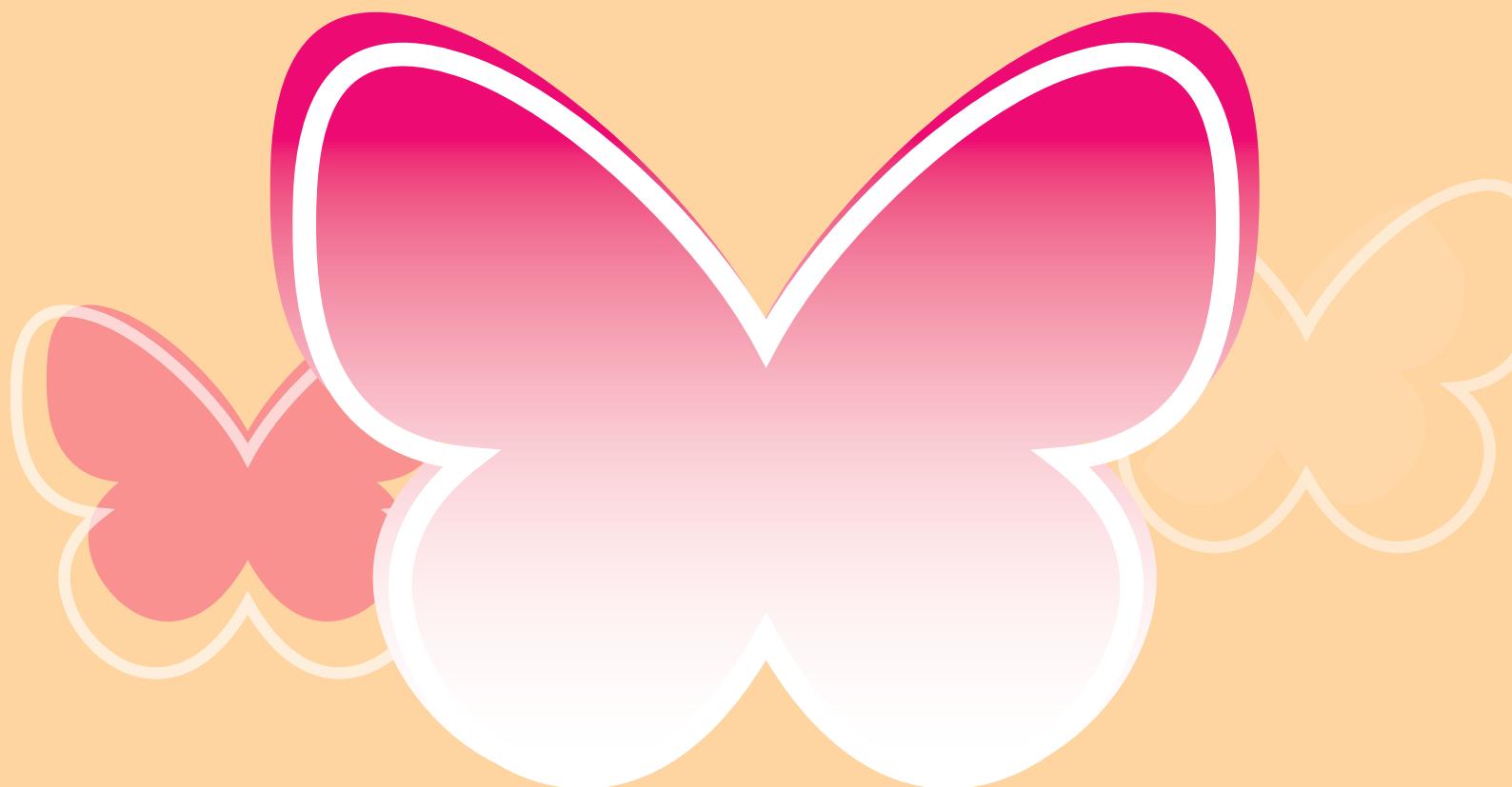


A VISION FOR CHANGE NINE YEARS ON:

A coalition analysis of progress



Mental Health Reform
Promoting Improved Mental Health Services

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In this report on the implementation of the government mental health policy *A Vision for Change* (AVFC), Mental Health Reform gives a summary assessment of progress under each chapter heading. Overall progress is indicated using a butterfly symbol, widely used as the symbol for *A Vision for Change*. A blank white butterfly indicates that no progress has been made, while a fully pink butterfly indicates that the AVFC recommendations for that chapter have been fully implemented.



Introduction

Nine years on from publication of our national mental health policy is a good time to take stock, to step back and see how far our mental health system has journeyed down the road to that vision set down in 2006.

When *A Vision for Change* (AVFC) was published it had widespread support across the political spectrum and among people who use mental health services, their family supporters and professionals delivering services. Mental Health Reform (MHR) was established at that time as a coalition to try to sustain that consensus and make visible the public interest in better mental health services. Our coalition has grown from five to fifty-one member organisations and over 10,000 individual supporters.

This report seeks to provide our coalition assessment of how much of the vision in the national mental health policy has been fulfilled. The report was produced using evidence gathered from the Department of Health and other Government Departments, the HSE and other public agencies, published and unpublished research reports, our members' and advisory groups' feedback and the views of people who use mental health services and their family supporters as received in our public consultations. The report also draws on the results of a small-scale survey of 7 consumer panels.

Thank you to everyone who provided information and feedback for the report. We would also like to thank all of the staff in the HSE and other public agencies and the Department of Health and other Government Departments who continue to strive to make *A Vision for Change* a reality.

Chapter 1: Service user and family supporter/carer involvement

Broad outline of *A Vision for Change* recommendations

2

One of the most progressive recommendations in *A Vision for Change* is that service users and family supporters/carers should be involved in every aspect of mental health service development and delivery. Service user and family supporter/carer involvement should start at decision making at an individual level, through individual recovery/care plans (ICPs), and extend to the design, development and delivery of local services and national policy. The principle of partnership which underpins *A Vision for Change* sets out that service users, carers, those working in mental health services and the wider community should be involved in mental health service planning and delivery. *A Vision for Change* includes a number of recommendations to promote service user and family supporter/carer engagement in mental health services, including:

- Empowering service users through the development of their own individual care plans
- The provision of advocacy services (including self-advocacy supports)
- The development of peer-led services
- The involvement of service users and carers at all levels of the mental health services
- The appointment of a National Service User Executive
- The provision of information to individuals on how to make a complaint, and on the procedures to be followed

- Ongoing and timely communication of information relating to care options, medications, treatment options and therapies, legal rights and status, availability of services, training, housing, benefits and entitlements

Baseline in 2006

In the consultation for *A Vision for Change*, participants voiced “the need for service users to be viewed as **active participants** in their own recovery rather than as passive recipients of ‘expert’ care”.¹ In 2006, the Expert Group identified that in many areas across the country, individuals with mental health difficulties did not have access to advocacy supports. In areas where advocacy services did exist, there were so few that only individuals requiring inpatient treatment had access to an advocate. The Expert Group also recognised that inadequate information, or an absence of information, contributed to poor experiences for service users and carers, often exacerbating their mental health difficulties.

Progress to date

AVFC 3.1: Service users and carers should participate at all levels of the mental health system.

As recommended in *A Vision for Change*, in 2007 the National Service Users Executive (NSUE) was set up with the support of the HSE to inform the HSE and the Mental Health Commission on issues relating to user involvement and participation in the planning, delivery, evaluating and monitoring of mental health services.² However, NSUE is no longer funded by the HSE. A HSE-established Reference Group is currently developing new arrangements for service user and family supporter involvement at regional and local levels. An Interim Head of Service User Engagement was appointed to the HSE Mental Health Division Management Team in 2013.

There is no national data on the extent of family supporter involvement in individual recovery planning. Family members attending

1 *A Vision for Change*, p.13.

2 Information taken from NSUE's website www.nsue.ie/aboutus/

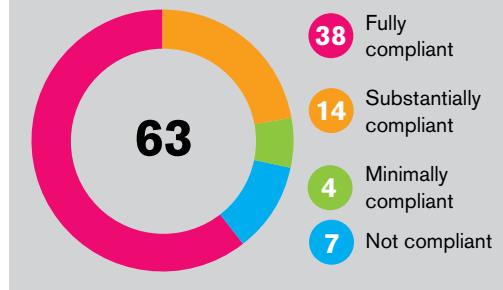
Mental Health Reform's consultative meetings in the past four years have consistently raised concerns about the barriers to their involvement in their loved one's treatment plans.

Current legislation does not provide for family supporter involvement in individual recovery/care planning.

The HSE Service User Engagement Office has reported that 8 out of 16 Area Mental Health Management Teams have a person with self-experience attending their meetings, and that all area mental health services have consumer panels or other forums in place or are in development to engage with those who use services and their families and carers.³ Mental Health Reform's survey of consumer panels showed that there is a lot of inconsistency across the country with regard to service user involvement in local area management. Furthermore, six out of seven consumer panels indicated that they believe that their group does not receive adequate funding from the HSE. Five out of seven consumer panels agreed that service users are involved as equal partners in the creation and development of their own care/recovery plans. However, four of the panels responded that family members were not given the opportunity to participate in care planning.

In December 2013, the Inspectorate of Mental Health Services sought feedback from a number of service users, carers, family representatives, consumer panels and advocacy groups across the country on service user involvement in mental health services. The Inspector concluded that despite significant service user involvement through the Kilkenny Consumer Panel, "service user involvement is very fragmented and some areas are not interested in service user views."⁴ Representatives of the group reported that "HSE levels of engagement are variable for service user involvement" and that "establishing consumer panels is challenging in some areas".⁵

1.1. Number of approved centres compliant with regulations on individual care planning in 2013



Source: Mental Health Commission Annual Report 2013.

In February 2015, Mental Health Reform's Grassroots Forum members identified some of the barriers to effective individual recovery planning, including inadequate resources to ensure the implementation of ICPs, a lack of recognition of the specific needs of individuals in the design of ICPs and a lack of communication and referral between different agencies and services to ensure that individuals have a choice in mental health supports. Members of the Forum reported that care plans are often filled out just because they have to be and there is often a lack of communication between service users and staff.

AVFC 3.2: Advocacy should be available as a right to all service users in all mental health services in all parts of the country.

There is currently no right to advocacy under the Mental Health Act, 2001, though individuals detained under the Act have the right to legal representation at a review tribunal. The statutory advocacy service envisaged in the Citizens Information Act, 2007 has not been implemented, though a non-statutory national advocacy service has been established for people with disabilities, including people with a mental health disability. The National Advocacy Service (NAS) established under the Citizen's Information Board provides an advocacy service to individuals with mental health difficulties, primarily those with complex and/or

3 Information received through correspondence with the HSE.

4 Inspectorate of Mental Health Services (2013) *National Overview Meeting: Service Users, Carers, Family Representatives, Consumer Panels and Advocacy Groups*, Dublin: Mental Health Commission, p. 5.

5 Ibid, p. 6.

severe mental health difficulties.

The Irish Advocacy Network (IAN) offers a peer advocacy service to individuals in acute inpatient units in each part of the country with the exception of Donegal. Although IAN's peer advocates can also meet with individuals in day centres, training centres, hostels and in the community, this occurs 'only where time allows'. STEER's advocacy service provides advocacy supports to individuals with mental health difficulties in the county of Donegal.

There is no national advocacy service for children under the age of 18 years.

4

AVFC 3.3: Innovative methods of involving service users and carers should be developed by local services.

There is evidence of some initiatives that have been implemented to promote service user and carer involvement, including the appointment of a peer support worker in West Cork and in Mayo, the delivery of leadership courses in DCU, the establishment of a service user-led Recovery College in Mayo, the Eolas family and service user education programmes, and the involvement of a service user in the Advancing Recovery Ireland (ARI) project at project management level.⁶ These initiatives have tended to be funded by short-term innovation funding from Genio or other local funding. The Gateway Rathmines peer-led community development project, Suicide or Survive, and Áras Folláin in Nenagh are examples of locally-generated peer initiatives. Peer-led and peer-run services have struggled to get sustainable funding from the HSE. The Irish Advocacy Network and the GROW organisation are the only two national-level peer-run services with mainstream HSE funding. Four out of the seven HSE consumer panels surveyed by MHR strongly disagreed that their local service area funds peer-led mental health services.

Findings from a report on stakeholder perspectives about ARI showed both facilitators of and barriers to service user/family supporter involvement in mental health services. The report identified difficulties in

"involving sufficient numbers of service users and family members in the recovery process, with many initiatives reliant on a small number of service users and limited family member involvement".⁷

AVFC 3.9: Information on the processes involved in making complaints or comments on mental health services should be widely available.

In 2013 the Mental Health Inspectorate reported that 86% (54 out of 63) of approved centres had a complaints procedure prominently displayed in the approved centre so that residents would be aware of how to make a complaint.

However, some service users and family supporters have told Mental Health Reform that they have difficulty making a complaint about mental health services. Of particular concern, some reported being afraid to make a complaint for fear of consequences to their future use of services.⁸

Information about how to make a complaint is published on the HSE website and on healthcomplaints.ie, and posted in all mental health service facilities.

In December 2014, the HSE appointed a confidential recipient to whom anyone can make a complaint or raise concerns about the care and treatment of any vulnerable person receiving residential care in a HSE or HSE funded facility, including individuals receiving mental health treatment in inpatient, outpatient and day centre clinics. The office of the confidential recipient has not yet received any complaints or concerns by or on behalf of individuals receiving mental health treatment.

7

Watts, M., Downes, C. and Higgins, A. (forthcoming)

Advancing Recovery in Ireland (ARI): An exploration of stakeholder perspectives: pre and post-ARI intervention", Dublin: School of Nursing and Midwifery, Trinity College Dublin.

8

Mental Health Reform's briefing paper on a complaints system details barriers to making a complaint about mental health services and is available at <http://www.mentalhealthreform.ie/mhr-position-paper-on-improving-the-complaints-system-for-the-mental-health-services/>

Summary assessment of service user and family supporter involvement

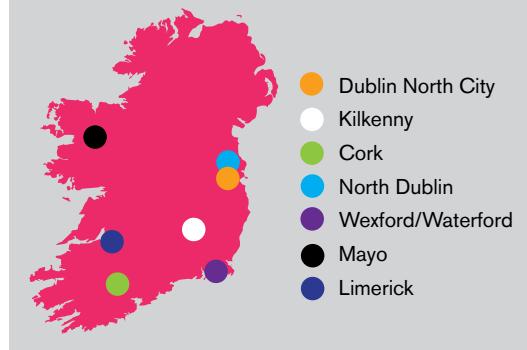


At a national level, the HSE's support for a National Service User Executive and establishment of the National Office for Service User Engagement has demonstrated a commitment to service user involvement at the highest level. Despite these developments, there are wide variations in levels of support for service user engagement in mental health services across the country, and many initiatives to involve service users have been driven by keen individuals at local level (e.g. local consumer panels). Only a handful of peer-led projects are in place across the country.

On an individual level, Mental Health Reform hears mixed reports about service user and family supporter involvement in recovery planning. It appears that some professionals are adopting a partnership approach welcomed by service users and family supporters, while others are not listening enough. Peer advocacy services are available for adults accessing inpatient mental health services across the country, however these services are unable to provide a comprehensive advocacy service in the community and there is no national advocacy service for children and adolescents under the age of 18 years.

Notwithstanding the new appointment of the confidential recipient by the HSE, there is no statutory independent complaints route for people engaged in mental health services in Ireland. This is a highly problematic situation given that mental health service users, unlike other health service users, can be involuntarily detained in health services.

1.2. Consumer panels in Ireland who gave information for this report



5

Consumer Panel Feedback in 2015

We hear from Millie in the Kilkenny Consumer Panel and other Panels across the country about their experiences of working with the HSE to improve services and to share their own personal expertise, as service users and family members.

The **Kilkenny Consumer Panel** started in September 2010, with the support of the HSE's Clinical Director for Carlow, Kilkenny and South Tipperary. Millie was volunteering with the Samaritans at the time, and heard about the Consumer Panel while at a meeting in her local hospital between statutory bodies and the voluntary sector.

Her son was in the hospital at the time and Millie has other family members who have experienced mental health services over the years. Millie's experience at that time was that the family wasn't involved, that they were ignored and not communicated with. Millie was interested in the idea of "a voice for family members and service users".

Millie joined the Consumer Panel in its first year and was Chairperson in its second year. Now, in its fourth year, the Chairperson and Deputy Chairperson are both service users, something Millie sees as hugely positive.

Millie says she has seen "fairly dramatic change" in the way mental health services interact with service users and family members since her first experiences of the services. "We were welcomed onto governance and

planning groups, right from the start. It came from the top."

Millie says that being involved with the Kilkenny Consumer Panel has been a good experience and that the Panel has had the opportunity to raise many issues with area management in the HSE over the years. However, she says that some aspects of the policy *A Vision for Change* are "aspirational and don't really happen on the ground". She cites the Consumer Panel's concerns as including the lack of an independent complaints mechanism, the overuse of medication and the lack of choice of treatments.

Members of other Consumer Panels from across the country give their perspectives:

One individual describes feeling "part of a team effort in many respects", saying that the Consumer Panel is often asked to consult on various pieces of work: "The value of the Consumer Panel is very much recognised by staff who always attend our meetings. We look forward to greater things here!"

Members of another Consumer Panel make the point that: "Consumer Panels are experts by experience and the HSE should take on board what they are saying. The HSE should be more open to having a representative from the local Consumer Panel on their area management team."

Others highlighted the need for Consumer Panels to be represented on HSE senior management teams and expressed interest in having a coordinating body for all Consumer Panels.

Finally, a member of another Consumer Panel shared their thoughts: "I believe that people with lived experience have a lot to offer services in supporting people with mental health issues but that experience is not always welcomed or appreciated in a way that is not just tokenism. However, the new Director of Mental Health seems committed to asking for lived experience to be used and I look forward to participating more on management teams and within the services for the betterment of the services."

Chapter 2: Social inclusion

Broad outline of AVFC recommendations

A landmark step in *A Vision for Change* was the inclusion of a dedicated chapter on social inclusion. Under the principles of inclusiveness and non-discrimination the Expert Group recommended that:

“Services should be inclusive of all the people in Irish society and should be delivered in a culturally appropriate way... Equal opportunities for housing, employment and full participation in society must be accorded to individuals with mental health problems.”

The Expert Group recognised that measures to prevent social exclusion (for example through the use of equality legislation) should be complemented by specific actions to ensure social inclusion such as:

- Tackling stigma and discrimination experienced by people with mental health difficulties
- Ensuring that children and adolescents remain engaged in the educational system
- Providing employment and housing supports
- The provision of culturally sensitive mental health services
- Addressing the links between poverty and mental health

Many of these measures require action on the part of Government Departments other than the Department of Health. Departments covering housing, education, social welfare and employment need to acknowledge their responsibility for implementing *A Vision for Change* and take specific actions to deliver on the policy.

