Mental Health Reform
Promoting Improved Mental Health Services

Mental Health Reform Pre-Budget Submission 2018

Time to Catch Up on Mental Health Investment

Recommendation 1: Ring-fence revenue funding of €55M in 2018 to sustain existing levels of service and development of new mental health services. Specifically, funding should be used in part to:

- Continue building staffing levels, across the mental health services, in line with *A Vision for Change* recommendations
- Develop 24/7 crisis intervention mental health services across the country
- Implement a national, electronic mental health information system
- Increase capacity of national advocacy services for both children and adults with mental health difficulties in hospitals, day centres, training centres, clinics, institutional-based settings and throughout the community, building on existing services

Recommendation 2: Invest in mental health in primary care to ensure that the mental health needs of the population are addressed at the lowest possible level of the mental health system

This should be achieved through the following measures:

- Extend the Counselling in Primary Care (CIPC) service to people on low to middle-incomes and increase the ceiling on the number of sessions to 20
- Provide a minimum of one dedicated staff grade or above mental health worker per primary care team
- Extend medical cards to all people who require long-term mental health treatment
- Fund research and pilot initiatives to evaluate the potential role of e-mental health within the Irish mental health system, with a view to mainstreaming e-mental health in Ireland
- Develop perinatal and infant health and social services outside of specialist mental health services to support the social and emotional development of children in their early years, in addition to the mental health needs of mothers/ families
- Invest in early intervention programmes which promote positive mental health and well-being of children and families, to be rolled out across the country

Recommendation 3: Provide a national sustainable funding stream for tenancy sustainment supports, where required, for individuals with severe and enduring mental health difficulties (including those transitioning from HSE supported accommodation and for mental health service users living in other types of accommodation in the community) in order to prevent homelessness and promote recovery

Recommendation 4: Provide funding to implement the internationally evidence-based approach to supported employment to ensure that all individuals with mental health difficulties, who want to work, are adequately supported to take up and sustain employment

Recommendation 5: The necessary resources should be allocated to implement a nationwide schools programme on mental health promotion and well-being for both primary and post primary schools

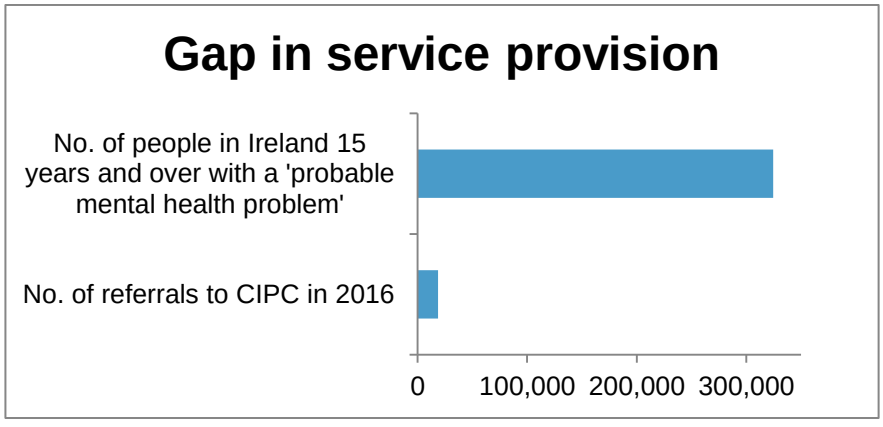
Introduction

Mental health is an issue that has a pervasive impact on Irish society. Demand for mental health supports has increased in recent years and mental health services have failed to catch up, becoming increasingly under-resourced and over-stretched.

- According to the World Health Organisation by 2030 depression is expected to be the largest contributor to disease burden
- According to the Healthy Ireland survey, almost 10% of the Irish population over age 15 has a 'probable mental health problem' (PMHP) at any one time.[1] This equates to approximately 337,000 people based on Census 2016 population data
- Almost 20% of young people aged 19-24 years have had a mental health disorder and 15% of children aged 11-13 years will also have experienced a mental health disorder[2]

Despite a downward trend in overall suicide rates in recent years,[3] suicide is still a huge concern in Irish society. Unicef Ireland's latest Report Card on Child Well-Being shows that Ireland has the fourth highest teen suicide rate in the EU/OECD region. The report documents that Ireland had an above average international suicide rate in the 15-19 age group between 2008 and 2013.

