Mental Health Reform
Promoting Improved Mental Health Services

Submission for Budget 2016

30th June 2015

INTRODUCTION

Nine years on from the publication of the national mental health policy *A Vision for Change*, there remain significant gaps in the mental health system in Ireland. Despite some developments, including an increase in the proportion of multi-disciplinary staff and investment in community based services, inequity remains in the mental health services with wide variation in the resources available in different services across the country. Between 2008 and 2015, there was a loss of over 1,000 mental health staff and staffing levels were only 77% of the recommended level in *A Vision for Change* as of January 2015. In child and adolescent mental health services, the situation is more severe with just over half of the staff required in post.

Mental Health Reform continues to hear reports among people with self-experience of mental health difficulties, family members/carers and professionals of the difficulties in accessing crisis supports. Inadequate mental health care within the primary care sector is hindering individuals accessing appropriate and timely mental health support. The Counselling in Primary Care service, although a positive initiative, is limited in that it only accepts referrals from medical card holders while primary care psychology remains under-resourced and under-developed.

A Vision for Change includes a dedicated chapter on the development of special categories of mental health service provision, not typically provided by generic mental health teams. Such categories of service provision include supports for people with mental health and intellectual disability, homeless people, people with dual diagnosis (co-morbid mental health and substance abuse issues) and people with eating disorders. Despite the Expert Group's recommendations, these services have received the least development since 2006 compared to other areas of the mental health service and require significant investment. Recovery and social inclusion supports for people with long-term, severe mental health difficulties also remain largely under-developed, while the new forensic mental health services envisaged in *A Vision for Change* have not yet been delivered. Furthermore, the innovative, peer-run services recommended in the policy remain sparse and lacking in secure funding.

People with mental health difficulties continue to experience significant social exclusion in Ireland, facing prejudice, unemployment and difficulties in accessing housing. 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.[1] In terms of housing, the national housing crisis is impacting very negatively on the ability of mental health service users to find and secure appropriate accommodation. 71% of Dublin Simon Community homeless clients report experience of mental health difficulties. The current rent supplement and housing assistance payment caps, alongside limited housing stock, are contributing to such issues and ultimately impacting on people's mental health.

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

In this context, Mental Health Reform calls on the Government to keep its commitment to mental health, to continue to invest in comprehensive, community based mental health services, to ensure that wider budget decisions concerning social welfare, housing and education are supportive of recovery from mental health difficulties, and to fund innovative supports, including peer-led initiatives that enable individuals recovering from mental health difficulties to live in the community.

Specifically Mental Health Reform recommends:

1. **Allocation of an additional €35 million for community mental health services in 2016, to be used in part to ensure**

    - Staffing levels recommended in *A Vision for Change* are met
    - A particular focus on staffing for child and adolescent mental health services
    - Capacity is built within perinatal and infant health services to enable professionals to support the social and emotional development of children in their early years
    - A focus on ensuring people who use mental health services have timely access to talking therapies
    - The allocation of funding to support teams to implement the recovery ethos and employ peer support workers in the HSE's mental health services
    - A dedicated funding stream is made available for the development of community peer initiatives
    - Funding for specialist long-term recovery and social inclusion supports for people with severe and enduring mental health difficulties
    - Investment in the development of mental health services for people with co-morbid mental health and intellectual disability, people with dual diagnosis (mental health and substance misuse difficulties), people experiencing homelessness and people with eating disorders
    - 24/7 crisis intervention services are available in every area of the country
    - That the potential for e-mental health is explored to enable the delivery of mental health supports and to empower people who use mental health services

2. **The Department of Health should ensure that the HSE implements a national mental health information system in 2016 that will report on the extent of service resources, provision, quality and outcomes for community-based mental health service delivery according to key performance indicators aligned to *A Vision for Change*.**

3. **Continue to fund a national stigma/discrimination reduction campaign**

4. **Continue to extend the Counselling in Primary Care service to meet the counselling needs of low to middle-income people with mild to moderate mental health difficulties and increase the ceiling on the number of sessions to 20**

5. **Further develop primary care psychology services to ensure adequate provision throughout the country**

6. **Extend free primary care to all people who require long-term mental health treatment and abolish the prescription levy for this group**

7. **Restore the Back to Work Allowance in order to support people with mental health disabilities into employment**

