver a reduction in the overall number of WTEs rather, an increase in WTEs might be expected depending on the use of ring-fenced funding of €35m which could include measures involving staff.

Table 23: WTE Mental Health Staff by HSE Regions 2009/2012

Mental Health Staff, HSE Regions	Actual WTE Mar 2009	Actual WTE Dec 2011	Actual WTE Jun 2012	Change Mar 2009 to Jun 2012	% Change Mar 2009 to Jun 2012
Dublin Mid-Leinster	1,984	2,116	2,081	+96	+4.86%
Dublin North-East	1,998	1,808	1,786	-212	-10.62%
South	2,832	2,512	2,453	-380	-13.41%
West	3,157	2,672	2,565	-592	-18.75%
Total	9,972	9,107	8,885	-1,087	-10.90%

Source: HSE, Assistant National Director for Mental Health, 2012

When the total figure for community and hospital staff is considered, the number of hospital staff is still predominant. At the national level only 22.6% of the total WTE is dedicated to community services while almost 73% of the WTE is allocated to hospitals (Table 24).

Table 24: WTE Mental health Staff 2012 in community services and hospitals

Mental Health Staff, HSE Regions	Total WTE Jun 2012	Community WTE Jun 2012	Community WTE as % of the total	Hospitals WTE Jun 2012	Hospitals WTE as % of the total
Dub Mid-Leinster	2,081	683	32.8%	1,291	62%
Dub North-East	1,786	601	33.7%	1,148	64.2%
South	2,453	164	6.7%	2,185	89%
West	2,565	558	21.8%	1,846	71.9%
Total	8,885	2,006	22.6%	6,470	72.8%

Source: HSE, Assistant National Director for Mental Health, 2012

Training for mental health staff in Ireland is mentioned in several reports but data at the national level are not provided and no national workforce strategy has been developed as

was recommended in Chapter 18 of AVFC. An example of a training initiative is the guidance compiled by the National Vision for Change Working Group[37]. This was intended to provide direction for all mental health services in establishing the role of team co-ordinator on Community Mental Health Teams as outlined in the national mental health policy AVFC.

Ireland has had a long tradition of providing private inpatient care for psychiatric patients, before any significant initiative in the public sector. In 1959 there were 12 private mental hospitals with 1,019 residents. These accounted for 5% of all residents in the country's mental hospitals. By 2010 private residents had fallen by half to 551 but due to the sharper fall in the number in public hospitals, these now accounted for 20% of psychiatric residents. There was a reduction of 46% in private inpatients between 1959 and 2010 compared to a decline of 87% in public inpatients over the same time.

In 2011 there were 69 inpatient centres for people with mental disorders approved under the Mental Health Act 2001. "The Register of Approved Centres" (Mental Health Act 2001) provides a three-year registration, so the number of approved centres is constantly changing. A number of new approved centres opened in 2011, while some also closed.[38]

Table 25 shows a breakdown of each hospital type for 2011.
In 2011 there were 7 private centres.

Table 25: Number of hospitals by hospital type

Hospital type	Number
General hospital psychiatric units	22
Psychiatric hospitals	31
Independent/private and private charitable centres	7
Child and adolescent units	6
Central Mental Hospital	1
Carraig Mór, Cork	1
St Joseph's Intellectual Disability Service	1
Total	69

Source: HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2011

[37] *Advancing Community Mental Health Services In Ireland*, AVFC and HSE, 2012
[38] Approved centres opened during 2011: O'Casey Wing, St Vincent's Hospital, Fairview; Hawthorn Unit, ConnollyHospital, Blanchardstown, Dublin; JoyceRooms, Fairview Community Unit, Fairview, Dublin. Approved centres closed during 2011: St Loman's Hospital, Dublin; Palmerstown View, StewartsHospital; The Haven Children's Residential Unit, Co Meath; Orchard Grove, Ennis; St Dympna's Hospital, Carlow.

Currently, the largest category of private sector patients is those who pay for private insurance. Generally health insurance entitles members to 180 days of inpatient care for mental illness per year and 91 days over five years in the case of addiction. According to the HRB data, addiction and depression appear to be the most common reasons for admission in private mental hospitals.

Data from the Irish Psychiatric Units and Hospitals 2011 (HRB) shows that percentage admissions for alcohol related illness in the private sector were almost double those of the public sector at 13% against 7%. Over one-third of all admissions to private centres had a primary diagnosis of depressive disorder. The comparable figure for general hospital psychiatric units was 29%, while that for psychiatric hospitals was 24%. Table 26 shows the percentage of admissions for various diagnoses in the different services.