In 2015, the National Registry recorded over 11,000 presentations to hospital due to self-harm, involving almost 10,000 individuals. Despite a decrease in the rates of self-harm in recent years, it has been identified that the rate of self-harm in 2015 was still 9% higher than in 2007, the year before the economic recession.



The high level of demand is also clearly demonstrated in the number of individuals accessing mental health services and supports. Between 2014 and 2016 the number of referrals to the Counselling in Primary Care (CIPC) Service increased by 28% from 14,407

[1] Department of Health (2015) Healthy Ireland survey 2015: summary of findings. Dublin: Department of Health.
[2] Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I (2013) The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group Dublin: Royal College of Surgeons in Ireland.
[3] Between 206 and 2015 the rate of suicides per 100,000 population decreased by 15%.

to 18,471.[4] In child and adolescent mental health services the number of referrals has grown from 8,663 in 2011 to 13,062 in 2014, i.e. by more than 50%. In its 2015/2016 Impact Report the Samaritans Ireland documented that calls to their helpline increased by 60% since it launched its free-to caller phone number in 2014.

Despite the high need for mental health supports, they continue to be severely under-resourced. Between 2012 and 2017 €175M was allocated for spending on the development of community based mental health services through Programme for Government (PfG) funding. As the mental health system is a people provided service a significant proportion of this funding was targeted towards the recruitment and retention of mental health staff.

However, the mental health services remain under-staffed by approximately 20% and still almost 800 staff below what was in place before the economic crisis. Between 2011 and 2017 the number of staff in post increased by only 7% (or 650 staff), from 9,107 at the end of 2011 to 9,757 in March 2017. However, there were almost 10,500 staff in post in 2008.

It must also be recognised that increases in mental health expenditure will be required to maintain, at a minimum, existing levels of service. The 2017 HSE Mental Health Operational Plan identifies that there will be a significant financial challenge in maintaining existing levels of service within the 2017 funding allocation. The cost of providing existing services at the 2016 level will grow in 2017 due to a variety of factors including national pay agreements / public pay policy requirements, quality and safety requirements, new drug and other clinical non pay costs, and price rises etc. No doubt, such challenges will exist in 2018 also. Furthermore, there is a risk that continued demographic pressures and increasing demand for services will be over and above previous planned levels, thus impacting on the ability to deliver services within existing budgets.[5]

Mental Health Reform calls on Government to provide stable, sustainable funding to protect existing, core levels of service, in addition to developing new mental health services which have received little to no investment to date. The Government must fully realise its national mental health policy *A Vision for Change*, (and any updated policy) in addition to its commitments to mental health as set out in the Programme for Government. This will require substantial investment, and is fundamental to improving the mental health outcomes of adults and children living in Ireland.

[4] Information provided by CIPC.

[5] The expected increase in the population of over 65 years and 85 years and over will have significant implications for the Psychiatry of Old Age (POA) services. Furthermore, there is an increase in the number of older people with dementia which can be associated with significant behavioural and psychotic symptoms where psychiatry of old age services are required. Additionally, the population of children nationally is expected to increase by 8,530 between 2016 and 2017 creating an additional demand on child and adolescent mental health services (CAMHS).

RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

Recommendation 1: Ring-fence revenue funding of €55M in 2018 to sustain existing levels of service and development of new mental health services. Specifically, funding should be used in part to:

- Continue building staffing levels, across the mental health services, in line with A Vision for Change recommendations
- Develop 24/7 crisis intervention mental health services across the country
- Implement a national, electronic mental health information system
- Increase capacity of national advocacy services for both children and adults with mental health difficulties in hospitals, day centres, training centres, clinics, institutional-based settings and throughout the community, building on existing services

The recent Sláintecare report recommends that mental health spending increase to 10% of overall health spend, while *A Vision for Change* recommended that Government ensure that the proportion of the total health budget allocated to mental health was progressively increased to 8.24%. However, in 2017, the total revenue budget for mental health was €853.7M. If fully realised this level of expenditure would equate to only 6% (approx.) of the overall (current expenditure) health budget of €14.15B. This represents a reduction in mental health funding as a proportion of the overall health budget from approximately 6.4% in 2016 and also constitutes a reduction from 13% in the 1980s.[6]

Internationally, the percentage of mental health funding as a proportion of the overall health budget is significantly higher at 13% in both Britain and Canada and 11% in New Zealand.[7]

Despite an increase in mental health spending of €88.6M between 2011 (€686.2M) and 2015 (€774.8M) allocated funding for the development of mental health services has remained below recommended levels.