8. **Ensure that rent supplement and housing assistance payment caps are in line with the private rental market so that people on rent supplement/HAP have a realistic chance of securing housing in the private rental market. Rent supplement levels should also be reviewed on a six month basis**

9. **The Department of Environment, Community and Local Government should provide funding in Budget 2016 for an additional forty individuals to transition from HSE supported accommodation into mainstream housing in the community**

10. **The Department of Environment, Community and Local Government and the Department of Health should jointly provide a dedicated funding stream for tenancy sustainment support for 600 individuals to transition from HSE supported accommodation during 2016**

11. **The Department of Education should provide funding to support the implementation of the national guidelines on mental health promotion and well-being for both primary and post primary schools**

    - Funding could be used to provide basic training for all primary and post primary school teachers so that they can identify children/adolescents at risk of developing a mental health difficulty and promote the mental health and well-being of children in line with the 'whole school approach'

12. **Continue to invest in family supports and parenting programmes, including the Triple P Programme**

RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

CURRENT SHORTFALLS IN RESOURCES

Despite the recruitment of over 800 new posts to date out of the 2012, 2013 and 2014 budget allocations, between 2008 and 2014 there has been a significant reduction in the number of mental health staff.

As of January 2015, there were 9,273 staff (Whole Time Equivalents) in post across the whole of the mental health services. This is approximately 77% of the recommended staffing level in *A Vision for Change* and means there has been a decrease of 1,200 WTEs (11%) since 2008.

There have been considerable staff losses in the area of mental health nursing, with a reduction of 1,063 nurses between March 2009 and September 2014.

Mental Health Reform welcomes the fact that there has been a doubling of the proportion of multi-disciplinary staff within community mental health teams since 2008, however, these teams still fall short of the full complement of staff recommended in *A Vision for Change*.

In child and adolescent mental health services, the situation is more severe with just over half of the staff required in post. 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 just 51.6% of the staffing level recommended in *A Vision for Change*. By the end of 2014, there were 63 partially complete community CAMHS teams in place. *A Vision for Change* recommends 77 teams.[2]

The reduction in staff as well as difficulties in multi-disciplinary staff recruitment has continued to negatively impact on provision of the type of service model envisaged in *A Vision for Change* that includes community based multi-disciplinary 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 to psychiatric units from 72% in 2006 to 67% in 2013.[3]

Mental Health Reform has also heard anecdotal reports of lengthy waiting times for these multi-disciplinary supports due to staff shortages. In Mental Health Reform's public meetings, 2015, people with experience of accessing mental health services cited waiting lists as a huge problem. One person explained that "you could be waiting two years to see a psychologist." Another individual spoke about the length of time that elapses between referrals…. "It's not quick enough".

[2] HSE Performance Assurance Report, December 2014, p. 57.
[3] Daly, A. & Walsh, D. (2014) Activities of Irish Psychiatric Units and Hospitals 2013, Dublin: Health Research Board, p.50.

The Children's Mental Health Coalition has cited Irish research to report that overall, services remain substantially under-resourced and "families find it difficult to access community CAMHS in Ireland due to a lack of information, restrictive referral criteria and pathways, lengthy waiting periods and a lack of out of hours/crisis service."[4]

In terms of early intervention, it is now widely accepted that the foundation for healthy, psychological, social and emotional health across the life span is developed in infancy and early childhood. Currently, in Ireland, the focus on the first few years of a child's life is on their physical development. Early intervention needs to include a response which places the social and emotional health and well-being of infants and toddlers on par with that of their physical health. Specific service gaps that exist in the area of infant mental health include: the absence of clinical psychology/ parent-child psychotherapists in maternity hospitals; a lack of training on infant mental health among staff working in maternity hospitals; under-staffed primary care psychology (primary care psychology is well placed to offer intervention to adults in the community to address pre-natal and post-natal issues); the absence of child specific Public Health Nursing posts.

Despite a number of existing early intervention programmes which have been funded by Government there is a need for investment in the development of early intervention services which specifically target the mental health needs of infants and young children. The gaps in services, as outlined above should be addressed through allocated funding.

Long-term recovery and social inclusion supports remain relatively under-developed, with mixed performance against *A Vision for Change* recommendations. There is a need for dedicated supports to meet the needs of individuals requiring long-term recovery and social inclusion supports, not provided for by generic community mental health teams. Among people with mental health disabilities, international evidence shows that approximately half of participants in supported employment programmes do not find competitive employment. The development of person-centred, recovery-orientated, on-going, recovery and social inclusion supports for individuals with a mental health difficulty who are unable to access competitive employment should be addressed as a priority.