Baseline in 2006

One of the strongest concerns voiced by service users and service providers during the consultation for *A Vision for Change* was the issue of stigma and discrimination for people with mental health difficulties. Service users also reported difficulties in securing housing and employment. In 2006, the National Disability Authority's public attitudes survey found that “by far the lowest level of willingness to employ people was for those that had mental health difficulties, with only 7% of respondents thinking employers would be willing to hire people with this disability”. The survey also found that the general public was least comfortable working with or living near someone with a mental health disability compared to other disabilities.⁹ Of the service users consulted in the process of the development of AVFC, 70% were dependent on welfare payments or had no income at the time, and 47% reported having a Junior Certificate qualification as their highest educational attainment.¹⁰

Progress to date

AVFC 4.1: All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.

AVFC 4.6: Evidence-based approaches to training and employment for people with mental health problems should be adopted and such programmes should be put in place by the agencies with responsibility in this area.

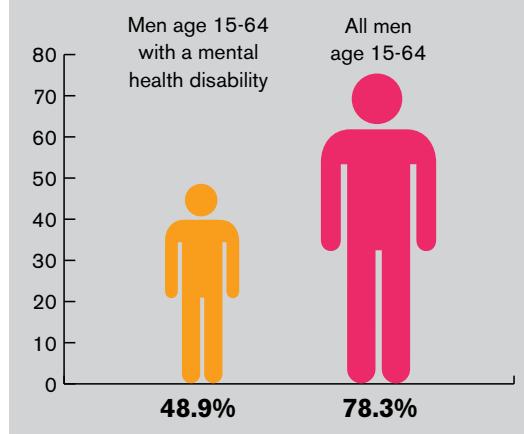
According to Census 2011 data only 43.8% of the working age population of people with a mental health disability are in the labour force compared to 61.9% of the overall population

⁹ National Disability Authority (2006) *Public Attitudes to Disability in 2006* available at <http://nda.ie/Publications/Attitudes/Public-Attitudes-to-Disability-Surveys/Public-Attitudes-to-Disability-in-Ireland-2006/Executive-Summary/Executive-Summary.html>.

¹⁰ Expert Group on Mental Health Policy (2004) *What We Heard. A Report on the Service User Consultation Process*, Dublin: Department of Health and Children.

over age 15.¹¹ People with a mental health disability are nine times more likely to be out of the labour force than those of working age without a disability, the highest rate for any disability group in Ireland.¹²

2.1. Male labour force participation in 2011



Source: Census 2011 Profile 8: Our Bill of Health - Health, Disability and Carers in Ireland

The HSE Mental Health Division and the Department of Social Protection are working with Mental Health Reform on a Genio-funded project to pilot the Individual Placement and Support (IPS) model of supported employment for people with mental health difficulties in four sites across the country. This pilot will be rolled out in 2015.

In 2012 the HSE published a review of HSE funded adult day services including those for people with a mental health difficulty. The review described wide variation in the programmes and activities provided by day services across the country, including in the use of individualised planning and quality assurance systems.¹³ In 2013 MHR carried out a study on the value of National Learning Network (NLN) rehabilitative and vocational training. The report identified the valuable role such training can have for people with mental health difficulties. Findings showed employment outcomes from

vocational training on par with international evidence, but a dearth of progression options for those not entering the labour force on completion of training.¹⁴ NLN has expressed concerns to MHR that in many communities NLN services are the only supports available to people with mental health difficulties, and that incomplete CMHTs in some areas are inhibiting an effective partnership model from developing between independent agencies and the HSE. NLN also advised that individuals with more complex needs have difficulty accessing INTREO services and being referred to appropriate supports.

AVFC 4.2: Evidence-based programmes to tackle stigma should be put in place, based around contact, education and challenge.

See Change, the national mental health stigma reduction partnership, was launched in 2010 and facilitated the second annual Green Ribbon campaign in May 2014. The campaign delivered over 500 events in communities and workplaces across the country. 300,000 Green Ribbons were distributed nationwide. According to research conducted by Millward Brown Lansdowne, 7 in 10 Irish adults feel more comfortable in having a conversation about mental health since the campaign.¹⁵

In the National Disability Authority's Attitudes Survey 2011, respondents still reported relatively higher comfort levels with having a work colleague with a physical, hearing or vision disability compared with a colleague with a mental health difficulty. Similarly, respondents reported low levels of comfort with people with mental health difficulties living in their community, in comparison to other types of disabilities.¹⁶ The See Change Attitudes Survey 2012 showed some improvement in attitudes towards people with mental health difficulties generally since

14 Mental Health Reform (2013) 'Final Report to National Learning Network: Research into the Value of Rehabilitative and Vocational Training and Support Services for People with Mental Health Issues', unpublished research report.

15 See Change (2014) *Green Ribbon Campaign, May 2014: Impact Report*, p. 24.

16 National Disability Authority (2011) *Public Attitudes to Disability in 2011* available at https://www.ucd.ie/t4cms/Public_Attitudes_to_Disability_in_Irelandfinal%20Report%202011.pdf.

11 CSO Census Profile 8 – Our Bill of Health – Health, Disability and Carers in Ireland.

12 Watson, D., Kingston, G. and McGinnity, F. (2012) *Disability in the Irish Labour Market: Evidence from the QNHS Equality Module*, Dublin: Equality Authority/Economic and Social Research Institute, p.19.

13 HSE (2012) *New Directions: Review of HSE Day Services and Implementation Plan 2012 – 2016*, p. 13.

2010, though “attitudes towards people with a diagnosis of schizophrenia still lag behind”.¹⁷ This survey also found that people were less likely to disclose that they had a mental health difficulty in personal and professional relationships than they had been in 2010.

AVFC 4.5: Mental health services should take account of local deprivation patterns in planning and delivering mental health care.

A model of allocation for resources was adopted by the HSE in 2006 and 2007 which related population served with deprivation using the Small Area Health Research Unit (SAHRU) index. This continued with the investment from Budgets 2012 and 2013, and the HSE continues to allocate development funding with the aim of maximising equity across regions, age and social need as appropriate.^{18,19}

AVFC 4.7: The provision of social housing is the responsibility of the Local Authority. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.

2.2. Households needing housing support due to a mental health disability



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The Housing Agency's housing assessment report, 2013 identified that 1,034 households in Ireland has a household member where the main need for social housing support is as a result of having a mental health disability.²⁰ In addition, there were approximately 625 residents in HSE medium and low supported accommodation in 2014²¹ who could probably live in local-authority controlled accommodation, given the right support.

Between 2012 and 2013 an audit was carried out in an acute mental health unit in Tallaght Hospital in relation to housing need.²² The study found that:

- On average, 38% of patients had accommodation related needs at any one time
- 98% of the long stay/delayed discharge inpatients had accommodation related needs
- Long stay/delayed discharge inpatients with accommodation needs accounted for 28% of all inpatients and for 72% of all inpatients with accommodation related needs

There was a discharge to homeless services

17 See Change (2012) *Irish attitudes towards mental health* available at http://www.seechange.ie/wpcontent/themes/seechange/images/stories/pdf/See_Change_Research_2012_Irish_attitudes_towards_mental_health_problems.pdf.

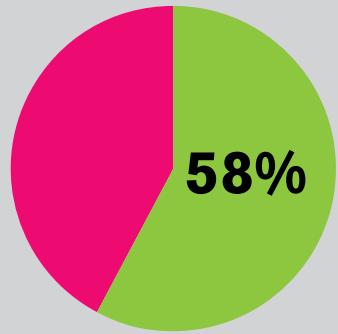
18 Information provided through correspondence with the HSE.
19 The Small Area Health Research Unit (SAHRU) at Trinity College Dublin was commissioned in early 1997 by the Directors of Public Health in Ireland to produce the 1st national deprivation index for health and health services research. The index and report was subsequently placed in the public domain. The original version was based on the 1991 Census. A total of five census based indicators, widely believed to represent or be a determinant of material disadvantage, were considered for possible inclusion in the SAHRU Deprivation Index. These were unemployment, low social class, no car, rented accommodation and overcrowding.

20 Housing Agency (2013) *Summary of Social Housing Assessments 2013: Key Findings*, p. 10.

21 Information received from the HSE Mental Health Division.
22 John Cowman (2013) *Prevalence of housing needs among inpatients: An audit of housing needs, over one year, in the acute mental health unit in Tallaght Hospital*, unpublished report, p.1.

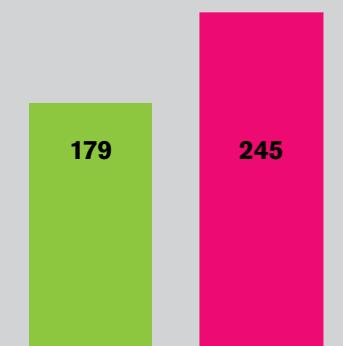
every 9.4 days (39 individuals in total). Notably, this represents a male: female ratio of 12:1

2.3. Proportion of homeless people in Dublin & Limerick with a mental health diagnosis²³



In a study carried out in 2013 among 599 people experiencing homelessness in Dublin and Limerick, 58% said they had been diagnosed by a doctor with at least one mental health condition, including anxiety, depression, schizophrenia or psychosis.²⁴

2.4. Psychiatric admissions of people with no fixed abode, 2006 and 2013



In 2006, there were 179 admissions of people with no fixed abode to psychiatric units and hospitals across the country. In 2013, there were 245 people admitted with no fixed abode, which represents a 37% increase.^{25, 26}

2.5. Every 9.4 days someone was discharged into homelessness from Tallaght Hospital acute mental health unit



The Housing Strategy for People with Disabilities 2011-2016 contains a separate chapter on people with a mental health disability with specific actions that address the need for better access to local authority housing supports, the transfer of HSE supported accommodation to local authority control and the need for social supports for people with mental health difficulties living in the community. A pilot project to transfer HSE accommodation to local authority ownership is underway in the Midlands. Several projects around the country, funded by Genio, have successfully supported people living in mental health residences and other arrangements, to move to independent living arrangements.

In December 2014, the Department of Environment, Community and Local Government made commitments to ensure in-reach mental health services into all emergency accommodation settings across the Dublin Region and to implement a formal discharge protocol with Dublin hospitals and homeless services to ensure that, as far as possible, no patient will be discharged into homelessness.²⁷ The HSE is working to finalise a discharge protocol with homeless services so that no patient will be discharged into homelessness.²⁸ In its Operational Plan, 2015, the HSE Mental Health Division commits to extending specialist services for homeless people with mental health difficulties in Dublin and other cities.

23 O'Reilly, F., Barror, S., Hannigan, A., Scrivener, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) *Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities*. Dublin: The Partnership for Health Equity.

24 Ibid.

25 Daly, A. & Walsh, D. (2014) *Activities of Irish Psychiatric Units and Hospitals 2013*, Dublin: Health Research Board, p.50.

26 Ibid.

27 Department of Environment, Community and Local Government (2014) *Action Plan on Homelessness*, p. 4-5.

28 Department of Environment (2015), *Action Plan to Address Homelessness Progress Report for Cabinet Committee on Social Policy & Public Service Reform – Meeting of 30 March 2015*, p. 7.

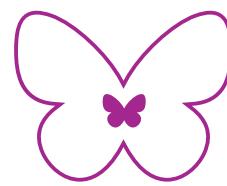
There is currently no dedicated funding stream for tenancy sustainment support for individuals with a mental health difficulty who require this support.

AVFC 4.8: Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters.

The Mental Health Commission's (MHC) Quality Framework includes reference to the need to provide culturally sensitive mental health services and incorporates specific standards requiring respect for individuals' culture, values, beliefs and religion as well as on the provision of interpreter services.

Mental Health Reform's position paper on ethnic minorities and mental health, 2014, identified the gaps in mental health services in responding to the mental health needs of individuals from ethnic minority groups including the Traveller community. It reports on the lack of specific policy on cultural competency within mental health services; a lack of understanding among professionals of individuals' social and cultural context; and a lack of appropriate language and communication supports.²⁹

Summary assessment of social inclusion



People with mental health difficulties continue to experience significant social exclusion in Ireland, facing prejudice, unemployment and difficulties in accessing housing.

MHR's survey of consumer panels shows that there is much inconsistency throughout the country in access to housing, education, social welfare and employment supports for people with mental health difficulties. For each of these supports, at least three areas report that they are 'occasionally' or 'never' available while another three or four areas report they are 'frequently' or 'always' available.

There are a number of recent government initiatives which aim to support people with mental health difficulties to become more integrated within the community. The Housing Strategy for People with Disabilities represents a positive commitment on the part of the Department of Environment, Community and Local Government to address the needs of people with a mental health disability while the upcoming employment strategy for people with disabilities contains some commitments that could benefit people with a mental health disability.

Despite these commitments, there have been few significant actions taken to address the issue of social inclusion since 2006. There is currently no dedicated funding stream for tenancy sustainment support for individuals with a mental health disability and no national programme to transition people from HSE to local authority-controlled housing, though plans are in train. And though Dublin North West catchment area is in the process of supporting more than 40 people to move into more independent living arrangements, the national housing crisis is impacting very negatively on the ability of mental health service users to find appropriate accommodation.

Also, apart from the Department of Social Protection's recent engagement on a pilot of the Individual Placement and Support model of supported employment, there has been little new action to improve the employment outcomes of people with a mental health difficulty since 2006.

One of the strongest concerns voiced by service users to the Expert Group in 2006 was the issue of stigma and discrimination faced by people with mental health difficulties. See Change, the national mental health stigma reduction partnership, has delivered numerous anti-stigma initiatives in recent years, including its annual Green Ribbon campaign. While attitudes towards mental health have improved in general, national studies report continued negative attitudes towards people with mental health difficulties among a minority of the population, and changes in attitudes towards those with severe mental health difficulties have lagged behind.

At a public meeting in 2014, one person told Mental Health Reform about the change they have seen over the years: "When I was using services, I told nobody where I was going. If I had an appointment I would never say what it was for. I understand now that I was part of the problem of keeping the stigma going. I'm not ashamed of it anymore."

Case Study: Paul's story

Paul is now nearly 50 years of age. He had an apartment of his own in his mid-twenties but a series of traumatic events led to a breakdown and hospitalisation. He says he has been homeless, more or less, since the age of 26 – until recently, that is. Paul now lives independently with support from Hail Housing. It has been a long journey.

Paul first spent years living in St Brendan's hospital, Grangegorman, in Dublin, which he describes as the worst experience of his life because of the lack of privacy and the feeling of being locked in. After that, he spent seven years "moving backwards and forwards" between high and medium support hostels, which he says was "very stressful".

"Imagine sharing a room with 4 other men for years. There's no privacy, nowhere to relax."

At one point, Paul tried to live independently in a housing estate but felt that he didn't have enough support, and it didn't work out.

Then a few years ago, as part of the Genio Doras programme, Paul was able to secure his own apartment through the Peter McVerry Trust. He had the support of Louise, a Support Worker from Hail Housing connected to the Genio Doras project. Paul says:

"Louise was brilliant. She brought me to the Community Welfare Office, helped with my forms, sorted my rent and bills, helped me with moving my stuff etc. She was an absolutely brilliant help. If I ever had any problem, I knew she was there for me."

Now, Paul has a place to call his own and a network of friends in his local community, including old friends from his days in St Brendan's. He says that these old friends are also living in supported housing and are a great support to each other.

Paul sees his mental health nurse regularly, and credits his psychiatrist and psychologist with helping him to stay out of hospital. It has been four years since he was in hospital.

Paul doesn't often need to phone Louise, his Support Worker, but knows she is there if he needs her. He now has the space to pursue his interests, including martial arts, painting and languages. He has also been asked by Genio to speak to others about the benefits of moving into independent living in supported housing.

To anyone thinking about moving from an acute hospital or hostel into independent living, Paul says: "I have a life now. I didn't before. I'm happy with my life."

Chapter 3: Mental health promotion/ Mental wellbeing

Broad outline of AVFC recommendations

The Expert Group recommended that the mental health system should be based on the principle of 'early intervention', through the provision of mental health promotion at all levels of the mental health system. The Group identified protective factors for enhancing the well-being and quality of life among all age groups of the general population, in addition to addressing the needs of those at risk from, or experiencing mental health difficulties. The life-stages model of mental health promotion, as set out in AVFC, also identified the need to do targeted mental health promotion for minority populations. Recommendations on mental health promotion include:

- The design and delivery of evidence-based prevention and mental health promotion programmes
- The evaluation of all mental health promotion programmes against locally-agreed targets and standards
- The assignment of health promotion officers with responsibility for mental health
- Training and education programmes to develop capacity and expertise at national and local levels to promote mental health
- Extension of the Social, Personal and Health Education (SPHE) programme in schools to the senior cycle and that evidence-based mental health promotion programmes be implemented in primary and secondary schools

The policy also recognises the importance of addressing the broader social and economic determinants of mental health through an inter-agency approach.

Baseline in 2006

In 2006, the Expert Group acknowledged that there had been increased recognition of the importance of promoting positive mental health, not just among individuals experiencing mental health difficulties, but also across entire populations. The World Health Organisation advocated for the promotion of positive mental health as an integral part of improving overall health and well-being, and the World Health Reports of 2001 and 2002 were devoted exclusively to the issues of mental health and health promotion.³⁰

Progress to date

AVFC 5.1: Sufficient benefit has been shown from mental health promotion programmes for them to be incorporated into all levels of mental health and health services as appropriate.

The types of mental health promotion programmes that are delivered through the HSE's Health Promotion Unit include Health Promoting Schools and the delivery of Mindout and Zippy's Friends Programmes; GAA Healthy Club Initiative; Stress Awareness; Social Prescribing for Primary Care; supporting interagency and partnership planning for mental health awareness and promotion; delivering parenting programmes; ASIST and Safetalk resources and delivery; mental health programmes through youth work; Traveller health supports; men's health and women's health initiatives; and the Smart Start programme for preschools.