Aside from the moral and social implications, there is a strong economic basis for investment in mental health services. The Healthy Ireland framework reports that the economic cost of mental health problems in Ireland is €11B per year, much of which is related to loss of productivity. In 2008, it was identified that mental health difficulties cost the Irish economy around €3B or 2% of GNP annually and most of the costs are in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement.[8] Moreover, the WHO have recently reported that every US$ 1 invested in scaling up treatment for depression and anxiety leads to a return of US$ 4 in better health and ability to

[6] College of Psychiatrists Ireland (2015) Press Statement: 9th October 2015: Budget Submission 2016, available at http://www.irishpsychiatry.ie/Libraries/External_Affairs/Budget_Submission_2016.sflb.ashx.
[7] Evelyn Ring "Low spend on mental health is criticized". Irish Examiner (Dublin) 10th October 2015, available at http://www.irishexaminer.com/ireland/low-spend-on-mental-health-is-criticised-358584.html.
[8] Kennelly,B.,E.O'Shea (2008) The Economics of Mental Health Care in Ireland, Dublin: Mental Health Commission.

work.[9] This evidence suggests that the individual and social returns from adequate investment in mental health in Ireland are likely to be "high and sustained".[10] Furthermore, enhanced investment will ensure the type of community and recovery based mental health system envisioned in the current mental health policy.

Specific areas which require investment include the following:

Continue building staffing levels, across the mental health services, in line with A Vision for Change recommendations

While there have been difficulties in the recruitment of professionals to mental health services in recent years, additional investment is required to increase the number of staff in post to staffing levels recommended in *A Vision for Change* (i.e. 12,000). As of March 2017, there were 9,757 WTEs in post in mental health services across the country,11 representing just 80% (approx.) of the recommended staffing level in AVFC. There have been significant reductions in the number of staff in post since 2008 (i.e. almost 800 or 7%) despite recommendations by the Expert Group for increases in mental health staffing.

The situation is more severe in child and adolescent mental health services. The HSE's recent report on specialist mental health services shows that as of December 2015, there was a total of 603.95 staff in child and adolescent community mental health teams nationally (521.41 clinical staff). This represents just 51.6% of the staffing levels recommended in *A Vision for Change*. Despite concerted efforts by the HSE to improve staffing levels in CAMHS in the last couple of years, this equates to an increase of just 2.1% nationally on the 2014 position.

The ongoing shortfalls in staffing across child and adolescent mental health services has resulted in many challenges for children and families in Ireland in accessing mental health supports, including:

- continued gaps in service provision for 16 and 17 years olds
- the admission of children to adult psychiatric units (primarily due to out of hours supports)
- increased challenges for particular groups of children and young people in accessing mental health services, including those in the care and justice systems and children with autism

It is imperative that specialist mental health services for particular groups of children and young people, such as children with a mental health and intellectual disability are developed as a matter of priority through the recruitment of specialist staff.

One approach to be taken by Government in increasing the number of mental health staff is to enhance the recruitment of allied health professionals to community mental health teams.

[9] World Health Organisation (WHO) 'Investing in treatment for anxiety and depression leads to fourfold return', media release, 13th April 2016 available at http://www.who.int/mediacentre/news/releases/2016/depressionanxietytreatment/en/.
[10] Kennelly,B.,E.O'Shea (2008).
[11] See HSE January – March 2017 Quarterly report.

AVFC sets out a model of modern mental health care that relies on multidisciplinary teams to support the recovery and social inclusion of people with severe mental health difficulties. Its recommendations entail a significant increase in number and involvement of allied health professionals (social workers, occupational therapists, psychologists, peer support workers, etc.). Yet the total number of allied health professionals is still well below *A Vision for Change* recommended levels.