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."[5] It is important that investment is allocated to the development of long-term recovery and social inclusion supports across the country, in addition to home–based and assertive outreach teams.

[4] 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.
[5] HSE (2014) Final Report of the Expert Review Group on Community Mental Health Services in Galway/Roscommon, Appendix P

With regard to innovation, Mental Health Reform has previously welcomed the HSE's commitment to instill the recovery ethos in all mental health services. Such organisational change requires resources to support capacity-building of staff, service users and family members/supporters. It is important to sustain the momentum from the Advancing Recovery in Ireland projects by continuing to invest in organisational change in 2016.

Following on from the recovery model, one of the strongest messages to come out of the consultation that fed into *A Vision for Change* was that people with poor mental health want alternatives to medication, including access to counselling and psychotherapy. This view was reiterated in the Independent Monitoring Group's consultation meetings held in 2012 as well as by the HSE [6] and in Mental Health Reform's consultation meetings conducted in 2011. Despite an acknowledgement at national level of an over reliance on medication and a lack of alternative therapies, there is evidence that this gap still exists.

In 2015, Mental Health Reform sought feedback online from people with experience of mental health difficulties on their experience of mental health supports. A considerable amount of people who took part in this survey were concerned with what they perceive to be an overemphasis on medication-centred treatment. Many respondents were also concerned that this approach was being used as a result of a lack of resources in other areas of the mental health services and that medication was not a satisfactory long term solution. A prominent point in relation to medication was that many service users believed that they might benefit from talking therapies but that these were often not available. One participant said: "There's far too much drug therapy for issues such as depression and anxiety, drugs which are only a temporary fix. Behaviour therapy at least gives you skills to manage your mental health."

The Kilkenny Consumer Panel has also cited concerns about the overuse of medication and the lack of choice of treatments for people with mental health difficulties.[7]

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.[8]

Investment needs to be allocated to the development of alternative therapies in the delivery of mental health care, and particularly, in access to talking therapies for people being treated within mental health services. This includes ensuring an adequate number of skilled professionals are available to deliver talking therapies.

[6] Health Service Executive Primary Care and Mental Health Group (2012) Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services: A Guidance Paper, Naas: Office of the Assistant National Director Mental Health, HSE, p.11.
[7] Mental Health Reform (2015) A Vision for Change Nine Years On: A Coalition Assessment of Progress, Dublin: Mental Health Reform, p. 6.
[8] (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).

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. People with intellectual disability, co-occurring substance misuse difficulties, or who are homeless all have higher risk of developing mental health difficulties than the general population. Yet these services have received the least development since 2006 compared to other areas of the mental health service.

A Vision for Change recommends that mental health services for people with intellectual disability should be provided by mental health and intellectual disability (MHID) teams across the country. Despite, a recommendation of 300 posts for adult MHID in a *Vision for Change*, there are 12.95 adult MHID posts under the auspices of or funded by the HSE. An additional 150 MHID posts/ 15 CAMHS MHID teams were recommended for child and adolescent mental health services. There are currently only 4.9 MHID CAMHS consultants in post under the auspices of or funded by the HSE.[9]

Despite the high prevalence of mental health difficulties among people who are homeless, community mental health teams for people who are homeless continue to be understaffed. The total staff complement of these teams is only 13.84 WTEs.[10] [11] 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.[12] The Dublin Simon Community published a Health Snapshot in 2014 in which 11% of a representative sample of people using Dublin Simon services reported having a diagnosis of schizophrenia, and an additional 11% reported a diagnosis of psychosis. The high prevalence of schizophrenia and psychosis among people who are homeless indicates the need for specialist mental health services in this area.

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 general community mental health teams providing an addiction service with a staff complement of 20.4 WTEs.[13] In some parts of the country, addiction services are not provided by the mental health service. 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.[14] In 2011, the Mental Health Commission identified that dual diagnosis rates among people in Ireland are reported to be between 30% and 80%.

[9] Information provided through correspondence with the HSE.
[10] Information provided through correspondence with the HSE.
[11] 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.