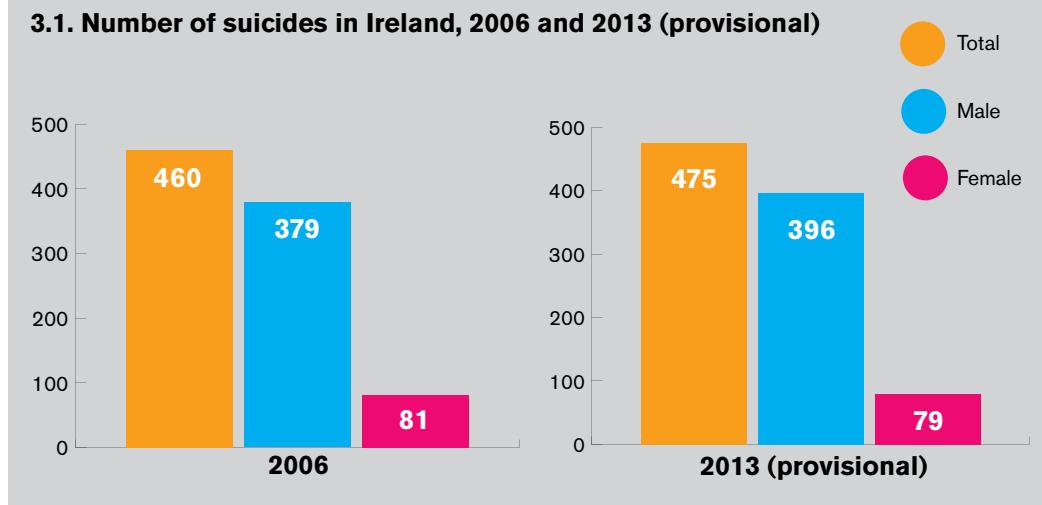
The HSE also provides funding for SpunOut, the National Youth Health Programme, Pieta House (counselling) and Headstrong (youth engagement).³¹

The National Office for Suicide Prevention, NOSP, was established by the HSE in 2005 to implement *Reach Out*, the national

³⁰ Cited in *A Vision for Change*, p. 46.

³¹ Information provided by HSE health promotion unit.

3.1. Number of suicides in Ireland, 2006 and 2013 (provisional)



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strategy for action on suicide prevention. NOSP started with a budget of €500,000 in 2005. The office's budget was €8.8 million in 2014, and €7.9 million in 2013. #Littlethings is the new mental health and wellbeing campaign, launched at the end of 2014 by the National Office for Suicide Prevention.³² The #littlethings campaign provides guidance on simple, evidence-based measures that can enhance people's mental health. NOSP funds a range of initiatives promoting mental health, including its Please Talk campaign for 3rd level students, a code of practice for family resource centres, and a programme in the GAA. In 2009, NOSP commenced a programme aimed at supporting organisations who are concerned about the impact the economic downturn may be having on the mental health of the Irish population. NOSP is also supporting the delivery of mental health promotion programmes targeted at unemployed people.³³

In January 2013, the National Guidelines on Promoting Positive Mental Health and Suicide Prevention in Post-Primary Schools were published.³⁴ These were followed by the publication of the National Guidelines on Promoting Positive Mental Health and Suicide Prevention in Primary Schools in January 2015.³⁵ Following a national consultation run

by the office of the Minister for Children and Youth Affairs with children and young people on mental health, a campaign targeted at this age group was launched in October 2009 called www.letsomeoneknow.ie and received 17,500 unique visits.

There is a sub-group of the interdepartmental subcommittee on health between the Department of Health and Children and the Department of Education and Science which oversees the implementation of 'Reach Out' actions and other relevant national health and education policies pertaining to suicide prevention and mental health in the education setting.³⁶

The publication of the Guidelines is positive; however, there is a need for a clear implementation plan for ensuring the Guidelines translate into action. Training and support for schools is needed in order to implement a whole school approach. The cuts announced by Government in relation to guidance counsellors has led to less one-to-one time for students with guidance counsellors, resulting in reduced support for students experiencing mental health difficulties. A survey of 83 principals in 2015 showed 57% of secondary schools had reduced one-to-one supports offered by guidance counsellors since 2012.³⁷

³² Information on the campaign is available at <http://www.yourmentalhealth.ie/Get-involved/LittleThings-campaign/>.

³³ Information received through correspondence with the HSE.

³⁴ Department of Education and Skills (2013) *Well-being in Post Primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention*, Dublin: Department of Education and Skills.

³⁵ Department of Education and Skills (2015) *Well-being in Primary Schools: Guidelines for Mental Health Promotion*,

Dublin: Department of Education and Skills.

³⁶ Information received through correspondence with the HSE.

³⁷ See 'One-to-one school counselling cut' in The Irish Examiner, Monday, 6 April, 2015 available at <http://www.irishexaminer.com/ireland/one-to-one-school-counselling-cut-322367.html>.

Statistics on suicide

The total rate of suicide for men and women of all ages in Ireland in 2010 was 10.9 per 100,000, the 11th lowest rate of suicide in the EU.³⁸

The number of deaths by suicide in Ireland is below the profile for most EU countries. However, the figures for men aged 15 to 19 and 44 to 64 years are particularly high by international comparison.³⁹

The official CSO figures indicate that there were 554 deaths by suicide in 2011 in Ireland. This is the highest figure since 2001 and marks a 12% increase on 2010. However, provisional data from 2012 and 2013 suggest a levelling-out of this rise, and perhaps a decreasing trend.⁴⁰

AVFC 5.3: A framework for inter-departmental cooperation in the development of cross-cutting health and social policy should be put in place.

The Healthy Ireland Framework 2013-2025 envisages an Ireland “where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone’s responsibility”.⁴¹ The framework takes a whole-of-Government and whole-of-society approach to improve the health and wellbeing of the population.

The Cabinet Committee on Social Inclusion, chaired by the Taoiseach and composed of the relevant Ministers, gives overall strategic direction to the development of policies to combat poverty and social exclusion and ensures that their implementation is regularly monitored and promoted at the highest level.

AVFC 5.4: Designated health promotion officers should have special responsibility for mental health

promotion working in cooperation with local voluntary and community groups and with formal links to mental health services.

There are nine whole time equivalents (WTEs) appointed to the National Office for Suicide Prevention.

There are five Suicide Resource and Mental Health Promotion Officers (3 fulltime) assigned to the HSE Health Promotion Unit. In addition, there is one Mental Health Promotion Officer who is funded through an external agency. There are approximately 100 other health promotion staff that engage in mental health promotion work through a variety of contexts, including training programmes.^{42,43}

Summary assessment of mental health promotion/mental wellbeing



While the Expert Group highlighted the importance of mental health promotion within a population health approach to the policy, the mental health promotion recommendations of *A Vision for Change* (as distinct from suicide prevention), particularly around evaluation of mental health promotion programmes, assignment of dedicated mental health promotion officers across the country and mainstreaming mental health within school curricula, were not implemented.

Community and voluntary groups have developed a wide range of mental health promotion initiatives that are being delivered in local communities. The National Office for Suicide Prevention has grown in its resources

42 Information received through correspondence with the HSE Health Promotion Unit.

43 The HSE Health Promotion Unit is currently carrying out a staff census which will capture more accurately the activities of the office. This work will clarify the position on mental health promotion. It must be noted that while some of the mental health promotion work is carried out consistently across the country there are often regional and local variations. This depends on local needs and local partners engaged in those developments.

38 National Office for Suicide Prevention *Annual Report 2013*, Dublin: NOSP, p. 69.

39 Ibid, p. 3.

40 Ibid.

41 Department of Health (2013) *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013 – 2025*, Dublin: Department of Health, p. 5.

and has funded some of these initiatives. The HSE and NOSP have also developed national awareness raising initiatives ('Look after yourself, look after your mental health', yourmentalhealth.ie and #littlethings).

So too, the HSE's support for Headstrong, the National Centre for Youth Mental Health, and its educational and early intervention programmes has increased during the period, to the point where Headstrong's Jigsaw service reached 3,256 young people in 2014.⁴⁴

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3.2. Headstrong's Jigsaw service



There is potential for the upcoming suicide prevention strategy to mark a shift towards a more evidence-based, national programme on mental health promotion, which would be welcome. The importance of ensuring that all children are educated in how to look after their mental health cannot be overstated. The Children's Mental Health Coalition has expressed concerns that the national guidelines on mental health promotion for both primary and post primary schools require an effective implementation plan to ensure they translate into action. It is vital that mental health promotion becomes embedded in the school curriculum and that schools are able to implement a 'whole school approach' to mental health.

Case study: Mental health promotion

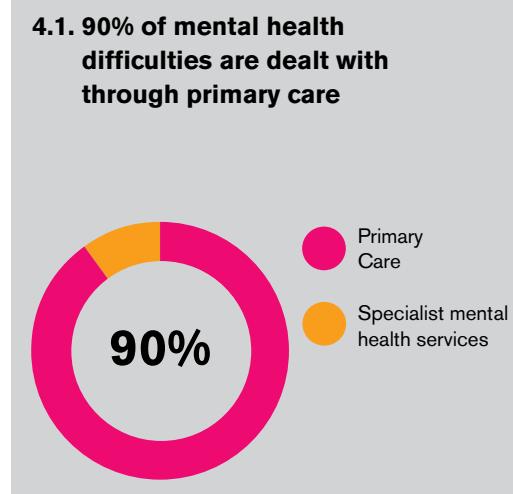
The member organisations of Mental Health Reform deliver a range of mental health promotion programmes to participants in community settings, in workplaces and in institutions such as schools, colleges and prisons. Many of these programmes are funded by the HSE or NOSP. Examples include:

- Aware
 - 'Beat the Blues'
 - 'Wellness at Work' programme
 - Monthly lectures in Dublin
 - CBT based therapeutic programme 'Life Skills' that can be accessed in a group or online format
- Mental Health Ireland
 - Information sessions on topics related to mental health such as 'Stress Control' and 'Roots of Empathy'
 - ASIST training
- Grow
 - Community educational programmes
 - Outreach to schools and health centres to individuals in every region of Ireland
 - Workplace programme in the Midlands region
- Suicide or Survive
 - Wellness workshop (online and offline
 - WRAP programme to students, prisoners and communities in Dublin and around Ireland
- Console
 - Suicide prevention programme
 - 'Question, Persuade, Refer'
- Headstrong, National Centre for Youth Mental Health
 - Community engagement educational programmes to young people and parents on promoting good mental health practices
 - Capacity building workshops to professionals and volunteers who work closely with young people to help support and promote their mental health

Chapter 4: Mental health in primary care

Broad outline of AVFC recommendations

One of the key principles of *A Vision for Change* is ‘coordinated services’. This principle sets out that “seamless mental health services should be available in a continuum stretching from the community at large to primary care and specialist mental health services”. The Expert Group recommended that links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalised. The Expert Group recognised the pivotal role of primary care services in addressing the mental health needs of the population. It identified that 90% of mental health difficulties are dealt with in primary care without referral to a specialist mental health service. GPs in primary care also have a key role as ‘gatekeepers’ to the mental health service; for the majority of people, access to a mental health service is through referral from a GP.⁴⁵



45 This is supported by the WHO's report *Mental Health: New Understanding, New Hope* which emphasises the importance of primary care in mental health. The first of the ten recommendations made by this report was that treatment for people with mental disorders should be provided in primary care.

A Vision for Change contained a number of recommendations to enhance the capacity of primary care to address the mental health needs of the population, including:

- The provision of a comprehensive range of interventions in primary care for mental health difficulties that do not require specialist mental health services
- The availability of mental health professionals in the primary care setting
- The introduction of a range of incentive schemes to ensure mental health issues can be addressed in primary care
- Implementation of the consultation/liaison model to ensure effective communication between primary care and specialist mental health services
- Ensuring that all mental health service users are registered with a GP
- The delivery of appropriate mental health training among GPs across the country

The Expert Group also recommends that research and information on the prevalence of mental health difficulties and the interventions provided is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.

Baseline in 2006

In 2006, the Expert Group identified a number of barriers to addressing mental health difficulties at primary care level. The Group reported that the treatment most usually offered to individuals with mental health difficulties in primary care was medication. “GPs and service users have expressed a desire for far greater availability of other treatments, such as psychological therapies and the need for greater availability of mental health professionals within the community”. It also identified a number of additional barriers, including the absence of centrally collected information on the type of services or treatments provided to people with mental health difficulties in primary care. At the time of AVFC, no information was available on the

number of psychologists, counsellors or other mental health professionals working from GP practices. The report also highlighted difficulties in recruiting GPs to deprived areas where mental health needs are greatest, and a lack of collaboration between primary care and specialist mental health services. In terms of knowledge about mental health in primary care, a study of GPs published in 2004 found that 68% of GPs had no specific training in mental health, while a further 32% had training that consisted of a clinical placement or on-the-job training.⁴⁶

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Progress to date

AVFC 7.1: All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.

AVFC 7.6: Mental health professionals should be available in the primary care setting.

There continues to be a lack of data on the provision of mental health care in primary care settings. The numbers of primary care psychologists are unknown. The HSE Counselling in Primary Care Service (CIPC) was established on a nationwide basis in 2013 to improve access to psychological therapy through primary care. The service provides counselling in primary care to adults who hold a General Medical Services (GMS) card presenting with mild to moderate psychological difficulties.

The majority of CIPC clients are seen within three months of referral. Figures for 2014 indicate that at the end of November 2014 there were 248 people waiting for counselling for 3 to 6 months (approximately 2% of referrals during 2014) and approximately 81 clients had waited for longer than 6 months (<1%).⁴⁷

An analysis carried out by Brendan Kennelly has found that €204 million was spent in Ireland on medications for mental health

disorders in 2010 under the GMS scheme, the Drug Payment scheme and the Long Term Illness scheme.⁴⁸

The CIPC service expects to provide an average of 3,500 counselling sessions per month in 2015. In excess of 16,000 referrals have been made to CIPC to date and 10,601 in the first 3 quarters of 2014.⁴⁹

AVFC 7.3: All mental health service users, including those in long-stay wards, should be registered with a GP.

There is no data to confirm the number of people engaged with community-based mental health services that are registered with a GP. In 2013, 87% of approved inpatient units were compliant with the regulation on the general health of inpatients.⁵⁰

In a number of Mental Health Reform's public meetings in 2013 and 2014, people raised the issue of GP knowledge of mental health, with one individual saying that "some GPs admit they've never dealt with certain problems before and they don't know what to do." Another individual spoke more positively: "My GP recommended a course as a way of starting to get my life back. I get great support from my GP."

AVFC 7.2: Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.

The Irish College of General Practitioners (ICGP) is currently conducting a study into the prevalence of individuals presenting to out-of-hours GP services in the South East of Ireland with mental health difficulties. The study will examine what services individuals can access if referred by their GP and if individuals avail of these services. Other than

46 Copyt, M. (2004) *Mental Health in Primary Care*, Dublin: Health Service Executive/Irish College of General Practitioners.

47 Information received through correspondence with the HSE.

48 (See Kennelly, B (2014) 'The economics of mental health care in Ireland', in *Mental Health in Ireland: Policy, practice and law* edited by A. Higgins and S. McDaid).

49 Information received through correspondence with the HSE. Mental Health Commission Annual Report 2013, p.21.

this study, Mental Health Reform is unaware of any national prevalence study within primary care since publication of AVFC.

AVFC 7.5: It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.

The consultation/liaison model has not been implemented on a national basis though the HSE mental health section has engaged in some activity to improve communication between primary care and specialist mental health services. The HSE published the guidance paper 'Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services' in 2012.

Plans are in train for a clinical programme on Early Intervention for Psychosis which was developed in 2013. The programme will detect individuals in the early, at-risk stage of psychosis and also provides multi-disciplinary support and treatment for people with a first episode of psychosis. Dr. Margo Wrigley took over as HSE Mental Health Clinical Lead in April 2014 and has continued to progress the implementation of this programme, specifically on:⁵¹

- Continuing training and in particular ensuring that those trained have on-going supervision and that there is development of Irish based trainers to ensure self-sustainment
- Securing funding for the appointment of a Clinical Lead for this Programme and additional staffing for the IPS intervention in late 2015

A review of the programme proposal

- Developing an interim Standard Operating Procedure to ensure that the hubs that are up and running are able to do so in an evidence-based and safe manner

There are two other Mental Health Clinical Programmes. The Clinical Programme on the Assessment and Management of Self-Harm in Emergency Departments is operating

since the beginning of December 2014. This programme improves the immediate treatment and follow-up support for individuals who present in Emergency Departments having engaged in self-harm. The HSE is also in the process of developing a Clinical Programme on Eating Disorders.

AVFC 7.11: The education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy.

While there have been some initiatives to increase the capacity of GPs to provide mental health care, including e-learning modules through the Irish College of General Practitioners (ICGP), the Primary Care Resource Pack and a course provided by Dublin City University (in partnership with the ICGP and the HSE), there has not been a national programme to ensure that all GPs have adequate training in mental health in primary care. The HSE in partnership with ICGP has funded a Mental Health Project role which has developed a range of materials and training programmes to support GPs and General Practice in particular. Approximately 100 primary care professionals took part in the mental health training provided through Dublin City University.

As part of MHR's 2011 consultation with service users it was noted that there was a lack of knowledge among GPs about mental health issues and that many GPs are not aware of mental health support services available in the community.⁵²

51 Information received through correspondence with the HSE.

52 Mental Health Reform (2013) *Mental Health in Primary Care: A Briefing Paper*, Dublin: Mental Health Reform.

Summary assessment of mental health in primary care



The primary care strategy, 2001 acknowledges the central role of the primary care sector in health delivery, including mental health.⁵³ Despite the publication of this strategy and the primary care chapter in AVFC, there remain significant gaps at primary care level in the delivery of mental health supports.

While the introduction of the Counselling in Primary Care Service in 2013 was welcome, this service is available to medical card holders only and has a limitation of eight counselling sessions for each individual accessing the service.⁵⁴ Lengthy waiting lists for CIPC for a small number of people have been reported with approximately 81 people waiting more than six months to be seen by the service. CIPC is available to adults only and does not provide support to children and adolescents under the age of 18 years.⁵⁵

Although some plans have been made on the development of a 'shared care' collaborative approach to mental health delivery in Ireland, national systems for shared care are not yet in place.⁵⁶

The lack of training among primary care professionals, particularly GPs, is a significant obstacle to effective use of primary care. Of particular concern is the lack of information on the number of mental health professionals (e.g. psychologists) in primary care. Such primary care mental health professionals are an essential component of an efficient mental

health system, helping to provide treatment within the primary care setting and limiting inappropriate referrals to specialist mental health services. Without adequate capacity in primary care, it is likely that individuals are ending up in specialist mental health services who might not need to be served there. There is a clear research gap on the presentation, detection and treatment of mental health difficulties at primary care level in Ireland. This is problematic for effective service planning, workforce training, delivery and evaluation.

Case study: Regina's story

Regina is in her early forties and has been using mental health services since the age of eighteen. She was first hospitalised about fifteen years ago. She says of this time in her life: "I didn't go along with the services at first because I was in denial and I was ashamed of myself."

Hospitalised again eight years ago, Regina met a young doctor who was doing his psychiatric training in the acute psychiatric ward. She says: "He had such empathy. He made me feel like a person, not a number."

Regina was delighted when this young doctor went on to join on to join a GP's practice nearby, given that he had known her as an inpatient. However, he only stayed a year and Regina was upset when he left.

A few years ago, this doctor opened up his own practice around 20 miles from Regina's home, and he became her regular GP. She describes one occasion when she bumped into her doctor in town and his support made all the difference:

"He met me in town and recognised that I wasn't well. He asked me to go back to the surgery with him for a chat. I ended up in hospital after that. He has great understanding, and really spends time with you. He is not trigger-happy with the medication. He's like a counsellor – he takes an interest talks and listens. He doesn't judge you. I would always go to him first if I was in a crisis. I'd trust him with my life."