In its 2017 Operational Plan, the Mental Health Division states that "there is a significant requirement to reduce agency and overtime expenditure…" through targeted work force planning. A greater focus on the recruitment of allied health professionals has the potential to address, in some part, the increasing cost pressures associated with agency staff and overtime.

Develop 24/7 crisis intervention mental health services across the country

In February 2017, Mental Health Reform welcomed a statement by then Minister of State for Mental Health Helen McEntee, that work was underway on a roadmap for developing out-of-hours access to mental health services. Mental Health Reform is seeking a firm commitment by the Department of Health to publish this roadmap as a matter of priority.

AVFC sets out clear recommendations on the need for 24/7 crisis mental health supports and more recently, the suicide prevention framework Connecting for Life made a commitment to the provision of a co-ordinated, uniform and quality assured 24/7 service for individuals in need of mental health care.

In addition the HSE Mental Health Division Operational Plan 2017 includes a commitment to "to provide 7 day service responses for known mental health service users in crisis, including provision of a weekend service in nine locations nationally".[12] The 2017 plan also commits to "reviewing existing out of hours services and exploring ways to improve 24/7 crisis intervention arrangements and consider pilot sites".[13]

The requirement for crisis services can be demonstrated by the prevalence of individuals presenting to emergency departments (EDs) with mental health difficulties. As outlined above, the number of people presenting to emergency departments throughout the country following self-harm was close to 10,000 in 2015 and the number of people who died by suicide in the same year was over 450. Ireland continues to have one of the highest rates of suicide among young people in Europe.

Yet, eleven 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. In the absence of community-based supports, EDs are often the only option for individuals in crisis, even for those already known to the mental health services. This finding is reflected in a

[12] See HSE Mental Health Division Operational Plan 2017.
[13] Ibid.

study by Jigsaw that identifies the lack of out of hours supports for children and young people.[14]

The lack of crisis supports across the country is consistently reported to Mental Health Reform by people with self-experience, family members and carers as well as mental health professionals. There is broad based consensus across the mental health community that accessing supports through hospital EDs is inappropriate and distressing to an individual experiencing a mental health crisis. Furthermore, people often express concerns that medical professionals in EDs do not have the specialist training to appropriately respond to someone in mental and/or emotional distress.

One person said: “A&E was a horrible experience. I’ve had to go to A&E at times and it has taken 8 hours, 10 hours and even 11 hours to be seen.

Of note, the rate of hospital readmissions among people with mental health difficulties is significantly higher in Ireland than in the UK. The OECD has reported that a high rate of unplanned re-admissions to hospital is an indicator of the quality of several dimensions of the mental health system. It states that some countries, such as the United Kingdom, use community-based “crisis teams” to stabilise patients on an outpatient basis, effectively reducing admissions.

In the UK, the NHS has published clinical standards which state that "a high quality, efficient patient pathway is dependent on access to high quality mental health services across the seven days of the week to provide timely and appropriate input to patient assessment, on-going care and discharge support”. Furthermore, the NHS produced a report on transforming urgent and emergency care services in England. This report set out guidance for the development of mental health crisis supports, including that effective local crisis care pathways should be developed.

A small number of mental health teams across Ireland have being offering a more appropriate, responsive way in to urgent support, including the provision of 7-day-week day hospital alongside home treatment teams and 24/7 telephone support from specialist mental health staff. The result of implementing such a service in Celbridge mental health services was 27% lower costs [per capita] and half the rate of overall admissions and length of stay.[15] While it requires enough community mental health team staff to be available across 7 days, it results in less staff being needed in acute units.

Mental Health Reform has consistently called for the delivery of holistic, 24/7 community based crisis mental health services across Ireland.

[14] Headstrong, The National Centre for Youth Mental Health (2013) Economic Burden and Cost to Government of Youth Mental Ill-Health. Dublin: Headstrong, p. 5.

[15] Gibbons, P., A., Lee, J.Parkes, & E. Meaney (2012) Value for money: a comparison of cost and quality in two models of adult mental health service provision. Dublin: HSE.