[12] O'Reilly, F., Barror, S., Hannigan, A., Scriver, 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.
[13] Information provided through correspondence with the HSE.
[14] HRB Activities of Psychiatric Units and Hospitals 2013, Table 2.6a.

There has been some innovative development in the forensic mental health services, including the introduction of a diversion system into mental health services at remand stage. However, regional, community based forensic mental health services remain underdeveloped and there are still no specialist forensic mental health services for children and adolescents or people with mental health and intellectual disability. 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. Forensic, community based services need to be developed for people with mental health difficulties as a matter of priority.

In terms of crisis supports, more than nine years after the publication of *A Vision for Change*, mental health services are still not uniformly providing the basic model of care that includes 24/7 crisis intervention, home-based and assertive outreach treatment, with crisis houses, as the norm in all areas. 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. There are very few crisis houses in place. Ireland continues to have a high rate of suicide, while this gap in crisis services is allowed to persist. Given that people who use mental health services are at higher risk of suicide than the general population, ensuring accessible 24/7 crisis intervention supports for this group could have a significant impact on the number of suicides. It is also important to support the community and voluntary sector which is providing vital mental health supports in the community, including helplines and out-of-hours crisis supports.

> "Out of hours is a very difficult time and A&E was a horrible experience. I'm bipolar and I've had to go to A&E at times when I've been on a high and it has taken 8 hours, 10 hours and even 11 hours to be seen. I did actually think after the last time that if I had slit my wrists I would've been seen quickly because I had a physical injury."
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> Feedback at MHR Public Meeting 2015

International evidence suggests that investing in mental health services will reduce the healthcare costs in other areas of the health sector. Mental health difficulties often increase physical health problems and can make existing physical health problems worse. Altogether, the extra physical healthcare caused by mental health difficulties was estimated in 2012 to cost the NHS at least £10 billion.[15] However, when people with physical symptoms receive psychological therapy, the average improvement in physical symptoms is so great that the resulting savings on NHS physical care outweigh the cost of the psychological therapy.[16] Effective mental health treatment can also generate other large savings to the government, for example by increasing employment or improving the behaviour of children. As one example, the Improving Access to Psychological Therapies programme in the UK has

[15] Centre for Economic Performance (2012) How Mental Illness Loses Out in the NHS, p. 1
[16] Ibid

almost certainly paid for itself through reduced disability benefits and extra tax receipts.[17] Likewise, when children are treated for conduct disorder, the costs are almost certainly repaid in full through savings in criminal justice, education and social services.[18]

By investing in mental health services, the Government will ensure savings in other areas of expenditure, such as social protection, housing and health care.

1. Recommendation: Allocation of an additional €35 million for community mental health services in 2016, to be used in part to ensure

- Staffing levels, as recommended in *A Vision for Change* are met
- A particular focus on staffing for child and adolescent mental health services
- Build capacity within perinatal and infant health services to enable professionals to support the social and emotional development of children in their early years
- A focus on ensuring people who use mental health services have timely access to talking therapies
- The allocation of funding to support teams to implement the recovery ethos and employ peer support workers in the HSE's mental health services
- A dedicated funding stream should be made available for the development of community peer initiatives
- Funding for specialist long-term recovery and social inclusion supports for people with severe and enduring mental health difficulties
- Investment in the development of mental health services for people with co-morbid mental health and intellectual disability, people with dual diagnosis (mental health and substance misuse difficulties), people experiencing homelessness and people with eating disorders
- 24/7 crisis intervention services are available in every area of the country
- That the potential for e-mental health is explored to enable the delivery of mental health supports and to empower people who use mental health services

IMPLEMENTATION OF A NATIONAL MENTAL HEALTH INFORMATION SYSTEM

Mental Health Reform continues to be concerned about the lack of a national information system for the mental health services. MHR welcomed the allocation of €0.5 million in the 2013 budget to develop such an information system and acknowledges the HSE's commitment to progressing this project. However, under the current system it is not possible to tell how many mental health service users are waiting for psychological therapies, how many have an individual care and recovery plan, or how many service users are satisfied with their community-based mental health service. Neither is there published information on any of the standard outcomes indicators used internationally to assess mental health service

[17] Ibid, p. 2
[18] Ibid

effectiveness, such as service users' employment status, housing status and educational level.