Table 26: Percentage of total admissions for some diagnoses in different type of hospitals

Diagnosis/Type of Admission 2011	% of Total Admissions in Private Hospitals	% of Total Admissions in Public Hospital Psychiatric Units	% of Total Admissions in Public Psychiatric Hospitals
Alcohol addiction	13%	7%	7%
Depression	36%	29%	24%
Schizophrenia	7%	23%	26%
Involuntary admissions	1.5%	11%	13%

Source: adapted from HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2011

It is evident that the public and private services deal with different patients. The public sector deals with more challenging individuals: according to HRB data (2011) involuntary admissions accounted for 13% of all admissions to psychiatric hospitals and 11% of admissions to general hospital psychiatric units. However, involuntary admissions were only 1.5% of total admissions to private centres. Just 7% of all admissions to private centres had a diagnosis of schizophrenia compared with 23% to general hospital psychiatric units and 26% to psychiatric hospitals.

Taking the ten-year period 2002–2011, HRB (2011) data shows that while admissions to general hospital psychiatric units increased from 41% to 55% and admissions to psychiatric hospitals decreased from 41% to 23%, admissions to private centres increased from 18% to 22%. While it is clear that the private sector plays a significant role in the provision of mental health services, particularly with respect to inpatient activity, it is difficult to assess whether patients in these facilities are receiving the most appropriate care for their circumstances.

One of the major criticisms of the Irish system, as noted by Dr Dermot Walsh[39] is that Irish private psychiatric services are mostly inpatient based and are largely centralised in Dublin and the eastern periphery of the country and that community services are not comprehensively provided to patients. AVFC on the contrary aims to deliver comprehensive specialised services with emphasis on community care. The two services cannot easily be merged but the private sector could potentially contribute to the implementation of mental health reform. These two services must work together to develop a system that leads to improved outcomes, ensures faster access and increases efficiency. Partnerships in mental health care, particularly between public and private psychiatric services, are being increasingly recognised as important for the efficient organisation of services. However, public and private mental health services do not

[39] Private practice and the public good, Irish Medical Times, September 30, 2011

always work well together due to differences in financial incentives, treatment approaches, communication difficulties, lack of clarity regarding roles and responsibilities and varying perceptions of each other's expertise.

An innovative example comes from The Public and Private Partnership in Mental Health Project, a project founded by the Commonwealth Department of Health and Aged Care in 1999.[40] The aim was to improve collaboration between private psychiatrists, the public mental health sector and general practitioners. In particular, private psychiatrists provided supervision and training for GPs. Among the most significant findings of the project was the degree of cultural change required to impact on the complex service system. This is an interesting example since expanding the role of the GPs is also among AVFC targets.

The mental health service system is made up of a number of key provider groups. Integration and collaboration between all of them is required to optimise the service and to allow consumers to be able to access the right service type at the right time and with the right coordination between service providers.

Within the health sector, public-private partnerships (PPP) are the subject of intense debate as they bring together a variety of players with different and sometimes conflicting interests and objectives. They also work within different governance structures. True partnership is about combining different resources, skills and expertise, ideally in a framework of defined responsibilities, roles, accountability and transparency, to achieve a common goal that might be unattainable by independent action.

PPPs have a number of recognised benefits. They can enhance government's capacity to develop integrated solutions, facilitate creative and innovative approaches and reduce the cost and/or time to implement a project. These are all important for the implementation of mental health reform. It might be helpful to recognise the slow progress in AVFC implementation; and to reflect on what has to be done in order to reach AVFC goals. This might provide an opportunity to think about the feasibility and possible advantages of integrating private and public sectors.

Further insights could be gained if it was possible to update the above data. Statistics from EU countries, figures on numbers of psychiatric beds, numbers of psychiatrists, and nurses per 100,000 population would all help. However, while data on Irish psychiatric units and hospitals are routinely collected, the corresponding information for community services is not available at the national level. The Mental Health Commission regularly publishes reports on individual mental health facilities but these do not allow conclusions to be drawn at a national level.

[40]Department of Health and Aged Care.Planning Guidelines for National Demonstration Projects in Integrated Mental Health Care.Commonwealth of Australia, Canberra, 1999.

Sources of Information and References

In undertaking the analysis, several sources of data and information have been employed. These included:

Department of Health and Children	'A Vision for Change' (2006), Report of the Expert Group on Mental Health Policy - Annual Output Statements
Health Service Executive	- National Service Plans: - Annual Reports - National Service Plans - Performance Monitoring Reports (monthly) - Capital Plans (2011-2016) - 'A Vision for change' Survey Results (Jan. 2011) - 'A Vision for Change' Implementation Plan 2009-2013
Dep. of Finance	- Revised Estimate Volume
Mental Health Commission	- Annual Reports - Inspection Reports - 'From Vision to Action', an analysis of the implementation of 'A Vision for Change' (2009)
Health Information and Quality Authority	- Guidance on Developing Key Performance Indicators and Minimum Data Sets to Monitor Healthcare Quality (2010)
Health Research Board	- HRB Statistics, Activities of Irish Psychiatric Units and Hospitals 2010 and 2011
Independent Monitoring Group	- Sixth Annual Report on implementation 2011 - Fifth Annual Report on implementation 2010 - Fourth Annual Report on implementation 2009
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