A national, electronic mental health information system should be implemented in 2018 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 mental health policy

Mental Health Reform has been calling for an ICT-based national mental health information system in budget submissions since 2013. Yet four years later, the specification for a system has yet to be developed. It is not acceptable that more than eleven years after publication of *A Vision for Change*, there is no information system to account for the more than €850M in public expenditure on mental health care.

In 2009, Indecon completed a review of Government's progress on implementation of *A Vision for Change.*[16] Among the key findings of the report, was that there was a lack of available detailed data and information that would be required to facilitate the ongoing monitoring of funding, expenditure and human resource allocation across the mental health services and the assessment of progress on implementation of AVFC.

The report recommended that new performance indicators and up-to-date data should be "developed and published" to progress implementation and monitoring of the national mental health policy. Indecon reported that effective performance indicators would help prioritise resources and increase value for money, enabling the State to progressively improve services and thereby realise the right to health over time in accordance with its obligations under international human rights law.

While, the governance of mental health systems relies on accurate and timely information for effective service planning, implementation and monitoring, in Ireland, information on community mental health services is not routinely collected at the national level. There is no information on the numbers of people resident, admitted and discharged from HSE community residences, or the number of people using mental health day services such as day hospitals, clinics and day centres. Moreover there is a complete absence of data collection on the number of people accessing particular mental health treatments, for example, talking therapies, and the numbers of individuals on waiting lists for such supports.

The development of an appropriate mental health information system based on key performance indicators will assist in the full transparency and accountability for the evaluation, planning, funding and effective and efficient delivery of mental health services.

Increase capacity of national advocacy services for both children and adults with mental health difficulties in hospitals, day centres, training centres, clinics, institutional-based settings and throughout the community, building on existing services

Mental Health Reform has previously highlighted that there are significant gaps in existing advocacy supports for people with mental health difficulties. There is currently no statutory right to advocacy, as recommended in *A Vision for Change* and envisaged in the Citizen's

[16] Indecon (2009) Review of Government Spending on Mental Health and Assessment of Progress on Implementation of A Vision for Change available at https://www.amnesty.ie/sites/default/files/report/2010/04/Indecon_Report%20to%20Amnesty1%20Sep%202009.pdf.

Information Act, 2007. Existing advocacy services are limited in their remit. The National Advocacy Service (NAS) established under the Citizen's Information Board provides a non-statutory advocacy service to people with disabilities, including individuals with mental health disabilities. However, it focuses primarily on individuals who reside in HSE supported accommodation. The Irish Advocacy Network (IAN) offers a peer advocacy service to individuals across the country, prioritising services to individuals in acute inpatient units. Both services are under-resourced.

In particular, it is evident that there is significant unmet need in terms of advocacy supports for people with mental health difficulties living in the community. *A Vision for Change* recommends that "all users of the mental health services – whether in hospitals, day centres, training centres, clinics, or elsewhere – should have the right to use the services of a mental health advocate."[17] This right has yet to be realised.

In a recent small scale study in one urban area in Ireland investigating the views of mental health service users on independent advocacy supports available in the community the following was identified:[18]

- There is a very low level of awareness of existing advocacy services for people with mental health difficulties and very few individuals have accessed such services[19]
- Two thirds of participants (67%) stated that they did not know how to make a complaint about mental health services
- 78% of participants had not heard of the HSE complaints service 'Your Service Your Say'
- 62% of participants indicated that it was difficult or very difficult to make a complaint
- A high percentage of participants had experienced difficulties in accessing supports and/or entitlements[20]

Despite the recognition of the importance of children and young people to actively participate in their own mental health care there is currently no national advocacy service for children engaged in mental health services in Ireland. There is a concern that this group of children and young people are not being heard in terms of their experiences of the services, in addition to their will and preferences.