Therefore, there is an urgent need for an information system that can report on the extent of service resources, provision, quality and outcomes of community mental health services. The development and roll-out of a national information system for mental health services is vital to enabling the HSE Director for Mental Health to plan service delivery. It is also important for empowering service users and family members to hold mental health services to account for good quality service delivery.

2. Recommendation: The Department of Health should ensure that the HSE implements a national mental health information system in 2016 that will report on the extent of service resources, provision, quality and outcomes for community-based mental health service delivery according to Key Performance Indicators aligned to *A Vision for Change*.

FUND A NATIONAL STIGMA/DISCRIMINATION REDUCATION CAMPAIGN

The See Change stigma reduction partnership has been an important means of stimulating public discussion about mental health and has begun to have an impact in reducing negative attitudes towards people with mental health difficulties. The See Change Attitudes Survey 2012 showed some improvement in attitudes towards people with mental health difficulties generally since 2010, though "attitudes towards people with a diagnosis of schizophrenia still lag behind."[19] Attitudes towards people with severe mental health difficulties do not appear to have improved, leading to their continued social exclusion and hindering their recovery. Attitudinal and behavioural change is a slow, long-term process that requires sustained support.

3. Recommendation: Continue to fund a national stigma/discrimination reduction campaign

INVESTING IN PRIMARY CARE MENTAL HEALTH SERVICES

The HSE's Counselling in Primary Care service is a positive early intervention programme that seeks to ensure medical card holders with mild to moderate mental health difficulties have access to up to eight sessions of counselling. Approximately 15% of the population can be expected to be experiencing anxiety or depression at any one time.[20] In 2014, the CIPC service received a total of 14,407 referrals, demonstrating the demand for such a service. However, it was allocated a development budget of €3.8 million which represents just one-

[19] 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_mentl_health_problems.pdf.
[20] Information taken from the Increasing Access to Psychological Therapies service in the UK NHS.

half of one percent of the mental health service budget in 2014.[21] This compares to investment of £300 million for the Increasing Access to Psychological Therapies (IAPT) service in the UK which represents 5% of the UK mental health spend.

The CIPC service has the potential to reduce the number of individuals referred on to specialist mental health services as well as to improve the number of individuals returning to work who may be off work due to mental or emotional distress. The similar programme running in the UK (the IAPT programme) has been proven to be cost-effective and has increased the number of individuals with mental/emotional distress returning to work.

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.[22] 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 in 2014.[23] Furthermore, CIPC is available to adults only and does not provide support to children and adolescents under the age of 18 years.

In addition to the extension of the CIPC service, Mental Health Reform recommends the further development of primary care psychology services. Such services are often the first point of referral for many children and adults with mental health needs. However, they are not available in all parts of the country and in some areas the service is only offered to children (0-18 years). Enhancing psychology in primary care services would ensure the development of an integrated service that meets the mental health needs of the population at all levels.

4. Recommendation: Continue to extend the Counselling in Primary Care service to meet the counselling needs of low to middle-income people with mild to moderate mental health difficulties and increase the ceiling on the number of sessions to 20

5. Recommendation: Further develop primary care psychology services to ensure adequate provision throughout the country

FREE GP CARE/ MEDICAL CARDS FOR PEOPLE REQUIRING LONG-TERM MENTAL HEALTH TREATMENT

Access to free healthcare is an important issue for individuals with long-term mental health difficulties who may require long-term treatment for both their physical and mental health. In the context of Government policy that supports people being de-institutionalised and living in the community, lack of a medical card can undermine an individual's ability to access mainstream primary care and continue their treatment. People who have been receiving

[21] See HSE Mental Health Division Operational Plan 2014, p.21.
[22] Carr, A. (2007) The Effectiveness of Psychotherapy: A Review of Research prepared for the Irish Council of Psychotherapy, Dublin: Irish Council of Psychotherapy
[23] Information provided through correspondence with the HSE.

mental health treatment free of charge from mental health services may hesitate to be discharged to their GP if they think their costs will increase.

Irish research has found that those with low incomes but without a medical card are less likely to visit a GP. The costs of a GP visit, plus the ongoing costs of multiple prescriptions for psychotropic medication could deter someone from taking medication that helps to maintain their mental health. A sudden stoppage of medication due to financial concerns, without adequate preparation or medical support, could easily result in an individual having a relapse and requiring hospitalisation which is much more expensive than providing ongoing health services. Lack of security about the medical card is also known to be a deterrent to individuals with disabilities who might otherwise take up work.