Regina says that her GP is so good because he looks after her whole health, physical as

53 Department of Health (2001) *Primary Care: A New Direction*, Dublin: The Stationery Office.

54 Carr, A. (2007) *The Effectiveness of Psychotherapy: A Review of Research prepared for the Irish Council of Psychotherapy*, Dublin: Irish Council of Psychotherapy.

55 Weaver, T., et al. (2003) 'Comorbidity of substance misuse and mental illness in community mental health and substance misuse services', *British Journal of Psychiatry* 183:304-313.

56 The Irish College of General Practitioners. (2011) *Primary Care Teams - A GP Perspective*. ICGP, Dublin.

well as mental. He is also well linked in to the local community and knows what other supports are available.

In the last year, Regina has completed a college course on mental health and says: "I have blossomed in my own journey. The course gave me insight and made me aware of my own triggers."

Of mental health services, Regina says: "Now I'm happy with the service that I have. That's because I have a great GP and a great psychiatrist and I have done the journey myself but I think there's a lot can be done for mental health within Ireland. If you don't have good mental health, you have nothing."

Chapter 5: Adult mental health services

Broad outline of AVFC recommendations

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The Expert Group recommended a person-centred, community-based, recovery-oriented model for adult mental health care which would be provided through Community Mental Health Teams (CMHTs). CMHTs should offer multidisciplinary, home-based and assertive outreach care, 24/7 crisis intervention arrangements, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families. The principle of 'recovery' should underpin adult mental health service delivery.

The Expert Group recognised that specialist rehabilitation and recovery community mental health teams should be provided for people with severe mental health difficulties which cannot be adequately met by the general adult CMHTs. The Expert Group defined 'rehabilitation' as a "facilitative process that enables disadvantaged individuals to access as independent a life as possible in social, cultural and economic terms".⁵⁷ *A Vision for Change* sets out specific recommendations for the provision of rehabilitation and recovery services, including:

- A strong commitment to the principle of 'Recovery' through the work of the rehabilitation teams
- The establishment of dedicated rehabilitation teams across the country - Community-based interventions through assertive outreach should be the primary method of service delivery
- Physical resources should be provided for rehabilitation teams such as day centres and service user/ peer led services
- Opportunities for independent housing should be provided by

appropriate authorities with flexible tenancy agreements being drawn up in accordance with each service user's needs. Arrangements that best enable service users to move from high support to low support and independent accommodation need to be considered

- Rehabilitation and recovery mental health services should develop connections with statutory and voluntary service providers to support community integration
- The development of accessible mainstream training support services and formal coordination structures between rehabilitation services and employment/training agencies
- Evaluation of rehabilitation services should include quality-of-life measures and the assessment of the benefit and value of these services directly to service users and their families

Baseline in 2006

The Expert Group noted while "Planning for the Future (1984) provided the strategic framework for adult mental health services to evolve from an institutional to a community-based service model ... the operational system of mental health services has continued to be predominantly hospital-based."⁵⁸

The Expert Group identified a number of shortcomings in the adult mental health services across the country, including:

- A lack of suitable community-based mental health services
- A lack of multi-disciplinary teams and thus multi-disciplinary assessments for individuals with mental health difficulties
- A lack of specialised mental health services (such as mental health services for older people and for people with intellectual disability) which ultimately inhibits the development of general adult mental health services

- Fragmented service planning and delivery
- A lack of integrated care planning

The Expert Group noted a lack of understanding within mental health teams of the social context in which mental health difficulties arise and the types of social supports which may be required to foster recovery. One consequence of this shortcoming in services was a high rate of relapse and readmission. In 2006, over 70% of all psychiatric admissions were readmissions. A striking comment by the Expert Group was that “current mental health service provision does not recognise the capacity of the individual to recover and to live lives that are personally and socially meaningful to them”.⁵⁹

Between 2007 and 2009, fifteen public psychiatric hospitals remained in service. At the end of 2013 there were five remaining hospitals in service.⁶⁰ These have been replaced with acute psychiatric units in general hospitals as recommended in *A Vision for Change*. Until the remaining psychiatric hospitals are closed, the staff resource cannot be redeployed to CMHTs.

Progress to date

AVFC 9.1: CMHTs should offer multidisciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families.

There are currently 119 general adult community mental health teams across the country, of which five are specifically defined as home-based treatment teams.⁶¹ Despite a doubling of the proportion of multidisciplinary staff within teams since 2008, none of these teams have the full complement of staff recommended in AVFC, though most have at least one member from each of the recommended disciplines. The HSE has

advised that all community mental health teams provide specialist secondary care to service users across a variety of locations, including the individual's home.⁶²

Information is not available on the types and extent of availability of treatments. For example, data is not available on the extent of waiting lists for psychological, social work or occupational therapy input. However, MHR has heard anecdotal reports of lengthy waiting times for these multidisciplinary supports due to staff shortages.

At a public meeting in 2013, one person told Mental Health Reform about the frustration of waiting lists: “When you know that you need the help and you go to the people looking for this help...you're told ‘Oh you have to go on a waiting list’...it’s sad when you have to fight for that.”

While the HSE has reported that most CMHTs have the ability to respond to urgent/crisis referrals by GPs during daytime hours, with slots for such cases to be seen that day or the next working day, access to urgent treatment outside normal working hours is still through the on-call medical system which operates in all acute hospitals with a 24 hour emergency department. Some mental health services provide an out-of-hours telephone service to known mental health service users and family members (e.g. Nenagh, Celbridge) and at least one has a 7-day-a-week day hospital (Celbridge). The HSE reports that 9 of 17 mental health areas have weekend cover in place for existing mental health service users across the entire catchment area and the remaining 8 have this partially in place.

The current re-admission rate to adult acute inpatient units is 67%.⁶³ This re-admission rate has remained largely static throughout the entire period of implementation of AVFC. However, a value-for-money review comparing a traditional, hospital-based service to a service providing home treatment and 5-day-a-week day hospital support found that the latter was able to reduce re-admissions to 58% compared to 72% in the traditional service.⁶⁴

59 *A Vision for Change*, p. 94.

60 Inspectorate of Mental Health Services (2013) *19th century public psychiatric hospitals due for closure*, p. 1.

61 Information provided through correspondence from the HSE.

62 Ibid.

63 Daly, A. & Walsh, D. (2014) *Activities of Irish Psychiatric Units and Hospitals 2013*, Dublin: Health Research Board, p.50.

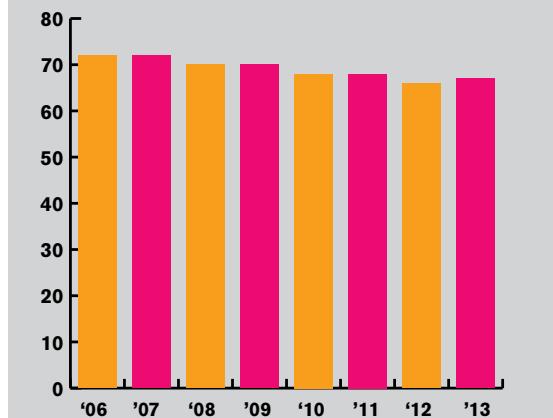
64 Gibbons, P., Lee, A., Parkes, J. and Meaney, E. (2012) *Value*

In Mental Health Reform's online survey in 2014, service users reported that "waiting times ...in crisis situations were serious issues" within the mental health services. Accident and emergency rooms were commented on by some respondents as being "ridiculous and inappropriate for the patient and very distressing for families". In addition, respondents felt that they had nowhere else to go when in crisis except A&E, yet this meant long waiting times and "inappropriate conditions for someone in mental distress".

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In 2006, 72% of all admissions to psychiatric units/hospitals were re-admissions and in 2013, 67% of all admissions were re-admissions.⁶⁵

5.1. Psychiatric re-admission rates, 2006-2013



The HSE has engaged in initiatives to improve the practice of multidisciplinary teamwork within teams. The HSE published a series of Guidance Papers in 2012 to support teamwork and instituted an Enhancing Teamwork programme. The HSE reported that in 2014 the Enhancing Teamwork programme had continued as well as agreement reached on the approach to the role of Team Coordinators.⁶⁶

In terms of support for individuals who self-harm, a National Clinical Programme for the assessment and management of individuals

presenting to emergency departments following self-harm has been introduced. This involves Clinical Nurse Specialists in psychiatry who work in emergency departments to provide a more rapid response to those who present with episodes of self-harm. 24 of the 35 nurses approved for this programme have been recruited and are deployed in a number of hospitals. Following an assessment by the nurse, a care plan is drawn up involving the person and their next of kin (if they consent). Each person is offered the support and care that is clinically appropriate thereafter. This might include referral to a service specialising in the care of people with suicidal ideation or self-harm, referral to the primary care psychology services and or to the local community mental health team.⁶⁷ As part of this clinical programme, clinical activity is being collected and it is hoped that if this intervention has a positive outcome it may be possible to extend the operational hours to ensure a more comprehensive response within emergency departments.

Separately, the Suicide Crisis Assessment Nurse (SCAN) project was rolled out in two sites (Cluain Mhuire and Wexford)⁶⁸ to provide a consultation and referral point where GPs were concerned about the suicide risk for one of their patients. According to the GPs involved in the evaluation of SCAN, it resulted in significantly better outcomes for patients than traditional mental health services.⁶⁹

The SCAN project is currently operating in Wexford, Waterford, North Dublin, Tallaght, Cork North Lee, Laois/Offaly, Galway/Roscommon, Donegal and Sligo. The service will be incorporated into hospitals in all areas which are at various stages of development.⁷⁰

The recovery principle should underpin this policy.

The Advancing Recovery in Ireland (ARI),

for Money: A comparison of cost and quality in two models of Adult Mental Health Service provision, Kildare, HSE, p.22.

65 Daly, A. & Walsh, D. (2014) *Activities of Irish Psychiatric Units and Hospitals 2013*, Dublin: Health Research Board, p. 50.

66 HSE Performance Assurance Report December 2014.

67 Information received through correspondence with the HSE.

68 HSE (2012) *Research Evaluation of the Suicide Crisis Assessment Nurse (SCAN) Service* available at <http://www.nosp.ie/scan-report-2012.pdf>.

69 Ibid.

70 Information received through correspondence with the National Office for Suicide Prevention.

initiative is funded through the Genio Trust.⁷¹ A total of seven sites participated in ARI between 2013 to 2014.

Rehabilitation and recovery services remain relatively under-developed, with mixed performance against *A Vision for Change* recommendations. In a review of the Galway/Roscommon community mental health services published by the HSE in 2014, the review group commented that, “..... progress has been slow in many parts of the country, with many mental health services having either no community rehabilitation and recovery teams or only token services. Other services have much more developed community rehabilitation and recovery teams but most suffer from being under-resourced, often missing key members of the multidisciplinary team.”⁷² Clearly some services have made conscious efforts to implement the recovery ethos, particularly those involved in the Advancing Recovery in Ireland project; however, the review group found that in the Galway/Roscommon area, some people in community residences were being “over-provided”⁷³ with care and that some could have lived independently. The group also found that few residences were providing activities that promoted community integration, mainstream employment or mainstream housing.⁷⁴

Elsewhere, in 2014, the Inspectorate of Mental Health Services published an overview of 24-hour community residences throughout the country for the period 2009 to 2013. The report identified that “although most residences are too large, overall the care and treatment of residents in 24-hour supervised residences has improved since 2005 and it appears that the major factor influencing this improvement has been the move of clinical care to rehabilitation teams and the consequent implementation of individual multidisciplinary care planning.”⁷⁵ In 81% of

residences which were under the care of a rehabilitation team, residents had an individual multidisciplinary care plan, whereas only 24% of residences which were under the care of a general adult team had such plans.

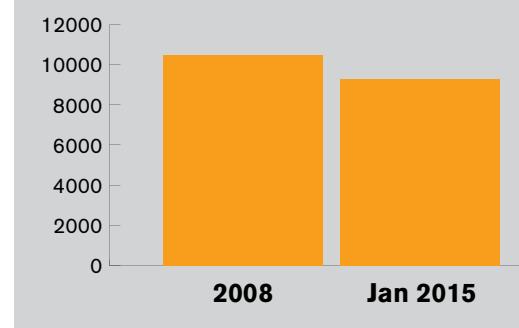
Summary assessment of adult mental health services



25

During the early years of implementation of AVFC little development of CMHTs took place and when the economic crisis hit, resources were hit hard with the loss of more than 1,000 staff. Since 2012 additional investment has resulted in real change in the composition of mental health services to become more multidisciplinary.

5.2. Staff numbers (Whole Time Equivalents) in mental health services



HSE initiatives to improve team-working and coordination of supports for individuals have also been undertaken and are reflected in improved experiences of mental health services by service users and family supporters. The HSE intends that every CMHT will have a Team Coordinator in place and that 50% of teams will have undertaken the Enhancing Teamwork programme during 2015.⁷⁶

71 Information available at <http://www.genio.ie/multimedia/programme-manager-blog/march-2014-mental-health-programme-blog>

72 HSE (2014) *Final Report of the Expert Review Group on Community Mental Health Services in Galway/Roscommon*, Appendix P.

73 Ibid , p. 19.

74 Ibid

75 Finnerty, S. (2014) *Inspectorate of Mental Health Services:*

5.3. Multidisciplinary and overall staff in mental health services 2008-2014

Year	Total staff	Multidisciplinary staff	MDT as proportion of staff overall
2014 ^A	8,967	1,154	12.9%
2013 ^B	8,906	1,024	11.5%
2012 ^C	8,909	740	8.3%
2011 ^D	9,107	716	7.9%
2009 (March) ^E	9,972	578	5.8%
2008 ^F	10,476	645	6.1%

26

However, the reduction in nursing staff as well as difficulties in multidisciplinary staff recruitment has continued to negatively impact on provision of the type of service model envisaged in the policy that includes multidisciplinary support, home-based treatment and 24/7 crisis support. This lack of service development is reflected in the modest reduction in the re-admission rate from 72% to 67% during the period.

There have been positive developments in the introduction of the National Clinical Programme for Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm and the roll out of the Suicide Crisis Assessment Nurse (SCAN) project. Both initiatives aim to provide a more rapid response for people presenting to emergency departments who have self-harmed. However, home-based treatment and assertive outreach are not universally available. In response to a lack of crisis services, the HSE has committed to developing weekend services for people already engaged in the mental health services, who would benefit from contact over the weekend. Despite this commitment, there is a need for mental health services across the country to provide a basic model of care that includes 24/7 crisis intervention with the establishment of crisis houses as the norm in all local areas.

The Advancing Recovery in Ireland Genio-funded project sought to build the capacity of mental health services in seven sites across the country to instill the recovery ethos in everyday practice. Despite challenges identified in the pilot phase of ARI it sparked

- A HSE, Performance Assurance Report, December 2014
- B Ibid
- C Ibid
- D HSE, Census, December 2012
- E HSE, Census, December 2013
- F HSE, Vision for Change Implementation Plan, 2009-2013

creative recovery initiatives in the sites and the HSE's commitment to mainstream the recovery ethos is welcome. In MHR's survey, five out of seven HSE consumer panels indicated that they strongly agreed that mental health professionals in their area conveyed a hopeful attitude about their recovery.

However, there is an overriding concern that rehabilitation and recovery services for long-term mental health service users have been de-prioritised over the last 9 years. With more than 7,000 people with mental health difficulties using adult day activation services, it is evident that some people with mental health difficulties will require ongoing activation and social inclusion support.⁷⁷ Services for these individuals have been cut significantly in the past few years while other parts of adult mental health services have received new investment.

5.4. Advancing Recovery in Ireland sites



- Mayo,
- Galway,
- Cavan/Monaghan,
- Dublin,
- Carlow/ Kilkenny/ South Tipperary,
- West Cork,
- Mid West

Case study: Anne Foley, New Ross CMHT

Anne was referred to the mental health services in Wexford 16 years ago. She was diagnosed with depression and hospitalised for 3 months. She was on a lot of medications that were to define her life for the next 10 years.

Five years ago Anne was hospitalised again for a short time, but this time things were different. She explains:

"I was referred to the local mental health centre, Maryville, in my town. Here I was looked at as a whole person, not just my illness. With the help of the team, I was able to reduce my medication. I was lucky in that at this time new treatment plans were being devised to treat people with mental health issues, which included a care plan where the whole team treating, your GP and yourself were involved in making up your treatment plan.

I now have a keyworker, Helen, who oversees my care, and is my first point of contact and the person I would see most often. The team in Maryville became my life-line and gave me the belief that I could lead a normal life and still recover from depression. The first 10 years after my original diagnosis went by in a haze where I was locked away inside myself, living but not living fully. Maryville and Helen changed all that, along with a lot of work on my part.

I started to live again, I got back into education, started to set goals and achieved

them, started enjoying my life, my children, my new grandchildren, and my family, my brothers and sisters, nieces and nephews, and my friends. My keyworker makes time for me if I need her. She would often recognise I was unwell before I would. I've learned how to deal with my thoughts and how to change negative thinking and thoughts into positive ones."

Anne is fully aware of the difference her community mental health team has made to her life. She says: "I heard my granddaughter ask my daughter a couple of years ago: 'Why is nanny able to play with me now where she could not before?' and my daughter tell her: 'Because nanny was sick when you were born and were younger, but now she is better so she is able to play with you.'"

Anne now advocates for change in the mental health services to continue and is a spokesperson for change. She says: "For 10 years I was lost to my family but I have found my way back."

Chapter 6: Children and adolescents

Broad outline of AVFC recommendations

28

A Vision for Change set out recommendations for best practice in the provision of mental health promotion and prevention as well as the delivery of mental health services for children and adolescents. Key recommendations include the following:

- The need to prioritise the full range of mental health services from primary to specialist mental health services
- The need to provide mental health services to children and adolescents aged 0-18 years
- Service users, carers and their families should be given the opportunities to influence developments within mental health services based on their own experiences
- Mental health promotion and primary prevention should be targeted at child populations at risk
- Evidence-based mental health promotion programmes should be implemented in primary and post primary schools
- The Social, Personal and Health Education (SPHE) programme should be extended to include the senior cycle, as well as the junior cycle in post primary schools
- Expansion of CAMHS community mental health teams
- Clear links should be developed between CAMHS and community and primary care services
- The development of four inpatient units in Cork, Limerick, Galway and Dublin, with the appointment of fully staffed

multi-disciplinary teams

- Early intervention and assessment services for children with autism to include comprehensive multi-disciplinary paediatric assessment and mental health consultation where necessary

The Expert Group also recommended the development of the following specialist services for children and adolescents:

- An eating disorder team
- A high-secure unit
- 4 substance misuse and dependency teams
- 1 mental health of intellectual disability (MHID) team per 300,000 population/15 CAMHS MHID teams
- 2 forensic teams

Baseline in 2006

In 2006, the Expert Group identified current shortfalls in child and adolescent mental health services, including:

- Insufficient numbers of child and adolescent community mental health teams and services⁷⁸ and inequitable variation in the distribution of child services across the country
- An absence of dedicated adolescent mental health services on a national basis
- Insufficient inpatient and day hospital facilities
- An absence of dedicated child and adolescent forensic mental teams
- Paediatric liaison services were not available in the majority of major hospitals outside of the three national children's hospitals based in Dublin

78

CAMHS CMHTS were well below the norms recommended by the Working Group on Child and Adolescent Psychiatric Services in 2006, according to the Expert Group on mental health policy.