Mental Health Reform has previously recommended the establishment of a dedicated advocacy service to ensure that the advocacy needs of children with mental health

[17] AVFC (2006) p.25.
[18] Mental Health Reform (2017) The Advocacy Needs of Mental Health Service Users Living in the Community. Dublin: MHR.
[19] Only 13.6% of people had heard of the Irish Advocacy Network and only 10.6% had heard of the National Advocacy Service for People with Disabilities. Only 4% of participants had used the National Advocacy Service for People with Disabilities, and just 2% had used the Irish Advocacy Network.
[20] A quarter of participants (25%) had experienced difficulty getting supports from mental health services, while a quarter (25%) of participants also had difficulty attaining supports from social welfare services. Closely behind this, was difficulty in getting support from local authority housing services (24%); 16% of participants had difficulty accessing supports from employment services, while 16% had difficulty attaining supports from other mental health services. 9% had difficulty accessing supports from An Garda Síochána, as did 9% of participants from education or training providers.

difficulties are being met. In a study with young people engaged in mental health services it was identified that "a national advocacy service for young people with mental health difficulties in Ireland should be established as a matter of urgency as it will help young people to express their views about their treatment and help them advocate for better quality services".[21]

The Expert Group report on review of the Mental Health Act, 2001 made specific recommendations on the availability of advocacy services to children and families engaged in mental health services.

In February 2016, the United Nations Committee on the Rights of the Child published its concluding observations on Ireland's compliance with the UNCRC. Among its recommendations were for Government to consider the establishment of a mental health advocacy and information service that is specifically for children and accordingly accessible and child-friendly.

Recommendation 2: Investment in mental health in primary care to ensure that the mental health needs of the population are addressed at the lowest possible level of the mental health system

Extend the Counselling in Primary Care (CIPC) service to people on low to middle-incomes and increase the ceiling on the number of sessions to 20

The Counselling in Primary Care service is limited in that it only accepts referrals from medical card holders, has a limitation of eight counselling sessions and is currently only available to individuals over the age of 18 years. It is also fundamentally limited by a shortage of resources compared to need.

In 2014, CIPC was allocated a development budget of €3.8M which represents just one half of one percent of the mental health service budget.[22] This compared to investment of £149M at that time for the Increasing Access to Psychological Therapies (IAPT) service in the UK.[23]

The demand for CIPC is steadily growing and as outlined above the number of referrals to the service has increased by almost 30% between 2014 and 2016. The waiting lists for access to a first appointment also demonstrate increasing demand on the service. Of the 2,530 clients waiting for counselling nationally at the end of April 2017, 29% (727) of clients were waiting between 0–1 month, 47% (1,183) of clients between one and three months, 15% (489) between three and six months and 5% (131) of clients were waiting over 6

[21] Buckley, S et al (2012).Mental health services: the way forward. The perspectives of young people and parents. St Patrick's University Hospital, Dublin.
[22] See HSE Mental Health Division Operational Plan 2014, p.21.
[23] Department of Health/IAPT (UK) (2012) IAPT Three-Year Report: The first million patients, available at http://www.iapt.nhs.uk/about-iapt/.

months.[24] Under the UK's IAPT service the target is that 75% of referrals would be seen within six weeks and 95% within 18 weeks.[25]

Mental Health Reform welcomes the commitment in the Programme for Government to "extend counselling services in primary care to people on low income".[26] It is imperative, however, that adequate resourcing is provided to ensure that this commitment translates into practice and is carefully aligned with the presenting need of each particular CHO. Data from early 2017 demonstrates that referral rates and waiting lists for CIPC vary across the country and are significantly higher in some CHOs than in others.

The existing limitations of the Counselling in Primary Care service, in addition to the increasing demand for the service demonstrate the pressing need to adequately resource CIPC so that it can respond in a timely manner to individuals in need of such supports. 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 IAPT programme has been proven to be cost-effective and has increased the number of individuals with mental/emotional distress returning to work. Over a three year period it has supported over 45,000 people to move off sick pay and benefits.[27] Economic gains are also expected in terms of people retaining employment and to employers, who benefit from a reduction in sick days. It has been identified that the programme will enable savings to the NHS in the areas of:

- reduction in healthcare usage by those who recover
- reduction in long-term repeat prescriptions for antidepressants due to the greater enduring effect of talking therapies compared with medication
- reduction in GP appointments
- reduction in outpatient appointments and procedures
- reduction in inpatient bed days

Provide a minimum of one dedicated staff grade or above mental health worker per primary care team