Mental Health Reform has heard from members of its Grassroots Forum, made up of people with self-experience, family supporters and family members that the possible loss of a medical card is a barrier to people with mental health difficulties taking up employment.

One member said that:

> "Having a medical card and being able to work are like 'gold'. If I had to give one up I would give up working to keep my medical card. When you are able to keep up work with a mental health difficulty, 'you feel part of the real world'. At the same time, you shouldn't live in fear of losing your medical card."

Another member said that:

> "Forgetting to renew one's medical card is a significant trap for people, especially older people. The process to reapply for a medical card once it had expired is lengthy and could put vulnerable people at risk of losing their card."

Mental Health Reform considers that it will be important to provide people with long-term mental health conditions the security of a medical card, including free prescriptions, in order to help prevent relapse and support their ability to live in the community.

6. Recommendation: Extend free primary care to all people who require long-term mental health treatment and abolish the prescription levy for this group

RECOMMENDATIONS FOR THE DEPARTMENT OF SOCIAL PROTECTION

RESTORE THE BACK TO WORK ALLOWANCE

The Back to Work Allowance Scheme was available for 3 years only between 2006 and 2009. In the Supplementary Budget April 2009 it was announced that the scheme was to be closed to new applicants from 1 May 2009.[24] In 2008, prior to this announcement, 3,558 people were in receipt of the benefit under the Scheme[25] and in 2013 there were 11 remaining recipients of the scheme.[26]

In 2008, 95,754 people were in receipt of Disability Allowance and in 2013 this number increased to 106,279 people. Despite a decrease in expenditure through the abolition of the Back to Work Allowance, there is a significant increase in the number of people availing of Disability Allowance, ultimately increasing expenditure in this area of social welfare.

The Back to Work Allowance Scheme encouraged unemployed people (among others) to take up employment. People participating in the scheme were entitled to keep a percentage of their social welfare payment along with secondary benefits for a period of up to three years.

The National Learning Network has advised Mental Health Reform of the negative impact of removing the Back to Work Allowance on supporting people with mental health difficulties into employment, saying that:

> "When the scheme was in operation individuals would receive 75% of their Disability Allowance plus their salary for the first year, 50% of their Disability Allowance in the second year and 25% of their Disability Allowance in the third year. This was a huge incentive for all qualifying individuals to enter into employment. "

7. Recommendation: Restore the Back to Work Allowance in order to support people with mental health difficulties into employment

RAISING RENT SUPPLEMENT/HOUSING ASSISTANCE PAYMENT CAPS

Mental Health Reform has consulted with mental health social workers operating in mental health services across the country in relation to the rent supplement cap and how this is impacting on people with mental health difficulties in finding appropriate housing accommodation.

[25] Department of Social Protection, Statistical Information on Social Welfare Services 2009, Table A9.
[26] Department of Social Protection, Statistical Information on Social Welfare Services 2013, Table A9.

Feedback provided by a number of social workers highlighted the difficulties for people with mental health difficulties (and in receipt of rent allowance) in securing accommodation in the private rental market.

One social worker states that:

> "It is almost impossible to source accommodation that will accept rent supplement…those who are fortunate enough to source accommodation accepting rent supplement invariably are supplementing the rent supplement themselves, beyond the agreed contribution as outlined by the Department of Social Protection."

Another social worker explains that "even with individually negotiated rent supplement increases it has been impossible to get rent supplement accommodation for clients."

Focus Ireland has reported that "the disparity between rent supplement and the market rate is resulting in families losing their tenancies and becoming seriously at risk of homelessness". 71 families were referred to the Focus Ireland family homeless team in April 2015. An inability to meet rental payments constitutes the largest factor in the increase in families accessing Focus Ireland services. Current rent supplement rates were set in June 2013, and have not been reviewed since this date. However, rents in Dublin have increased by approximately 10% each year. The current rent supplement limit for a couple or single parent with two qualified children in Dublin is €975. A Daft report from Q1 2015 found that the average rents in Dublin range from €1,194 to €1,690.

The number of families with dependent children experiencing homelessness is significant. The latest figures from the Dublin Region Homeless Executive show that in the week of May 18th-24th there were 1,034 children in 490 families in emergency accommodation. This compares with 970 children in 442 families in emergency hotel-type accommodation in April 2015. It is recognised that homelessness can have a negative impact on the emotional and behavioural development of children. It is important that specific measures are put in place to address the high proportion of children and families experiencing homelessness.