- Mental health services for children and adolescents with autism and autistic spectrum disorders were not always accessible

Progress to date

AVFC 10.1: The need to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents is endorsed in this policy.

The HSE is unable to provide information on the numbers of psychologists working in primary care.

In January 2015, the CAMHS waiting list had increased to 2,866 cases, an 8% increase on January 2014 (2,661). A total of 429 children were waiting more than 12 months to be seen by the service.⁷⁹

The HSE reports that all cases are triaged and urgent cases seen as a priority. A significant proportion of non-urgent cases are on waiting lists less than 3 months. This should be seen in the context of an increase in referrals to CAMHS teams from 8,663 in 2011 to 13,062 in 2014, i.e. by more than 50%.

AVFC 10.2: Child and adolescent mental health services should provide mental health services to all aged 0-18 years.

Following an assessment in March 2014 it was identified that:⁸⁰

- 31 of the 63 CAMHs community mental health teams accept referrals of all young people up to the age of 18
- 19 teams accept referrals of all young people up to the age of 17
- Five of the 63 CAMHS CMHTs accept new referrals up to age 16 but provide a service to existing service users after reaching their 16th birthday
- Eight of the 63 teams accept re-referrals

of all those over 16 who have previously attended the service and continue to provide a service to existing service users after their 16th birthday

AVFC 10.3: Service users and their families and carers [should] be offered opportunities to give feedback on their experience and to influence developments within these services.

A national protocol on service user, family member and carer feedback is yet to be developed for CAMHS. The HSE reported that “individual mental health services may have engagement mechanisms that the Office of Service User Engagement will support if required as that Office becomes more established”.⁸¹

The 2014 HSE National Listening meetings were open to all service users, family members and carers in the mental health services, including CAMHS; however, the HSE Mental Health Division recognises that the majority of attendees were individuals involved with general adult mental health services. A pilot listening meeting has been planned with one CAMHS service but has been delayed in the absence of the Interim Head of Service User Engagement. The Reference Group for the Mental Health Division includes members with self-experience of CAMHS, as well as experience and involvement in youth mental health services such as Jigsaw and advocacy projects.

It is also noteworthy that there is currently no national advocacy service for children and young people using public mental health services in Ireland.

AVFC 10.4: Programmes addressing mental health promotion and primary prevention early in life should be targeted at child populations at risk.

Atlantic Philanthropies, sometimes in conjunction with Government and other organisations, has invested over €127 million in 30 partner agencies and community groups running 52 prevention and early intervention services and programmes across the country. The Prevention and Early Intervention

79 HSE Performance Assurance Report January 2015.

80 HSE (2014) *Fifth Annual Child & Adolescent Mental Health Service Report 2012 – 2013*, p. 58.

Initiative (PEII) supports diverse services, across a wide range of settings and age groups, working in a number of areas such as early childhood, learning, child health and development, child behaviour, parenting and promoting inclusion. Of the 25 evaluations carried out on PEII supports so far, 22 of the programmes or services can be deemed effective or as showing promising results.⁸²

AVFC 10.5: Extension of SPHE to the senior cycle and evidence-based mental health promotion programmes [should] be implemented in schools.

30

The Relationships and Sexuality Education element of the SPHE curriculum has been made compulsory at Senior Cycle.⁸³

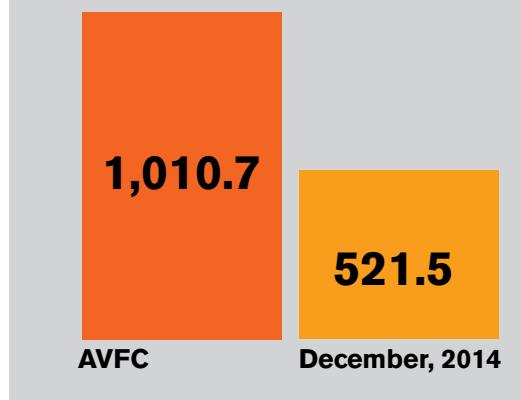
AVFC 10.7: Two CAMHS CMHTs should be appointed per 100,000 population; plus one liaison CAMHS CMHT per 300,000 population.

By the end of 2014, there were 63 community CAMHS teams in place. *A Vision for Change* recommended 77 community CAMHS teams.⁸⁴

As of December 2014 the number of clinical staff in post in community child and

adolescent mental health services (CAMHS) was 521.5 whole time equivalents (WTEs). This represents 51.6% of the staffing level recommended in *A Vision for Change* and is a 40.7% increase on the number of clinical staff that were in post in community CAMHS as of September 2011.⁸⁵

6.2. Clinical staffing levels within CAMHS CMHTs (WTEs)



AVFC 10.8: CAMHS CMHTs should develop clear links with primary and community care.

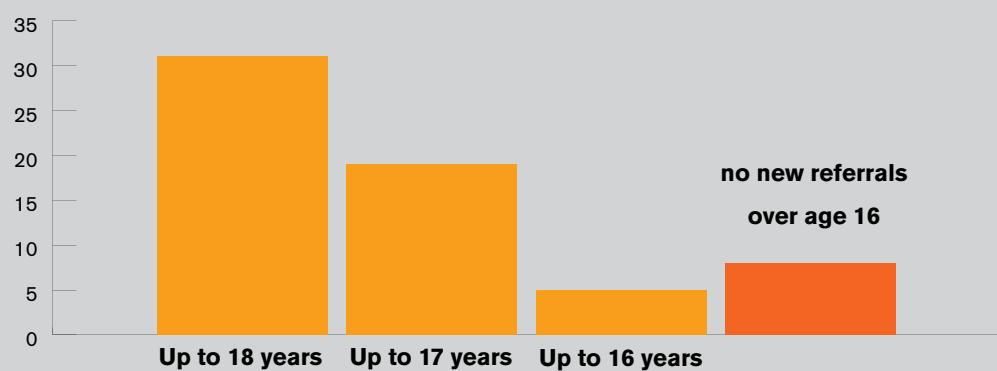
There is evidence to suggest that families in Ireland experience difficulties in accessing CAMHS due to a "knowledge deficit, a lack of information and a limited availability of specialist services".⁸⁶ The restrictive referral

82 Rochford, S., Doherty, N. and Owens, S. (2014) *Prevention and Early Intervention in Children and Young People's Services: Ten years of Learning*. Dublin: Centre for Effective Services.

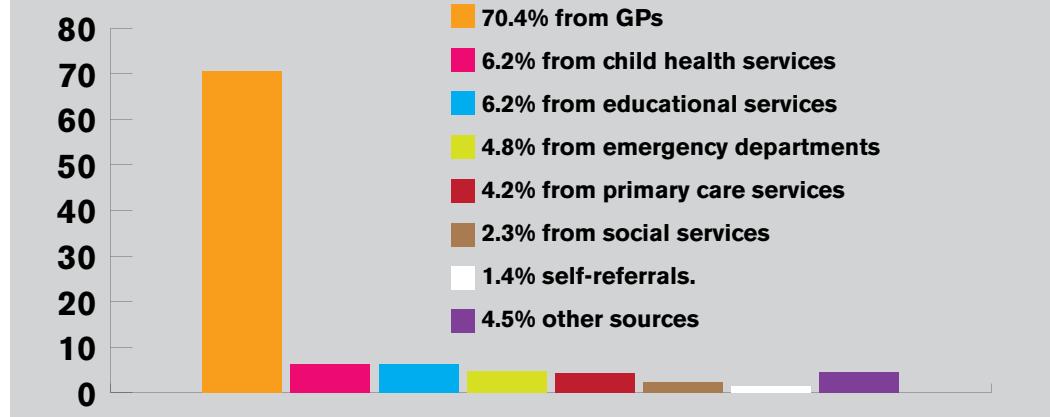
83 Information provided through correspondence with NEPS.
84 HSE Performance Assurance Report, December 2014, p. 57.

85 Information received through correspondence with the HSE.
86 Children's Mental Health Coalition (2015) *Meeting the Mental Health Support Needs of Children and Adolescents: A Children's Mental Health Coalition View*, Dublin: Mental Health Reform.

6.1. Number of CAMHS teams accepting new referrals of young people aged 16-18 years



6.3. Referrals to CAMHS and their sources, 2013



31

criteria to access community based CAMHS, the lengthy waiting period, and the lack of information about what to do during the waiting period have also been reported as barriers to accessing services.⁸⁷

The CAMHS Service Improvement Project Group is currently in the process of developing an agreed protocol between CAMHS and TUSLA, the Child and Family Agency, to enhance inter-agency working in the area of child and adolescent mental health services and supports. There is evidence to suggest that some CAMHS teams have liaison arrangements in place with primary services; however, a national protocol to support a standardised approach to inter-agency collaboration is yet to be developed.

The Children's Mental Health Coalition has identified that a key challenge to providing high quality, accessible mental health services and supports is inadequate interagency communication and collaboration. This challenge exists within mental health services, between mental health and primary care services as well as between mental health and child and family services.⁸⁸ The Taskforce on the development of a new Child & Family Support Agency (2012) made a number of recommendations for child and adolescent mental health services. Most notably, the Taskforce recommended

that child and adolescent mental health services should be directly provided by and transferred into the new agency. A key rationale for this recommendation was that there were "significant deficits in access to, and coordination between ... specialist mental health services and other services for vulnerable children and families."⁸⁹

According to the CAMHS annual report 2013 a total of 70.4% of referrals to CAMHS were received from GPs, 6.2% from child health services, 6.2% from educational services, and 4.8% from emergency departments. Primary care services accounted for 4.2% of referrals, including community psychology, speech and language therapy and occupational therapy; social services accounted for 2.3% of referrals. 1.4% of referrals were self-referrals. Adult mental health services, other child and adolescent mental health services, learning disability services, voluntary services, medico legal, and other services accounted for the remaining 4.5% of referrals.⁹⁰

⁸⁷ Coyne, I. et al (2014). *Adolescents and parents' experiences of attending child and adolescent mental health services (CAMHS) in Ireland: The report*. TCD, Dublin.

⁸⁸ Children's Mental Health Coalition (2015) *Meeting the Mental Health Support Needs of Children and Adolescents: A Coalition View*, Dublin: Children's Mental Health Coalition.

⁸⁹ Report of the Taskforce on the Child and Family Support Agency (2012) Dublin: Department of Children and Youth Affairs.

⁹⁰ HSE Fifth Annual Child & Adolescent Mental Health Service Report: 2012-2013, Table 4.1(a).

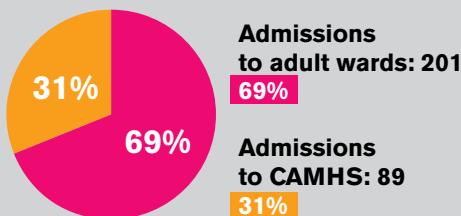
6.4. Number of inpatient CAMHS beds compared to *A Vision for Change* recommendation



32 AVFC 10.9: Four 20-bed inpatients units should be developed in Cork, Limerick, Galway and Dublin.

As of March 2015, the operational capacity of the child and adolescent acute inpatient units was 58 beds out of a total bed complement of 66.⁹¹ The AVFC recommended number of beds would equate to 108 inpatient beds based on Census 2011 population data.

6.5. Proportion of child & adolescent admissions to adult wards in 2014



Source: HSE Performance Assurance Report December, 2014

The Mental Health Commission's Code of Practice states that the placement of children in adult wards would be phased out by the end of 2011, with no child under 16 being placed in adult wards from July 2009, no child under 17 being placed in an adult unit by December 2010 and no child under 18 years to be admitted from December 2011.⁹²

By the end of December 2014, there had been 290 child and adolescent admissions, of which 201 (69%) were to age appropriate Acute Child and Adolescent Inpatient Units and 89 (31%) to approved adult mental health inpatient units.⁹³

The HSE has reported, "that some of these admissions relate to a crisis admission where no adolescent bed is immediately available. Distance to the nearest CAMHs inpatient unit can also be a factor when immediate clinical assessment and treatment may be the requirement. In some cases, the presenting clinical needs of the young person (who may be nearly 18 years old) may be more appropriately assessed and treated in an adult unit."⁹⁴

6.6. Number of children waiting more than a year to be seen, January 2015



AVFC 10.10: Early intervention and assessment services for children with autism should include comprehensive multidisciplinary and paediatric assessment and mental health consultation with the local CMHT, where necessary.

The CAMHS annual report 2013 reports that the number of presentations to CAMHS consistent with Autism Spectrum Disorder was 880 (10.3%) cases.⁹⁵

In recent decades there has been an increase in the number of children being diagnosed

91 Information received via correspondence from the HSE Mental Health Division.

92 Mental Health Commission (2006) *Code of Practice Relating to Admission of Children under the Mental Health Act*

2001, Dublin: Mental Health Commission.

93 HSE Performance Assurance Report December 2014..

94 HSE Performance Assurance Report December 2014, p.57.

95 HSE (2014) *Fifth Annual Child & Adolescent Mental Health Service Report 2012 – 2013*, p. 34.

with Autism Spectrum Disorder (ASD). In 2013 Staines and colleagues at the School of Nursing in Dublin City University undertook an estimate of the prevalence of ASD among 9,000 primary school children. The preliminary results estimated autism prevalence at 1%, broadly in line with international studies.⁹⁶

In April 2014 the National Disability Authority produced a report which mapped services and policies on ASD in Ireland. The report highlighted the need to develop an improved framework for assessment. Successive reports from the HSE to the Minister for Health under Section 13 of the Disability Act 2005 have highlighted the dilemma of limited therapy resources.⁹⁷

Summary assessment of children and adolescents



There are no CAMHS-specific quality standards and guidelines and no quality and outcome monitoring system for CAMHS.

This is not in accordance with good practice as advised by the World Health Organisation. The effectiveness of CAMHS treatment or intervention in terms of better outcomes for children is not being routinely measured in Ireland. Although the specialist, multidisciplinary CAMHS advisory group developed operational guidelines based on the Mental Health Commission's Quality Framework, these draft guidelines were sent to the HSE for approval in October 2013 and have not yet been progressed.

The HSE's Mental Health Directorate has established a CAMHS Service Improvement Project Group to address current shortfalls in child and adolescent mental health services, such as lengthy waiting lists and child admissions to adult inpatient units. The working group is currently in the process of

finalizing Standard Operating Procedures (SOPs) which aim to standardize service provision in all CAMHS teams across the country.

The Children's Mental Health Coalition has identified a number of existing gaps in child and adolescent mental health services and supports. Such gaps include the lack of specialist services for children and young people with co-morbid mental health and substance misuse difficulties, those with co-morbid mental health and intellectual disabilities, and those from ethnic minority communities. The CMHC has called for better service provision for children in the care system, children engaged in the youth justice system and children experiencing homelessness. Additional shortfalls identified by the Coalition include: a lack of capacity in primary care services to effectively detect, treat and appropriately refer child and adolescent mental health difficulties; a lack of community based supports; the absence of a national framework to support children and adolescents to effectively transition from CAMHS to adult mental health services; and the absence of the voice of the child in mental health service planning and delivery.⁹⁸

Given that three-quarters of mental health difficulties arise before the age of 25, it is evident that a renewed focus is required to develop child and adolescent mental health services, including primary care mental health services, so that they will be able to provide the high-quality early intervention mental health supports needed by children and adolescents.

96 Staines et al. (2013) *Autism Counts: Irish Autism Prevalence Study*, Dublin: Irish Autism Action.

97 National Disability Authority (2014) *Policies and services in Ireland for people with Autistic Spectrum Disorders*, Dublin: NDA.

98 Children's Mental Health Coalition (2015) *Meeting the Mental Health Support Needs of Children and Adolescents: A Coalition View*, Dublin: Children's Mental Health Coalition.

Case study: accessing Child and Adolescent Mental Health Services

Deirdre and Amy's story

Deirdre's daughter Amy is now fourteen. Amy first came into contact with Child and Adolescent Mental Health Services (CAMHS) when she was thirteen because she was self-harming. What her family didn't know was that she had already been self-harming for a year at that stage. Deirdre explains:

"Amy was having trouble in school. It was all getting too much for her. Things started going downhill."

Deirdre first brought Amy to an organisation specialising in suicide prevention treatment, but she wasn't ready to talk to them. Their next stop was at a children's hospital, where Amy was referred to her local CAMHS team. Although Deirdre was told it would be 6-8 weeks before they got an appointment, Amy was seen within two and a half weeks.

Amy has been getting regular counselling through the CAMHS team, but is still having ups and downs. She has been having behavioural problems and has been suspended from school. She has been on medication for nearly a year, but Deirdre says: "The medication isn't working. It keeps making her fall asleep."

Because of some recent problems Amy has been having in recent months, her CAMHS team have had to involve social workers and TUSLA, the Child and Family Agency. According to Deirdre, this is where things began to get complicated.

A referral for Amy to a specialist unit that should have been sent immediately was not sent for three months, after which time Deirdre received a letter telling her of a further 6-8 week wait for an appointment. Deirdre has found the whole experience very stressful and is worried about the long term effect on Amy and her education:

"I feel let down. We've been passed from one person to another. The specialist unit was the hope that we were waiting on but it took months to get an appointment even though

they had Amy down as an emergency."

Deirdre is still struggling with the situation, trying to access support for Amy and trying to keep her in school.

Chapter 7: Older people

Broad outline of AVFC recommendations

The Expert Group recommended that mental health care for older persons should extend over a continuum of services from health promotion, primary care and home care to acute general hospital care, specialist day care, acute psychiatric inpatient care, specialised mental health services continuing care, and non-specialist continuing care in hospital settings and nursing home care.

The proposed framework for service provision under AVFC emphasised the need to consider the interdependence of physical and mental health care in older persons and that there should be an extensive and integrated range of care options available to older people in Ireland.

Baseline in 2006

AVFC identified a number of major gaps in current mental health services for older people (MHSOP) which included the following:

- Absence of MHSOP in many catchment areas (most services catered for a population of older persons in excess of the recommended norm of 10,000 people over 65 years)
- Incomplete multidisciplinary representation in almost all existing MHSOP teams
- Lack of specialised acute units for older people
- Inadequate accommodation in continuing care facilities under mental health legislation
- Lack of dedicated day hospital facilities in almost all services
- A lack of emphasis on recovery and

positive coping skills in existing service provision

- In terms of physical resources, there were 62 acute designated assessment and treatment beds, some in specially designated locations within acute general hospital units; others available for MHSOP on request from the general psychiatric beds rather than being specifically designated. There were seven day hospitals providing somewhat less than 100 places and 469 continuing care beds.