Mental Health Reform has recently welcomed the sanctioning of the recruitment of 114 assistant psychologists for primary care teams across Ireland. The addition of these posts is a positive step towards providing earlier access to mental health support for children and adolescents. It is imperative, however, that such efforts by Government to increase capacity in mental health in primary care continue for both children and adults. Moreover, it is necessary that **the further recruitment of posts is focussed at the level of staff grade or**

[24] Information provided by CIPC.
[25] See Department of Health (UK) 'NHS England Investment in Mental Health 2015/2016', NHS England Strategic Finance Team, NHS available at http://www.england.nhs.uk/resources/pay-syst/.
[26] See A Programme for a Partnership Government 2016.
[27] Department of Health (2012) IAPT Three Year Report: The First Million Patients.Department of Health: UK.

higher. This will ensure that individuals accessing services are receiving mental health support from fully qualified professionals.

The Children's Mental Health Coalition (to which MHR has provided the secretariat) has previously recommended enhancing the capacity of primary care to provide mental health support. Specifically, it has identified that the appointment of mental health workers at primary care level are a critical success factor for the entire mental health system. Increasing the availability of mental health expertise within primary care teams would enable early intervention and reduce the number of referrals to specialist mental health services.

This position has been developed from international good practice, which recommends increasing the accessibility and effectiveness of mental health supports through the involvement of primary care professionals and the delivery of interventions in the primary care setting. The WHO states that, "pre-service and/or in-service training of primary care workers on mental health issues is an essential prerequisite for mental health integration".[28] It also notes that continuity of care is a core element of effective primary care and where there is an ongoing relationship between an individual health worker and a "patient" the quality of assessment and diagnosis is likely to be enhanced.

This is further reflected by the American Academy of Pediatrics Task Force on Mental Health in Primary Care that recognises the specific opportunities of the primary care setting in providing mental health care and the need to build on the unique skills of primary care clinicians.

In Ireland, the guidance document issued by the Vision for Change Working Group on Mental Health in Primary Care notes that there is a need to "ensure that sufficient numbers of professionals within primary care teams have the required skills and knowledge to work effectively with individuals with mental health related difficulties of a mild to moderate nature that do not require referral to secondary mental health services."[29]

There is some evidence that creating the specific role of 'primary care mental health worker' to coordinate mental health care across health and service settings can build mental health capacity in primary care services and promote mental health in the community.

The World Health Organisation notes that Primary Care workers in Mental Health (PCMH) can perform a number of key functions that could result in increases in good mental health outcomes for individuals. The functions recommended include "community mental health promotion, parenting support, managing comorbidity, case coordination, crisis intervention, treatment adherence, trauma reduction, referral to specialist mental health services and/or community agencies".[30]

The UK has significantly invested in creating and expanding this role of PMHWs in the workforce to bridge the gap between primary health care and secondary mental health

[28] WHO & WONCA (2008) WHO & WONCA (2008) *Integrating mental health into primary care A global perspective*. Geneva: WHO.
[29] HSE National Vision for Change Working Group (2012). Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services: A Guidance Paper. Health Services Executive, Dublin.
[30] WHO (2008).

services. A comprehensive discussion, evaluation findings and core competencies for primary mental health workers are published in the UK national CAMHS review, 2008.

In addition to the appointment of dedicated mental health in primary care workers there is a need for effective integration between the full team of primary care professionals, to ensure that individuals receive the full range of assessments and interventions required. This may include psychology, psychotherapy, counselling, social work, speech and language therapy, occupational therapy, nursing and/or the GP.

International good practice service examples of mental health in primary care include the regional initiative in Ontario, Canada where over 200 'Family Health Teams' have embedded an inter-professional, collaborative team approach to primary care, and a local initiative in the urban area of Macul, Chile where existing resources were leveraged to establish a multidisciplinary family health clinic with a particular focus on child and adolescent mental health.

Extend medical cards to all people who require 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. Furthermore, people who have been receiving 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.[31] 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 mental health disabilities taking up work, and therefore serves to further embed social exclusion for this group of people. In the Department of Social Protection's report on review of Disability Allowance Survey 2015, fear of losing social welfare benefits and fear of losing the medical card were most highly reported as barriers to achieving individual employment goals. The recent publication of the Make Work Pay for People with Disabilities report documents that the potential loss of the medical card [was reported by participants] as the single most important disincentive to taking up employment.