In the Tallaght mental health services, a project was carried out seeking private rented accommodation over an 11 month period for a number of people with mental health difficulties. Over the course of the 11 months, not one person was placed in private rented accommodation by accessing one of the standard and most popular routes, i.e. Daft.ie. By the end of the project, four people were placed in accommodation through word of mouth. The project staff attribute the difficulties in placing individuals in private rental accommodation to the rent supplement cap and the high number of landlords who will not accept rent allowance.

Additional concerns raised by some of the social workers consulted include the following:

- Delayed discharges from hospital or supported accommodation – one social worker describes that people often remain in hospital far longer than necessary in some mental health services because they cannot access appropriate accommodation. The duration of hospital stay has extended to over a year in some cases
- Individuals living in unsuitable accommodation are unable to secure alternative accommodation under the rent supplement cap, therefore, worsening their mental health
- Existing rent allowance tenants are being asked to leave their current accommodation and properties are being re-let for higher rents
- The rent supplement cap has resulted in older people becoming homeless, seeking nursing home accommodation rather than rent-supplement accommodation, despite the fact that many are well functioning, or require only minimal supports
- People are leaving their own communities where they have social supports, in order to source accommodation in other areas where the rental market is slightly cheaper
- People already in accommodation are waiting for their leases to expire and then entering homeless services due to rent increases

Overall, the social workers consulted agreed that rent supplement caps are out of line with market rates. Rental tenants are competing for limited housing stock and rent allowance tenants are at a greater disadvantage in competing for remaining properties due to the rent supplement caps. Reforming rent supplement policies, in addition to increasing the supply of social housing, should be a priority for Government moving into 2016.

However, the difficulties in securing rental accommodation go beyond the rent supplement caps. In situations where rent supplements are increased to market value, landlords appear unwilling to accept rent allowance. This ultimately is having a detrimental effect on people's mental health, including individuals with pre-existing mental health difficulties. One social worker states:

> "People tell me they are suicidal, they tell me they self-harm, that they feel like bad parents, like failures because they can't provide a safe and secure home for their family. They tell me they are being made [to] feel inadequate and shamed by landlords and estate agencies when they say they are on rent allowance."

The Australian Human Rights and Equal Opportunities Commission found that one of the biggest obstacles in the lives of people with mental health difficulties is the absence of adequate, affordable and secure accommodation. Despite the importance placed on the provision of adequate housing support to assist in an individual's recovery it is evident that people residing in Ireland with long-term mental health difficulties who are on benefits are under severe economic strain due to social welfare and related cuts. The additional stress put on people with disabilities due to the lack of recognition of the impact of the housing crisis on those on rent supplement with a disability is likely to negatively impact on their mental health.

8. Recommendation: Ensure that Rent Supplement/Housing Assistance Payment caps are in line with the private rental market to ensure that people on Rent Supplement/Housing Assistance Payment have a realistic chance of securing housing in the private rental market. Rent supplement levels should also be reviewed on a six month basis

RECOMMENDATION FOR THE DEPARTMENT OF ENVIRONMENT

An on-going difficulty in preventing homelessness and promoting deinstitutionalisation is the lack of a dedicated funding stream to provide medium and long-term tenancy sustainment support to individuals with long-term mental health difficulties. The Implementation Framework for the National Housing Strategy for People with Disabilities recognises that the HSE will be required to continue to provide health and personal social services for people transitioning from mental health service accommodation.[27]

The interim protocol agreed as part of the Housing Strategy for People with Disabilities states with regard to people transitioning from institutional settings that:

> "10.5. The appropriate supports from the HSE/Service Provider must be put in place for the individual and any services already being provided by the state should be assessed and continued if appropriate. A protocol will be put in place between the Housing Authority and the HSE/Service Provider to ensure that the appropriate supports are maintained for the individual."[28]

However, there is currently no dedicated funding stream within either the HSE's or the Department of Environment, Community and Local Government's budgets for tenancy sustainment support. The HSE's guidance paper Addressing the Housing Needs of People using Mental Health Services illustrates a range of housing and housing support models currently in operation which emphasise and underpin the requirement for tenancy sustainment support for those transitioning from mental health service accommodation.