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Progress to date

7.1. Number of Psychiatry of Old Age Community Mental Health Teams compared to *A Vision for Change* recommendation

AVFC recommended



May, 2015

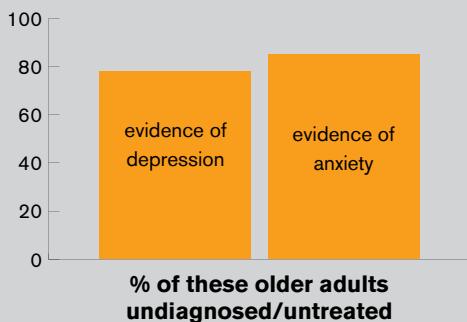


AVFC 13.1: Any person aged 65 years or over with primary mental health disorders or with secondary behavioural and affective problems arising from experience of dementia, has the right to be cared for by mental health services for older people.

Mental Health Services for Older People have been developed over the past 25 years, specifically for older people who develop functional mental health difficulties, such as depression after the age of 65. MHSOP also provide for individuals with dementia whose diagnosis is associated with significant behavioural and/or psychological symptoms. MHSOP aim to provide mental health supports within or as near to the individual's home as possible. Services within some catchment areas are complemented by day

hospital provision and acute inpatient care for individuals with more severe mental health difficulties.⁹⁹

7.2. Proportion of older adults with depression and anxiety who are undiagnosed/untreated



36

AVFC 13.4: Primary health care teams should play a major role in assessment and screening for mental illness in older people and should work in a coordinated and integrated manner with the specialist teams to provide high quality care, particularly care that is home-based.

As with mental health services for children and for adults under age 65, there is no data available on the extent of service provision or the number of presentations of mental health difficulties for people over age 65 within primary care.

The Irish Longitudinal Study of Ageing (TILDA) found that among people in Ireland age 50 and over, 10% had "clinically significant depressive symptoms" and 13% had "clinically significant anxiety symptoms". Among those with clinically significant symptoms, the study found a worrying level of under-diagnosis and under-treatment, with 78% of older adults with "objective evidence" of depression not reporting having been diagnosed, and 85% of older adults with "objective evidence" of anxiety reporting not having been diagnosed.¹⁰⁰ The information for this study was collected between October

2009 and February 2011.

AVFC 13.5: One MHSOP multidisciplinary team should be established per 100,000 population (46 teams).¹⁰¹

There are 27 psychiatry of old age community mental health teams nationally with 266.5 WTE staff in post in these teams. Specialist mental health services for older people are available in some parts of the country and do not exist at all in other areas.¹⁰²

The Expert Group recommended 46 psychiatry of old age community mental health teams, supported by 506 clinical staff in total.

The HSE has reported that where MHSOP services do not exist, priority has been given to the development of services through the appointment of mental health staff from the additional development posts allocated under Budgets 2013 and 2014. The following geographical areas have been identified for development: Wicklow, Kildare, part of Cork City, County Cork, Roscommon and the half of Mayo not already covered. Other posts were ring-fenced for psychiatry of old age to enhance existing community mental health teams in mental health for older people and specifically to enhance the health and social care professionals within these teams.

AVFC 13.7: Physical resources essential to service delivery, acute beds and continuing care, service headquarters, community-based and day facilities should be provided for MHSOP in each sector.

The Expert Group recommended that each mental health service should have access to a dedicated and separate old age psychiatry acute inpatient unit providing 8 beds per 300,000 total population with the equivalent number for older people being 8 beds per 30,000 people over the age of 65. In terms of physical resources available to the twenty three services, there are only six acute units for older people. Other beds are only

99 Information provided via correspondence from the HSE.

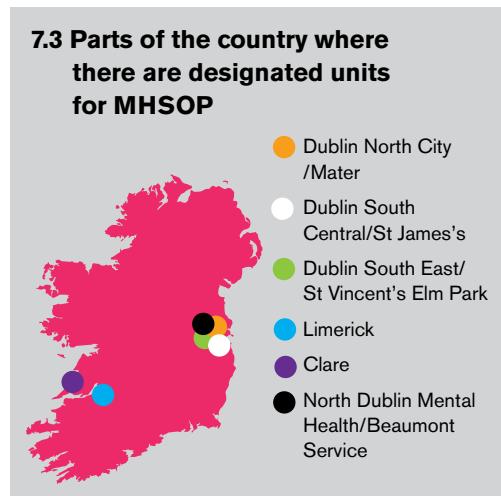
100 The Irish National Longitudinal Study on Ageing. Fifty Plus in Ireland 2011: First results from the Irish longitudinal study on ageing, chapter 6: 'mental health and cognitive function', available at <http://tilda.tcd.ie/publications/reports/>

101 In AVFC this recommendation is stated in terms of 39 teams, however based on Census 2011 the equivalent figure would be 46 teams.

102 Information provided via correspondence from the HSE.

available for MHSOP on request from the general psychiatric beds. There are seven day hospitals and only 14 continuing care units, both below the norm recommended by AVFC.¹⁰³ Dedicated old age psychiatry inpatient units are available in the services listed below:

- Dublin North City/Mater
- Dublin South Central/St James's
- Dublin South East/St Vincent's Elm Park
- Limerick
- Clare
- North Dublin Mental Health/Beaumont Service



A new unit is due to open in Cork University Hospital for the South Lee Service. In areas without specialist units, the psychiatry of old age service has access to beds in the general adult psychiatry wards. The HSE reports that in all future units there will be provision for a dedicated psychiatry of old age unit.

The Expert Group recommended that there should be 30 Approved Centre (Mental Health Act, 2001) continuing care beds per 30,000 population over the age of 65 for people with dementia associated with severe and intractable behavioural problems, typically physically aggressive behaviour. Such beds are available in the following units:¹⁰⁴

- Dublin North City/Mater Service

- Dublin South East/St Vincent's Elm Park Service
- Limerick Service
- Laois/Offaly Service
- South Tipperary Service
- Clare Service
- Wexford/Waterford Service
- North Dublin Service
- Carlow/Kilkenny Service
- Mayo Service
- East Galway Service

Some services have day hospitals which enhance the level of community care available to older people. Day hospitals reduce the requirement for acute inpatient care and facilitate earlier discharge. Services with day hospitals include:

- Dublin North City/Mater
- Dublin South Central/St James's
- Dublin South East/St Vincent's Elm Park
- Limerick
- Dublin South West/AMNCH
- Laois/Offaly
- Longford/Westmeath
- South Lee Cork
- Sligo Leitrim

However, as of 2010, the Inspector for Mental Health Services reported that 50% of mental health services for older people had no day centre or day care facilities.¹⁰⁵

¹⁰³ Information received through correspondence with the HSE.

¹⁰⁴ Ibid.

¹⁰⁵ Inspector for Mental Health Services (2011) *Mental Health Services for Older People – National Overview Report* 2010, available at http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/National_Overview_Report/

A Vision for Change does not refer to the need to provide specialist MHSOP for older people admitted to acute hospitals. All MHSOP services, aware of the crucial importance of providing a continuum of care to older people when and where they need it, assess and advise on the treatment of older people in acute hospitals. However, with the exception of one service, this is done through their MHOP community mental health team. The Mental Health Division is currently addressing this issue.

Summary assessment of older people

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Starting from a relatively low base in 2006, mental health services for older people remain under-resourced relative to the growing demand for this age group. It is still the case that not all areas of the country have specialist community mental health teams for older people, and not all have access to dedicated psychiatry of old age inpatient beds. Those community teams that do exist continue to be under-staffed relative to the recommended multidisciplinary complement, though recruitment by the HSE in 2015 may make further progress towards recommended levels.

Also of serious concern is the extent of untreated mild to moderate mental health difficulties among older people, shown by evidence emerging from Ireland's longitudinal study on ageing. With 78% of those older adults (aged 50 and over) with depression and 85% of those older people with anxiety being undiagnosed and untreated, this suggests that there is a large problem of unmet need for primary care mental health supports among older people in Ireland.

Chapter 8: Mental health services for people in the criminal justice system

Broad outline of AVFC recommendations

A Vision for Change included specific recommendations for forensic mental health services to serve people with mental health difficulties who come into contact with the criminal justice system and those with aggressive or challenging behaviour. The Expert Group emphasised that forensic mental health services should have “a strong community focus” as well as providing “secure inpatient care”, and that the principles underpinning *A Vision for Change* should apply to forensic mental health services, including person-centredness, multidisciplinary support, service user and family/carer involvement, and the right to advocacy support.

The Expert Group highlighted that all individuals in the criminal justice system should have the right to be treated in non-forensic mental health services unless there are “cogent and legal reasons why this should not be done.”¹⁰⁶

Baseline in 2006

The Expert Group recognised the need for forensic mental health services to widen their remit to work with An Garda Síochána in pre-charge and pre-court diversion schemes, despite the absence of a statutory basis for this. The Expert Group identified the difficulties experienced by people with mental health difficulties who are engaged with the courts, often for very minor offences in terms of discrimination and stigma. There

was also an absence or inadequacy of safe acute observation areas in general hospital mental health units, and forensic mental health services were centralised into the Victorian institution that is the Central Mental Hospital in Dublin.

Progress to date

AVFC 15.1.2: Forensic Mental Health Services (FMHS) should be expanded and reconfigured so as to provide court diversion and legislation should be devised to allow this to take place.

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Legislation on court diversion has not yet been passed in Ireland. However, it appears that existing structures for the majority of people for whom court diversion applies (i.e. people with severe mental health difficulties charged with very minor matters) are proving positive. For example, the screening of all committals at Cloverhill Remand Prison enables the prison to detect unmet needs. The psychiatric in-reach team at Cloverhill is then able to liaise with the district courts and with community mental health teams to develop appropriate care plans that in almost all cases are acceptable to the court with the agreement of all parties. Care plans may include arranging an outpatient appointment with the community mental health team; a voluntary admission to a local approved centre or an involuntary admission to an approved centre. Where an arresting Garda is concerned that a person may be suffering from a ‘mental health disorder and may pose a risk to themselves or others’, they may choose to make an application for admission to hospital under section 12 of the Mental Health Act 2001 as an alternative to prosecution. On appearing at court, the person may be granted bail or given any other non-custodial disposal in order that they may be enabled to access health care. Gardaí have a degree of discretion as to whether to grant bail from the Garda Station which provides an opportunity for persons to access or be diverted to mental health services without being remanded.¹⁰⁷

When a person is charged with a very serious matter then the Central Mental Hospital is the only route available. Ideally, local acute, low

secure units (a Psychiatric Intensive Care Unit, PICU), should be provided. However, such supports do not exist.

People with severe mental health difficulties who are charged with serious offences who present a danger to others have available to them admission to the Central Mental Hospital if they are found unfit to stand trial or they can choose to plead Not Guilty by Reason of Insanity (NGRI). Many people, however, who are unfit to stand trial nonetheless plead guilty or not guilty, choosing not to plead NGRI. In these situations a judge does not have the option of putting the question of NGRI before a jury.¹⁰⁸ In other jurisdictions, the judge has the sentencing option of making a hospital order, equivalent to an admission under Part 2 of the Mental Health Act. In serious matters the judge may add a Restriction Order having the same effect as a finding of NGRI under Section 5 of the Criminal Law (Insanity) Act. Such protections are not available under the Irish legislation.

Of the four prisons across the country that accept male individuals on remand (Cloverhill, Cork, Limerick and Castlerea prisons), Cloverhill prison currently provides screening for court diversion. The Central Mental Hospital is about to commence an in-reach service to Castlerea prison with a screening system due to be put in place by the end of 2015. The women committed to the Dóchas Centre Women's Prison are all screened and diverted as appropriate by an in-reach service. There appears to be no screening process in place in Cork.¹⁰⁹

In 2013, 10,729 men and 2,326 women (13,055 in total) were committed to Irish prisons. Of these, 3,123 people in total were committed to Cloverhill Prison on remand. Following screening, 460 new referrals were seen by the forensic mental health services. Of these 46 were referred on to prison addiction services, 185 were discharged to prison GPs, 19 were discharged to General Practitioners in the community, 81 were discharged to community mental health teams or drugs rehabilitation services in the community, 33 were admitted to local

approved centres, 5 as voluntary patients and 28 as involuntary patients under the Mental Health Act and 20 were admitted to the Central Mental Hospital under Section 15 of the Criminal Law (Insanity) Act.¹¹⁰

AVFC 15.1.3: Four additional multidisciplinary teams for forensic mental health services should be provided; one per HSE region

AVFC 15.1.6 An additional community-based, child and adolescent forensic mental health team should also be provided.

The National Forensic Mental Health Service (NFMHS) has a total of two acute multidisciplinary teams, two medium multidisciplinary teams and two rehabilitation and recovery teams, in addition to the Cloverhill in-reach team. While regional multidisciplinary teams have not been developed, the FMHS provides in-reach clinics in the following prisons: Cloverhill, Mountjoy, Dóchas Centre, Wheatfield, the Midlands, Portlaoise, Arbour Hill and St Patrick's Young Offenders Institution.¹¹¹

There is no forensic community mental health team for children and adolescents. According to the HSE's Mental Health Division Operational Plan 2015, a seed CAMHs community based forensic mental health team will be operational by quarter 4 of 2015.¹¹²

Separately from the FMHS, there is a Psychology Service operating within the Irish Prison Service. There are currently 18 (17 WTEs) psychologists employed within the Irish Prison Service. They are located in Mountjoy, Wheatfield, Arbour Hill, Portlaoise, Munster area (Cork and Limerick Prison) and North West (Castlerea and Loughan House).¹¹³ Despite the recruitment of two additional psychologists to the Irish Prison Service (to be assigned to the Portlaoise prison) in 2015, three psychologist posts will be lost at the end of May 2015. This will bring the number of psychologists to 17 (16 WTEs).

110 Ibid.

111 HSE Mental Health Division Operational Plan 2015, p. 92.

112 Ibid.

113 Information received through correspondence with the Irish Prison Service.

The waiting lists for individuals in prison to avail of psychological support vary across the service and can be significant. The service aims to triage all referrals within eight weeks. Those deemed suitable are then placed on an intervention waiting list. The waiting list for intervention is approximately eight to nine months in prisons where resources are limited, such as the Midlands prison.

The Psychology Service does not currently provide any community follow-up to people released from prison and refers on as appropriate to community-based services. Access to community-based psychology services varies across the country with extensive waiting lists and wait times in many areas. The possibility of some community follow-up being provided by the IPS Psychology Service will be considered in the upcoming review of the service.

The Director General of the Irish Person Service has sanctioned a comprehensive review of the role and function of the Psychology Service to be carried out in May 2015. The aim is that this review will help inform the future direction of the service.

AVFC 15.1.4: The CMH should be replaced

AVFC 15.1.6: A dedicated residential 10-bed [forensic] facility for child and adolescents should be provided.

Currently the FMHS continues to operate inpatient care from the Victorian Central Mental Hospital in Dundrum, Dublin. Successive Inspector's reports have found that this facility is "outdated and unsuitable as a mental health facility for the 21st century".¹¹⁴ An application for the construction of the new National Forensic Mental Health facility planned for the St. Ita's Hospital Portrane site was submitted to An Bord Pleanála in 2014. A public consultation and reply process was carried out on the plans for the site and a decision from An Bord Pleanála is expected in late May 2015 as to whether the application was successful. If the application is successful it is expected that construction

will be completed by the end of 2017 and the hospital will open in early 2018.¹¹⁵

The child and adolescent forensic mental health unit will be part of the new Forensic Mental Health Facility planned for Portrane.

AVFC 15.1.7: A 10-bed residential unit with multidisciplinary team for mental health & intellectual disability in context of criminal justice system.

The National Forensic Mental Health Service has received funding and manpower approval from the Mental Health Division to commission a mental health for intellectual disability team. Some members of the team are in post and a dual qualified consultant will be appointed to the team. The new national forensic mental health facility will include a 20 bed unit, 10 beds dedicated for those with a primary diagnosis of MHID and a further 10 for those with "dual diagnosis of mental illness and MHID".¹¹⁶

AVFC 15.1.8: Education and training in the principles and practices of FMH should be established and extended to appropriate staff, including An Garda Síochána.

According to the sixth annual report of the Independent Monitoring Group (IMG) the existing student programme for trainee Gardai was replaced with a new BA in Applied Policing. Unit 5 of the programme, 'Mental Illness Awareness', covers topics, such as 'types of mental illness', 'Garda powers and procedures' and 'transportation of persons with a mental illness'. The unit also includes ASIST suicide prevention training. The report identifies that 'where any gaps in mental health awareness training are identified, they will be examined with a view to developing further training in this area'.¹¹⁷

AVFC 15.1.9: A senior garda should be identified and trained in each Garda division to act as resource and liaison

115 Information received through correspondence with the Central Mental Hospital.

116 Information received through correspondence with the Central Mental Hospital.

117 Independent Monitoring Group (2012) *Sixth Annual Report on Implementation*, Dublin: Department of Health, p. 66.

mental health officer.

An Inspector has been nominated in each Garda division to act as liaison person to the approved centres in their division. A training programme has been developed and delivered by the Garda College for the appointed liaison Inspectors.¹¹⁸

Summary assessment of mental health services for people in the criminal justice system

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Nine years after publication of *A Vision for Change*, people with severe mental health difficulties are still being treated in a Victorian institution that has been described by the Inspector of Mental Health Services as "outdated and unsuitable as a mental health facility for the 21st century". While there has been innovative development of a diversion system into mental health services at remand stage, regional, community-based forensic mental health services remain under-developed and there are still no specialist forensic mental health services for children and adolescents or people with mental health and intellectual disability. This leaves a forensic mental health service struggling to cope within an unsuitable facility and without the teams to support the 'community-focused' care recommended by the Expert Group.

Feedback from the Irish Association of Social Workers is that local CMHTs are reluctant to take back patients or accept individuals who have become involved with the criminal justice system. The appointment of a liaison person in each Garda division has been a positive step, as has increased training for the Gardai. These steps hold the potential to improve the experience of individuals with mental health difficulties who come in contact with Gardai either under the Mental Health Act, 2001 or criminal law.

Chapter 9: Special categories of service provision

A Vision for Change includes a dedicated chapter on special categories of mental health service provision. The Expert Group recommended the development of mental health services for people who need supports not typically provided by generic mental health services, including homeless people, people with co-morbid mental health difficulties and substance abuse problems, people with eating disorders and people with co-morbid mental health difficulties and intellectual disability.