It is important that a dedicated funding stream for tenancy sustainment support is provided so that the Government's policy of deinstitutionalisation is not hindered by a gap in housing support in the community.

9. Recommendation: The Department of Environment, Community and Local Government should provide funding in Budget 2016 for an additional forty individuals to transition from HSE supported accommodation into mainstream housing in the community

[27] Department of Environment, Community and Local Government (2012) National Housing Strategy for People with a Disability 2011-2016: National Implementation Framework, p.11.
[28] Department of Environment, Community and Local Government (2013) Protocol for the Provision of Housing Support to People with Disabilities (draft).

10. Recommendation: The Department of Environment, Community and Local Government and the Department of Health should jointly provide a dedicated funding stream for tenancy sustainment support for 600 individuals to transition from HSE supported accommodation during 2016

RECOMMENDATION FOR THE DEPARTMENT OF EDUCATION

In January 2013, the National Guidelines on Promoting Positive Mental Health and Suicide Prevention in Post-Primary Schools were published.[29] These were followed by the publication of the National Guidelines on Promoting Positive Mental Health and Suicide Prevention in Primary Schools in January 2015.[30] While the publication of these guidelines is a welcome first step, training and support for teachers is needed in order to implement a whole school approach.

People with self-experience and organisations involved in mental health should be resourced to deliver mental health promotion training in schools across the country. It is also important that the National Educational Psychological Service (NEPS) to schools is enhanced.

11. Recommendation: The Department of Education should provide funding to support the implementation of the national guidelines on mental health promotion and well-being for both primary and post primary schools

- Funding could be used to provide basic training for all primary and post primary school teachers so that they can identify children/adolescents at risk of developing a mental health difficulty and promote the mental health and well-being of children in line with the 'whole school approach'

[29] 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.
[30] Department of Education and Skills (2015) Well- being in Primary Schools: Guidelines for Mental Health Promotion, Dublin: Department of Education and Skills.

RECOMMENDATION FOR THE DEPARTMENT OF CHILDREN AND YOUTH AFFAIRS

Family supports and parenting programmes, including the Triple P programme, require adequate resourcing to ensure their continued delivery. In its evaluation of the Triple P programme, the UNESCO Child and Family Research Centre, NUIG, recommended that the programme be in line with TUSLA's commitment to outcomes-focused and evidence-based parenting supports. The report recommends that ongoing implementation of the Triple P Programme will require clear commitments in terms of statutory support. [31]

12. Recommendation: Continue to invest in family supports and parenting programmes, including the Triple P Programme

CONCLUSION

Despite the high prevalence of mental health difficulties in Ireland, the mental health system remains under-resourced, under-developed and over-stretched. 1 in 7 adults in Ireland will have experienced a mental health difficulty in the last year and 15.4 % of children aged 11-13 years and 19.5% of young adults aged 19-24 years have a mental health disorder. 75% of mental health difficulties arise before age 25. The number of suicides has remained high with between 495 and 554 deaths per year from 2009-2012.

Mental Health Reform recognises that the Government faces difficult choices in Budget 2016 in order to maintain control over the country's finances. However, it is important to recognise that individuals' mental health is a positive asset that will support the country's economic and social recovery. Our recommendations are based on cost-effective and evidence-based solutions that can help Government services for people with a mental health condition to be more efficient and at the same time can fulfil the Government's policy commitments on mental health.

Mental Health Reform's recommendations recognise the cross-departmental nature of mental health concerns. They point to the need for 'joined-up thinking', coordination and action to deliver necessary supports in areas such as mental health services, the development of peer-led initiatives, housing, mental health in the education system, social welfare, and enhancing the capacity within the primary care sector to address mental health difficulties at the lowest level.

We call on Government to incorporate these recommendations into Budget 2016.

[31] Fives, A., Pursell, L., Heary, C., Nic Gabhainn, S. and Canavan, J. (2014) Parenting support for every parent: A population-level evaluation of Triple P in Longford Westmeath. Final Report. Athlone: Longford Westmeath Parenting Partnership (LWPP).

ABOUT MENTAL HEALTH REFORM

Mental Health Reform is the national coalition working to promote improved mental health services and the implementation of the mental health policy *A Vision for Change*.

Mental Health Reform is available to discuss the above recommendations. Please contact Kate Mitchell, Policy and Research Officer at 01 874 9468 or via email at kmitchell@mentalhealthreform.ie for further information.