Baseline in 2006

In 2006, The Expert Group identified barriers for specific groups in accessing mental health services. Most mental health services for people with intellectual disability are provided by the voluntary and non-statutory sector. A report published in 2004 by the Irish College of Psychiatrists noted that “mental health/psychiatric services for people with intellectual disabilities remain under-resourced and grossly underdeveloped in many Health Board areas in Ireland. Some counties have no psychiatric service at all for people with intellectual disabilities”.¹¹⁹

The Expert Group reported that “homeless people are more likely to be hospitalised, and less likely to access community-based mental health services, than the general population.”¹²⁰ The Group noted that statutory housing authorities were making “negligible” provision for people with mental health difficulties, and that due to this lack of provision, the health services were funding 3,000 places in 400 mental health service residences.

The Expert Group highlighted that at that time “major responsibility for care of people with addiction lies outside the mental health system,”¹²¹ but that the National Advisory Committee on Drugs had advocated much closer collaboration between addiction programmes and general mental health services.¹²² In 2006, 40% of service users supported by CMHTs reported drug or alcohol misuse problems, illustrating the high prevalence rate of dual diagnosis and the requirement for services to meet this need.¹²³

In 2006, Ireland had only three designated specialist beds for the treatment of eating disorders in the public mental health service. Two eight-bed units were available in the private sector that took some public patients. Overall, the Expert Group identified a general lack of inpatient facilities for public patients; inadequate numbers of inpatient beds (with a slow turnover as length of stay can be long); severe deficits in multidisciplinary teams; the absence of specialised residential facilities (many people had to travel to the UK to avail of services); lack of data on the number of people treated for eating disorders; centralisation of services in Dublin; deficits in specialist provision for children and adolescents and a lack of communication and collaboration between child and adolescent mental health services and adult mental health services in relation to service provision, early identification and continuity of care.

Progress to date

AVFC 14.6: Mental health services for people with intellectual disability should be provided by a specialist MHID team that is catchment area-based (2 per 300,000), and

AVFC 14.8: One MHID team per 300,000 population should be provided for children and adolescents with intellectual disability.

There are 12.95 adult MHID posts under the auspices of or funded by the HSE. Approximately 300 posts for adult MHID were recommended in *A Vision for Change*.

119 Irish College of Psychiatrists (2004) *Proposed model for the delivery of a mental health service to people with intellectual disability*. Occasional Paper OP58.

120 *A Vision for Change*, p.144.

121 *A Vision for Change*, p.146.

122 *A Vision for Change*, p.147.

123 *A Vision for Change*, p. 146.

An additional 150 MHID posts were recommended for child and adolescent mental health services. There are 4.9 MHID CAMHS consultants.¹²⁴

Anecdotally, there is evidence of people, particularly children and adolescents with an intellectual disability experiencing difficulties in accessing mental health services. The Ombudsman for Children's Office has previously highlighted the difficulty some parents of children with intellectual disabilities face when trying to access CAMHS. In a 2013 report, the Ombudsman stated that: "In a third case securing a mental health assessment was very problematic. In this case a child protection assessment appears to have been dependent on a mental health assessment being secured. The handling of the mental health referrals by HSE CAMHS was a cause for concern. The referrals made on behalf of the child were reviewed seven times by HSE CAMHS and refused on the basis that CAMHS did not work with children with intellectual disability."¹²⁵

AVFC 15.2.5: Two MDTs should be provided, one each in North and South Dublin, to provide a mental health service to the homeless population.

There are four community mental health teams for people who are homeless and have a mental health difficulty; two in Dublin, one in Cork and one in Waterford. The total staff complement of these teams is 13.84 WTEs. A further 7.5 new posts were approved under Budget 2014 to provide for the further development of these services in Dublin South Central, Dublin North City and in the South of Ireland.¹²⁶

In April 2014, Mental Health Reform's Homeless Sector Advisory Group identified a number of gaps in services and supports for people who are homeless with mental health difficulties. Such gaps included; an absence of tenancy sustainment supports, particularly longer term, ongoing support; a lack of ring-fenced housing; time limits on support which

can often be stressful and can increase the risk of relapse; and inappropriate housing placements. Other gaps included: the lack of crisis support for people who are homeless; the absence of follow up plans for people discharged from hospital or released from prison at risk of becoming homeless; and difficulties in accessing mental health services for individuals who also have an addiction issue.

Back in 2013, Mental Health Reform heard at a public meeting in Wexford how the addition of an assigned mental health nurse for homeless people in the area was making a difference and improving the links between mental health and homeless services.

AVFC 15.2.6: CMHTs should adopt practices to help prevent service users becoming homeless, such as guidelines on discharge.

There are a number of policies in place to help prevent people accessing mental health services from becoming homeless, including the Mental Health Commission's Code of Practice on Admission, Transfer and Discharge from an Approved Centre and the Department of Environment, Community and Local Government's 20 Point Action Plan on homelessness.

In 2012 the HSE published a guidance paper entitled 'Addressing the Housing Needs of People Using Mental Health Services'. The document aims to assist mental health services in developing appropriate policies and procedures for addressing the housing needs of service users. It encourages services to identify the potential housing needs of people with mental health difficulties, alongside other areas of need/care for both those who currently reside in residences provided by or through the HSE and those who are newly presenting to mental health services.¹²⁷

However, a study in the Tallaght service between October 2012 and September 2013 showed that an inpatient was discharged to homeless services every 9.4 days.

124 Information provided through correspondence from the HSE.

125 Ombudsman for Children (2013) *A Meta-Analysis of Repetitive Root Cause Issues Regarding the Provision of Services for Children in Care*, Dublin: Ombudsman for Children.

126 Information provided through correspondence from the HSE.

127 HSE National Vision for Change Working Group (2012) *Addressing the Housing Needs of People using Mental Health Services: A Guidance paper*, Dublin: HSE.

AVFC 15.3.1: Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.

According to the HRB activities report on Irish psychiatric units and hospitals, 2,360 individuals were admitted with a primary diagnosis of alcohol or other drug disorder to an inpatient unit in 2013, representing 12.8% of all admissions. 1,268 were admitted to general psychiatric units, 379 to psychiatric hospitals/ continuing care units and 713 to independent, private or private charitable centres.¹²⁸

In 2011, the Mental Health Commission identified that dual diagnosis rates among people in Ireland are reported between 30% and 80%.

A study by Fiona O Reilly, Partnership for Health Equity (a collaboration between the HSE, the North Dublin City GP Training Programme and the University of Limerick) which surveyed 599 homeless people in Dublin and Limerick in 2013, found that dual diagnosis was the “norm rather than the exception” among the homeless population surveyed, and suicidality was highly prevalent in this group of people.

AVFC 15.3.4: Specialist adult teams should be developed in each catchment area of 300K population to manage complex, severe substance abuse and mental disorder.

Specialist community teams designated to address complex, severe substance abuse and mental disorder have not been developed. The available data indicates that there are seven community mental health teams providing an addiction service with a staff complement of 20.4 WTEs. In Dublin consultant psychiatrists working within the addiction services provide for people with drug addiction associated with mental health difficulties. Five work in the services for adults and two in services for adolescents. All are based in Trinity Court and provide clinics in

designated sites across Dublin City. There are also specialist consultant led mental health addiction services in Waterford and Mullingar.¹²⁹ In some parts of the country, addiction services are not provided by the mental health service.¹³⁰

There is anecdotal evidence to suggest that both adults and children with co-morbid mental health and substance misuse difficulties are experiencing challenges in accessing mental health services.¹³¹

AVFC 15.3.6: 2 additional adolescent multidisciplinary teams should be established outside Dublin to provide expertise for adolescents with co-morbid addiction and mental health problems, and this provision should be reviewed every 5 years.

No dedicated multidisciplinary teams have been established for adolescents with co-morbid addiction and mental health problems.

AVFC 15.4.1: Health promotion initiatives that support greater community and family awareness of eating disorders should be supported and encouraged.

AVFC 15.4.2: The activities of voluntary agencies in promoting awareness and responses to eating disorders should be supported.

Bodywhys, the national eating disorders association, co-ordinates an annual Eating Disorders Awareness Week to raise awareness and challenge stigma on eating disorders. Through a range of outreach programmes in the community, schools and colleges, awareness, information and education is delivered to a wide range of audiences.

Bodywhys receives funding from the HSE to provide a range of support services, including a national helpline; face-to-face support groups; online support groups and an outreach programme.

128 Information received through correspondence with the HSE.

129 Information received through correspondence with the HSE.

131 Information received through correspondence with Dual Diagnosis Ireland.

AVFC 15.4.5: There should be one full multidisciplinary team in a National Centre for Eating Disorders, for complex cases that cannot be managed by local CAMHS CMHTs.

AVFC 15.4.6 & 7: There should be four specialist multidisciplinary teams providing specialist inpatient, outpatient and outreach services for eating disorders, one per HSE region; with 24 public eating disorder beds nationally.

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The National Centre for eating disorders has not been established, but is proposed to be included in the new Children's Hospital.

The HSE has not established multidisciplinary specialist eating disorder services. According to the HSE, they and the College of Psychiatrists of Ireland are developing a Clinical Programme for Eating Disorders (from early intervention to tertiary care) and the HSE has just appointed a Clinical Lead for this Programme. 85 HSE staff have received specialist CBT training from Professor Chris Fairburn for adults with eating disorders. Training in Family Therapy for Eating Disorders, as required by children and adolescents, is starting with a first cohort of 35 staff in May 2015 and a second in Autumn 2015.

AVFC 15.5.1: There should be 13 Liaison Mental Health Teams nationally.

There are eight Liaison Psychiatry Services and these are based in the following hospitals: the Mater; Connolly; Beaumont; St Vincent's Elm Park; St James's; AMNCH (Tallaght); Cork University Hospital and Limerick University Hospital.

In addition there are three Paediatric Liaison Psychiatry Teams, one in each of the Paediatric Hospitals in Dublin (Temple Street University Hospital, Our Lady's Crumlin and the Children's Hospital in Tallaght).¹³² The Mental Health Division prioritized the development of these services in the 2014 allocation of posts. Additional liaison services were developed in Our Lady's Hospital

Drogheda in 2013 and new services are to be developed in Cavan, Sligo, Waterford and Kerry with two more consultants being recruited in Cork following allocation of posts and funding by the Division in 2014. The Mental Health Division funded the recruitment of a pediatric liaison team for Cork in 2014.

Other unmet need

While the Expert Group did not make recommendations on services for people with ADHD, the Irish National Council for AD/HD support groups (INCADDS) has reported that no ADHD support services are available through adult mental health services. The Council also reports the need for a range of care options for children presenting with ADHD to prevent serious long term complications. The Mental Health Division has recognized the need to provide services for adults with ADHD and intends to start a new Clinical Programme for this purpose this year. Children and adolescents with ADHD are assessed and treated by a CAMHS team. It is one of the more common reasons for referral to such teams. The Clinical Programme as part of its brief will ensure cohesive working between CAMHS and adult teams seeing people with ADHD to minimize the impact of the transition at 18. The Expert Group included ADHD among autism spectrum disorders that should be catered for through services for people with intellectual disability.¹³³

The Expert Group did recommend that services ensure they were accessible to people from minority groups including people who are deaf (see AVFC Section 4.8.1). People who are deaf are at particularly high risk of developing a mental health difficulty, with prevalence of 40-50%. There is a lack of appropriate and accessible mental health services in Ireland for individuals who are deaf. A pilot specialist Mental Health and Deafness service was established in 2005, situated in DeafHear. Having received 130 referrals between September 2005 and August 2008, this number of referrals is below the expected level given the size of Ireland's deaf community.¹³⁴ The lead Consultant for this service has identified that professionals working in the area of mental health often

receive little training in working with people who are deaf and have little exposure to this area of care in practice; there is a lack of qualified sign language interpreters/certified deaf interpreters and a lack of knowledge about this population among health care providers.¹³⁵

Summary assessment of special categories of service provision



The evidence on the provision of special categories of mental health service provision shows that these services have received the least development since 2006 compared to other areas of the mental health service.

Under the human right to the highest attainable standard of mental health, the Irish Government has a particular responsibility to provide services to marginalized groups. People with intellectual disability, co-occurring substance misuse difficulties, or who are deaf or homeless all have higher risk of developing mental health difficulties than the general population, yet they are least well served by existing mental health services. With just 4% of the staffing required for adult mental health and intellectual disability teams, no increased beds for eating disorders, just 13.84 posts in homeless teams, and no development of a specialist team for people with co-occurring substance abuse and mental health difficulties, it is clear that these high risk groups have not received the priority they should have in the implementation of *A Vision for Change*.

Case study: Valerie Farragher, dual diagnosis services

Valerie Farragher – Come back when you're sober

Valerie's story shows the frightening and dangerous gap that people can fall through when they have both an addiction and a mental health difficulty. This is known as having a 'dual diagnosis'. Most mental health services and addiction treatment centres in Ireland are currently not organised to treat such people holistically. In Valerie's case, when she asked for help for her mental health, she was told in no uncertain terms to deal with her addiction first.

Valerie had left school and married young, with three children by the time she was twenty-one. The birth of her third child was a traumatic one. Depression, weight gain and ill-health took hold while Valerie was pregnant with her fourth child. She kept frantically busy throughout this time, sometimes with the help of alcohol to give her energy.

Valerie describes this time as like she was "carrying heavy stones in my pockets", a feeling that continued for several years. "My heart and soul were held together with a shoe string."

Valerie had recognised her alcohol addiction but didn't know that she had underlying post-natal depression. She sought addiction counselling as well as treatment for food addiction, but describes the experience as "humiliating". On one occasion, when in A&E begging for a bed, she heard that sentence for the first time from a psychiatrist: "come back when you're sober".

Valerie's mental health continued to deteriorate, and she started hearing voices and self-harming. She says: "I was really having a full blown mental breakdown and the crash was approaching fast. I wasn't in any kind of treatment that could recognise this ... I was in addiction treatment. And most addiction treatment centres don't deal with mental health or have psychiatric back up."

It was not until she was hospitalised after a suicide attempt that Valerie was told she had

had untreated post-natal depression since the birth of her fourth child. Her recovery began with the help of medication and Aware support group meetings. She went on to become a facilitator with Aware and also did a course on community addiction studies.

Through her studies and contact with the charity Dual Diagnosis Ireland, Valerie learned more about the gaps in services for people like her, with an addiction and a mental health difficulty. She describes feeling hurt that her future wasn't deemed important enough for her to be given the right support:

"Did it really matter if I too was lost in the services? What difference would my life make to the world? After the tears came the anger. Ten years of my life, ten long, hard, suffering, painful, exhausting years had been taken from me and my family by depression and addiction. A lot of that happened in this story could have been avoided. Me begging to die, my children hurting, crying, distressed. My husband so broken and beaten."

Valerie and a close friend, Mary, have now set up a programme called New Choices in the west of Ireland, providing support and detox for people with a dual diagnosis. Valerie continues to raise awareness of the financial and human cost of ignoring dual diagnosis and advocates for better services. In Valerie's own words: "if I wanted things to change, then I would have to change them. I needed to surround myself with people who were fighting for change. Now, I'm on a mission."

Valerie has written a book about her journey, called *Come Back When You're Sober*, published in 2013.

Chapter 10: Accountability/ governance/ manpower

Broad outline of AVFC recommendations

A Vision for Change includes a number of key recommendations to improve the accountability and governance of mental health services in Ireland. First, the Expert Group recommended that the organisation and management of mental health services should be co-ordinated locally through multidisciplinary Mental Health Catchment Area Management teams. Management teams should be led nationally by a multidisciplinary HSE Mental Health Service Directorate whose members have “demonstrated competency and interest in service planning and management and should have training to equip them for this national role.”¹³⁶ Both area management teams and the national Directorate were to have service user representation. The Expert Group also recommended the establishment of an Independent Monitoring Group to monitor progress on implementation.

Progress to date

The closure of all of the old psychiatric hospitals and the reinvestment in mental health services from the capital gained from such closures is a key recommendation of AVFC. The Expert Group recommended that additional investment of €21.6 million per annum be made for seven years to implement the policy.

The framework of mental health service delivery proposed by the Expert Group included:

- Ongoing evaluation of services based on key performance indicators

- Development of mental health information systems
- A programme of capital and non-capital investment
- The implementation of a multi-professional manpower plan based on projected services plans

These recommendations are underpinned by the principles of ‘accountability’ (both clinical and corporate), ‘effectiveness’ and ‘equity’.

Baseline in 2006

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In recent years mental health services were managed at catchment area level by a structure recommended in Planning for the Future which consisted of three key individuals: the Clinical Director, Director of Nursing and Hospital Administrator. The Expert Group recognised that this structure encouraged isolation of catchment teams from each other and did not support the development of cross-catchment specialist mental health services.

AVFC 16.1: Mental Health Catchment Areas should be established with populations of between 250-400,000, taking into account current social and demographic realities.

Since 2006, Mental Health Services have been re-configured to consolidate resources among larger populations. In 2015 mental health services will be re-configured in line with the new Community Healthcare Organisations.

AVFC 16.2: Substantial upgrading of IT should occur to enable the planning, implementation and evaluation of service activity.

The HSE has not developed a national, IT-based mental health information system. Child and Adolescent Mental Health Services have produced regular annual reports with detailed information on activity and resources. The CAMHS annual reports have been very useful for monitoring progress against recommendations on CAMHS as well as showing increasing demand. The HSE’s

Mental Health Division Operational Plan 2015 commits to progressing the development of a National Mental Health Information System, with a target to develop a business case and project plan by Quarter 2 of 2015. Given the 3-5 year timeframe for the delivery of a clinical and operational mental health information system, the National Director for Mental Health, in the Service Plan for 2014, established the Interim Data Gathering Solution Project with the aim of supporting the community mental health teams to manage the performance information required of them for reporting on the service plan. As part of the Interim Data Solution Project, a Proof of Concept was conducted with three community mental health teams across CAMHs, General Adult and POA services. The eRostering Project has also been established which aims to provide an eRostering system across the mental health services within a 30 month timeframe. The objective of introducing an eRostering solution is to support services in ensuring that the right people with the right skills are in the right place at the right time and at the right cost. The Business Case for this project is complete.¹³⁷

AVFC 16.3: A National Mental Health Service Directorate should be established.

AVFC 16.4: Multidisciplinary Catchment Area Management Teams should be established.

The HSE Mental Health Division was established in 2013 and has operational and financial authority and accountability for all mental health services, including approved centres and community based teams (Child and Adolescent Mental Health, General Adult, Psychiatry of Old Age), National Forensic Mental Health Services, the National Counselling Service and the National Office for Suicide Prevention. The division is led by Anne O'Connor, National Director for Mental Health with the support of a National Mental Health Management team. This team includes a service user and a clinician to ensure clear alignment between the management function and effective services focused on service users.

The HSE reports that Mental Health Services Management Teams have been established in each catchment area since the introduction of Executive Clinical Directors in line with the Consultant Contract 2008. In each area the management team consists of an Executive Clinical Director, an Area Director of Nursing, a Mental Health Business Manager, Heads of Discipline and Service User representation. This has been a landmark development in the Mental Health Services based as it is on multidisciplinary clinical leadership guided by service user input. The HSE reports that this has been particularly successful in ensuring good leadership during the economic recession and has also allowed a focused approach on developing services and teams based on the additional monies allocated by government towards the mental health services in the past three years.

AVFC 17.4: Approximately 1,800 additional posts are required to implement this policy [based on the 2002 census]. This significant non-capital investment will result in mental health receiving approximately 8.24% of current, non-capital health funding, based on 2005 figures.

Expenditure on the HSE's mental health budget totaled €735 million in 2014 and represented 6% of overall HSE expenditure.¹³⁸ In 2006, mental health expenditure represented 7.2% of overall health expenditure. (Nominal expenditure is not possible to compare directly since accounting practice changed during the period).¹³⁹

¹³⁸ HSE Performance Assurance Report December 2014.

¹³⁹ Faedo, G. & Normand, C. (2013) Implementation of 'A Vision for Change' for Mental Health Services: Report to Amnesty International Ireland, Dublin, Amnesty International Ireland/Mental Health Reform.

10.1. Irish mental health spending compared to UK



Source: HSE Performance Assurance Report, December 2014 & Guardian Newspaper, 13th May 2015 'Mental Health Cuts are "Driving People to the Edge"

10.2. Mental health staffing, 2008-2014

2014	8,967
2013	8,906
2012	8,909
2011	9,107
2010	9,529
2009 (March)	9,972
2008	10,476

The total budget allocation for mental health in 2015 is €791.8 million, including the additional Programme for Government funding of €35 million, and represents an increase of €37.6 million or 5% compared to 2014.

As of January 2015, there were 9,273 staff (Whole Time Equivalents) in post across the whole of the mental health services.¹⁴⁰ This is approximately 77% of the recommended staffing level in AVFC and means there has been a decrease of 1,200¹⁴¹ WTEs (11%) since 2008.

The HSE Mental Health Division has reported

that it is working closely with the Human Resources and the National Recruitment Service to address difficulties attracting candidates to particular parts of the country. Multiple national and international recruitment campaigns are currently underway for medical consultant posts, senior and staff nurses.¹⁴²

AVFC 17.7: The full economic value of psychiatric hospital buildings and lands should be professionally assessed and realised.

The HSE's National Service Plan 2012 states that since 2006 there has been a total of €37m from sale of lands.

In the same period the capital expenditure on mental health infrastructure (excluding minor capital expenditure) was €244.53 million.¹⁴³

AVFC 18.6: A multi-profession manpower plan should be put in place, linked to projected service plans.

The HSE report that during 2014, an analysis of all staff employed in mental health services throughout the country was carried out. This information was used to determine the allocation of additional resources in 2014. The alignment of staffing resources with population data will continue throughout 2015 to fulfil the model of care as outlined in *A Vision for Change*. This work is also providing for the development of a funded workforce plan, which will identify the capacity of the current workforce, in addition to necessary training and development of existing and new staff.

AVFC 18.19: It is recommended that service users and carers should be consulted and involved in the development of educational programmes.

In recent years a number of initiatives have been undertaken to involve service users in the training of mental health professionals. The HSE funded a Service User Academic post in partnership with Dublin City University. People with self-experience of mental health services are also involved in training at

140 HSE Performance Assurance Report, January 2015.

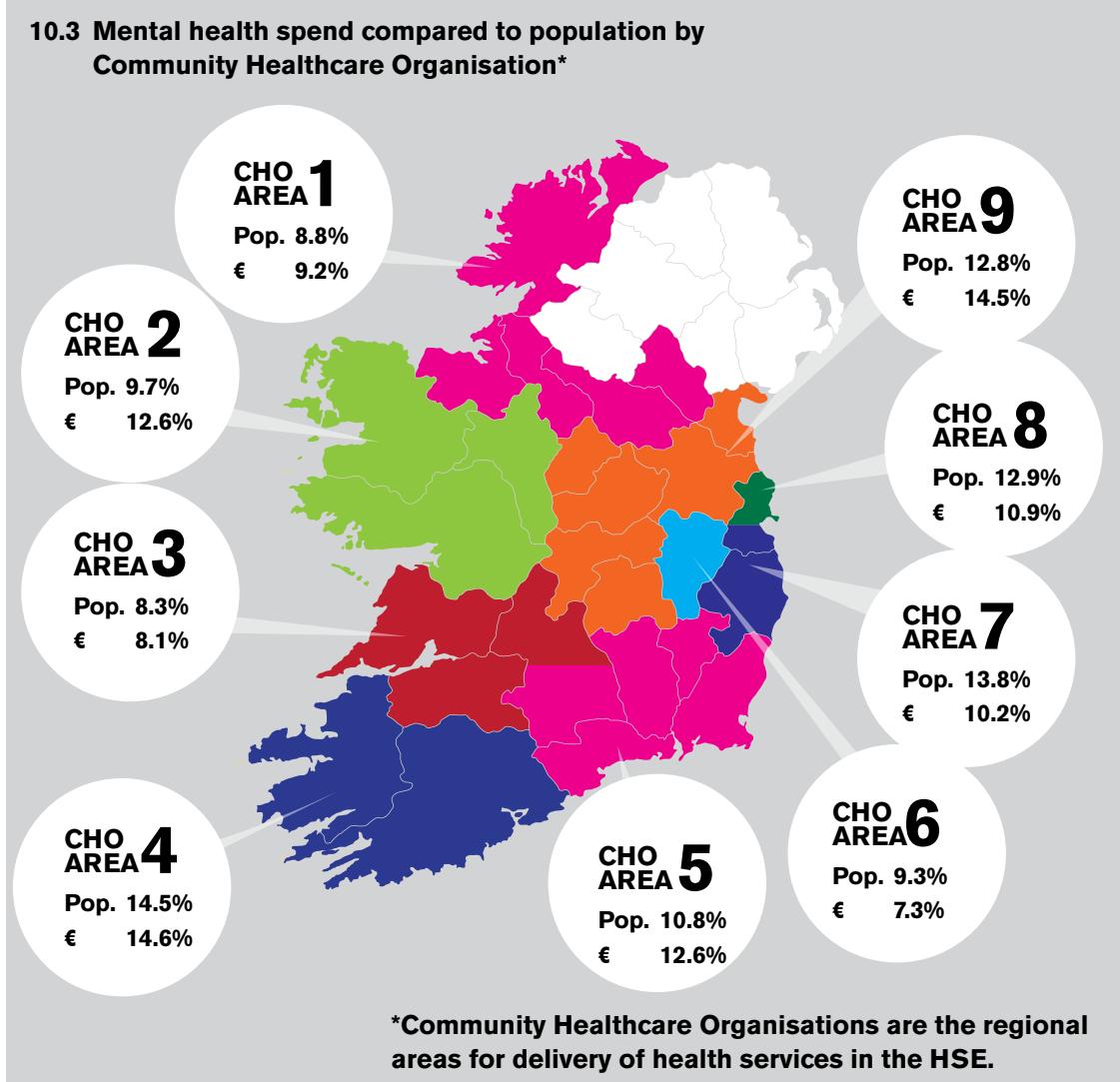
141 HSE Vision for Change Implementation Plan 2009-2013, p.10.

142 HSE Performance Assurance Report, January 2015, p. 75.

143 Information received through correspondence with the HSE.

10.3 Mental health spend compared to population by Community Healthcare Organisation*

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Source: HSE Mental Health Division Operational Plan 2015

Trinity College Dublin's School of Nursing & Midwifery through sharing their experiences with students.¹⁴⁴ The School of Psychology in TCD facilitates service user involvement in their clinical programme¹⁴⁵ and the Irish College of Psychiatrists has the REFOCUS group which is made up of 10 service users and 10 family members, who work with the College in improving training of psychiatrists.¹⁴⁶

A Co-operative Leadership programme has also been run since 2008 in which mental health services nominate a service user, family supporter and service provider to train together in leadership and change management skills.¹⁴⁷

However, in 2011 a study on the education and training available to professionals working in mental health services found that in the vast majority of courses (63%) (out of 137 completed questionnaires), curricula are planned and delivered without consultation or input from service users or carers.¹⁴⁸

AVFC 18.24: It is recommended that the position of mental health support worker be established in the mental health system to support service users in achieving independent living and integration in their local community.

Within the past three years peer support workers have been introduced to mental health services in Mayo. There are currently ten peer support workers working in this service following completion of a training programme. The peer support workers are

144 Information received through correspondence with Trinity College Dublin.

145 Information received through the Psychological Society of Ireland.

146 Information available at <http://www.irishpsychiatry.ie/Ext-Affairs-Policy/REFOCUSPsych.aspx>.

147 Information received through correspondence with the HSE.

148 Higgins, A. et al (2011) 'Service user involvement in mental health practitioner education in Ireland' *Journal of Psychiatric and Mental Health Nursing*, p.5.

not direct employees of the HSE but are employed and managed by a partner agency. In 2015, Genio funding provided by the HSE will also be supporting the appointment of two peer support workers in Cavan/Monaghan.

A Peer Support Worker has been appointed by the HSE to the Home Focus team in West Cork.¹⁴⁹ The national management team of the Mental Health Division is currently considering how to progress peer support developments.

AVFC 18.25: Advocacy training programmes should be encouraged and appropriately financed.

The Irish Advocacy Network (IAN) provides peer advocacy in mental health training through Dublin City University. The Network also offers self-advocacy training to people engaged in the mental health services. In 2013 the Wheel provided a two day advocacy training course to people with mental health difficulties in Dublin and Cork. Gateway also ran a course in advocacy in 2008 with a small number of people.

Summary assessment of accountability/governance/manpower



The Expert Group set out a framework of accountability for implementation of *A Vision for Change* that included a Mental Health Directorate, area multidisciplinary management teams, service user involvement, a national information system, and financial resources.

Since 2006 a substantial amount of effort has been invested within the HSE to set up the management structure. A significant advance was the establishment in 2013 of the Mental Health Division and the appointment of a National Director for Mental Health at the most senior management level, supported by a management team. The fact that the National Director now has budget-holding authority for the entire mental health service presents an

important lever to drive consistency of delivery across the country.

However, despite successive allocations of additional investment between 2012-2015, real expenditure on mental health services has yet to increase to the level envisaged by the Expert Group, and at the end of 2014 represented just 6% of overall HSE spend, less than it had in 2006.

Of particular concern is the continued substantial shortfall in staffing compared to recommended levels. Overall, the mental health services have suffered an 11% decrease in filled posts since 2008, whereas the Expert Group envisaged an increase of 1,200 posts. As of January 2015, there were 9,273 posts filled¹⁵⁰ which represents approximately three quarters of the recommended staffing level in AVFC. As mental health services are a people-provided service, it is difficult to see how the aspirations of the policy can be fulfilled without making real progress on recruitment and retention of the mental health professionals required.

As Prof. Charles Normand, Edward Kennedy Chair of Health Policy & Management at TCD, said in his analysis of AVFC implementation through 2012,

“Planning and managing a complex change in the absence of accurate and timely data is risky and likely to lead to unplanned gaps in the services provided. It is also hard to see how the managers of the [HSE mental health] service can hope to provide the necessary range and quality of services in the absence of information on current needs, current provision and the changing patterns of needs.”¹⁵¹

While the HSE has improved its data collection in recent years, fundamentally this same information gap still exists today, and nine years on from the publication of the Expert Group report on mental health policy, the information system that would enable proper planning for resource requirements is yet to be put in place.

An Independent Monitoring Group (IMG) was

¹⁵⁰ HSE Performance Assurance Report, January 2015.

¹⁵¹ Unpublished briefing note from Prof. Charles Normand to Mental Health Reform, December, 2012.

first established in 2006 and there have been a total of six IMG reports, the last covering 2011. The IMG's tenure lapsed in 2012 and the current Government did not appoint a successor IMG since 2012.

Case study: Making a complaint about mental health services

Ann's story

Ann's first contact with mental health services came when her 16 year old son, Robert, experienced mental health difficulties. Robert was diagnosed with schizophrenia and was hospitalised a number of times. Over the years, Ann had concerns about Robert's care, including the attitudes of some staff and how her son was treated. She complained but no one ever responded to Ann's complaint.

On one occasion, Ann noticed that Robert's condition was deteriorating and that he didn't seem to be responding positively to his medication. They both went to the hospital and were told to go through Accident & Emergency. This route, Ann describes as lacking "dignity and respect", took several hours and the environment further distressed Robert. He eventually saw a psychiatrist and was admitted that night.

The following day, Ann phoned the psychiatric unit and was told that her son had been discharged and that staff were unsure of his whereabouts. "I was stunned that they didn't know where he was or who he was with. I told them I was holding them personally responsible for his and our safety," said Ann. She eventually found Robert, however the situation greatly upset Ann and she decided to make an official complaint with the unit's clinical director. She then met with him and he assured her that he would look into the circumstances of Robert's discharge. Ann was dissatisfied with the manner in which staff handled her complaint and sent a copy of her complaint to the hospital's complaints officer.

Further incidents and frustrations with an inability to access services for Robert during the weekend and after office hours led Ann to complain once again. Ann repeatedly tried to make contact with her son's doctor but was told this wasn't possible. When she did

finally meet with the doctor, Ann felt she got her 'point across' but it had been a long battle. Ann only found out much later that she could have taken her concerns to the Ombudsman.

Throughout all of Robert's dealings with mental health services, Ann was never told how to make a complaint or what her rights were as her son's primary carer. Nobody explained that there was an advocacy service available. Ann describes her experience with the mental health services as isolating, tiring and draining and that to engage with it requires courage and energy. Ann said, "When you're going through it, you realise you are fighting a system and fighting a culture that doesn't listen to people and you get tired out."

Conclusion

In this report, Mental Health Reform has sought to provide a wide-ranging review of implementation of *A Vision for Change*. The report has covered all of the main elements of the policy:

- service user and family supporter involvement
- mental health promotion
- mental health in primary care
- social inclusion
- mental health services for children, adults and older people
- special categories of service provision
- accountability and governance issues

It is always challenging to produce an overall assessment. Inevitably this report provides a partial account – some information will have been missed out, some perspectives unfortunately omitted. We hope that these omissions will be forgiven and invite all interested parties to continue to provide us with feedback which we will incorporate into our advocacy work.

While this report documents a lot of activity related to recommendations in *A Vision for Change*, there is no doubt that the mental health system set out by the Expert Group has yet to be realised across the country. Each chapter of this report documents the partial realisation of the policy to a greater or lesser extent. Inequity remains, with variation in service models, choice of treatments and resources. Listening to people who use mental health services and family supporters is still not the norm, even at a one-to-one level. Primary care mental health services remain under-resourced and uncoordinated with mental health services. People with mental health difficulties continue to face significant social exclusion.

Implementation continues to be hindered by shortfalls in staffing and the lack of a clear

implementation plan providing a framework for implementation. Of serious concern is that throughout the last nine years, there has been no information system that can report on inputs, outputs and outcomes of mental health service delivery.

There are many factors that led to the partial implementation of *A Vision for Change*.

In the early years after publication of the policy, implementation was slowed by wider re-structuring within the new HSE and bogged down by the task of reconfiguring area management and delivery structures. Designated investment funds were lost to other parts of the health service and eventually stopped for a period of time. Early implementation also suffered from the lack of a mental health directorate with the skills and authority to manage and drive implementation, and the absence of an implementation plan.

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The economic crisis played a significant role in reducing mental health service resource, with 1,000 nurses lost in the first few years of the recession. The wider Government agenda to reduce the size of the public sector hit mental health services disproportionately, a result which could have been anticipated had the age profile of mental health nurses been taken into account. These losses have yet to be made up, and despite the allocation of additional funding in recent years, as of January 2015 staffing levels were 11% below those of 2008, rather than the increase envisaged by the Expert Group in 2006.

At the same time, demand for mental health supports has increased, pushing a bleeding mental health service very hard. The consequences of increased demand alongside reduced resources were shown in rising child and adolescent waiting lists and difficulties for adults seeking emergency treatment. The consequences for staff were probably a focus on crisis management, rather than fulfilling a new vision for mental health service delivery.

Yet many of the changes sought by people who use mental health services and their family supporters do not cost money – to be listened to, to be treated with respect, to have a say in one's own treatment. Such behaviours are more challenging in an under-resourced service, perhaps, but not impossible. And

in the face of huge challenges, some professionals strove to deliver this type of service, that is, to drive innovation locally, to involve people with self-experience and family supporters, and to embody a new ethos in their work, as evidenced by the Advancing Recovery in Ireland project, Headstrong and many other initiatives.

However, project-oriented innovation is not enough to develop a new mental health system. It is important to remember that the Expert Group said *A Vision for Change* needed to be implemented as a “complete plan”:

“It is crucial to the effective implementation of the policy that the key recommendations are seen as inter-related and interdependent and that they are implemented as a complete plan. A piecemeal approach to implementation will undermine the potential for real and complete change in our mental health services. The interdependence of the key recommendations in this policy is such that a failure to implement all of these recommendations in appropriate sequence will result in a less than effective mental health system.” (*A Vision for Change*, p.216).

In fact, as is evidenced in the chapters of this report, the implementation of the policy has been incomplete and uneven. Perhaps this is unsurprising given the lack of a detailed implementation plan, as called for by many stakeholders since publication, including Mental Health Reform. In November of 2009, the Mental Health Commission called for publication of such a plan “without delay”. It has yet to happen.

A Vision for Change was also intended as a whole-of-government policy. In an era where most people with mental health difficulties live in the community, the Expert Group recognised that social inclusion services would be vital to an effective mental health system. As this report has shown, the socio-economic position of people with mental health difficulties is not acceptable. The grinding realities of poverty, insecure housing and lack of employment are not good for

anyone’s mental health, much less those struggling to recover from mental or emotional distress. Key to the future recovery of people who experience such distress will be how much Government Departments responsible for housing, education, employment, social welfare and activation become fully engaged in promoting the recovery and social inclusion of those with mental health difficulties.

We hope this report will prove valuable to the process of renewing Ireland’s mental health policy for the next ten years. Thanks go to Kate Mitchell, Policy & Research Officer, Lara Kelly, Communications & Campaigns Officer, and Lisa McCormack, Administration Executive for their involvement in the production of this report. We would also like to thank the HSE’s Mental Health Directorate for their assistance in providing information for the report.

On foot of this report, MHR will produce a submission to the Department of Health with recommendations on the next phase of reform of Ireland’s mental health system. We look forward to continuing to work with the Minister for Mental Health, Government Departments, the HSE and other public agencies, our member NGOs, people who use mental health services, family supporters and professionals to achieve the vision of an Ireland where people with a mental health difficulty can recover their wellbeing and live a full life in the community.



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