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

[31] Nolan, A. & Nolan B. (2004) Ireland's Healthcare System: Some issues and challenges, Dublin: ESRI.

"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."

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

Fund research and pilot initiatives to evaluate the potential role of e-mental health within the Irish mental health system, with a view to mainstreaming e-mental health in Ireland

As prevalence of mental health difficulties throughout the population reaches significantly high rates, demand for care has also increased in recent years. This may be due to the economic crisis, pressure in the labour market, reduced stigma, as well as promotion of mental health and well-being. However, mental health services have not been able to keep pace, with its service capacity under increasing pressure, resulting in growing waiting times for people in need of support. In fact, even with sufficient numbers of trained clinicians, service costs could rise to unsustainable levels.

There is potential for e-mental health supports (e.g. apps, online modules, etc.) to improve accessibility and affordability of mental health care in Ireland, reducing the prevalence of unmet need. This, in effect, will address health inequalities and social exclusion, particularly in times of increased demand and over-stretched services. Currently, there are many people who do not receive proper assistance when faced with mental health difficulties. Long waiting times can be a deterrent, private supports can be expensive and there are still social stigmas which prevent people from seeking care. Online supports have the potential to reach these groups. If e-mental health is applied effectively, it can deliver personalised care, empower individuals to take ownership of their mental health and possibly result in cost reductions.

E-mental health can be used for preventive care, self-help and 'blended care' (online and face-to-face). Certainly, many younger people expect some form of online support which is more personalised and 24/7 accessible. In the My World Survey 'the internet' was selected by the majority of third level students as a source of information or support for their mental health that they would be likely to use. This finding was reflected in another study of third level students that demonstrates that, when seeking information or support for their mental health, students are most likely to use the internet and technology to look up information on mental health, whether for general information on mental health (85%) or for information on different mental health supports and services (81%).[32] Mobile apps and online programmes related to mental health and wellbeing were likely to be used by a relatively high proportion of students (30% and 40% respectively).[33]

[32] Karwig G, Chambers D & Murphy F (2015) Reaching Out in College: Help-Seeking at Third Level in Ireland, Dublin: ReachOut Ireland, p.24.
[33] Ibid.

Future in Mind, the UK policy on child mental health recognises the need to make better use of digital services in order to address the current gaps in a fragmented child and adolescent mental health system.[34]

There have been examples of good practice in e-mental health internationally. The Netherlands is considered a front runner in the area of e-mental health development (including product design) and implementation and almost 100% of mental health care centres are now offering e-mental health. All parts of the UK either have or are about to produce an e-health strategy within which mental health is addressed and in Belgium e-mental health has received growing support with at least 20% of treatment centres occasionally offering e-health.

In Ireland, the Life Skills Online programme (based on CBT) facilitated by Aware was subject to a randomised control trial and the results of the study clearly show that participating in the programme [statistically] significantly reduced depression in the people in the treatment group, while those who were in the control group had no significant reduction in depression in the same time period.

The Department of Health has stated that e-health will be "a critical enabler to deliver the change and transformation required to introduce new models of care", including in the area of mental health.[35] However, e-mental health has not featured yet as a distinct area of work in Ireland's e-health strategy. There is an opportunity to develop e-mental health supports to enhance the mental health outcomes of individuals through improved accessibility, particularly at a time when services do not have the capacity to meet current levels of demand.

Such supports should be complemented by the development of a national e-mental health strategy, following consultation with key stakeholders in Ireland and with our peers in Europe.

Develop perinatal and infant health and social services outside of specialist mental health services to support the social and emotional development of children in their early years, in addition to the mental health needs of mothers/ families.

This should be complemented with investment in early intervention programmes which promote the positive mental health and well-being of children and families, to be rolled out across the country

A number of international strategy documents have stated that the perinatal and early years period provides a unique opportunity for the prevention of mental health difficulties in addition to the early intervention of mental health challenges with which mothers and infants may present.[36] Fundamental to this, is supporting the development of the parent-infant relationship.

[34] Department of Health (2016) *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. DoH: UK.

[35] HSE & Department of Health (2015) E-Health Strategy for Ireland, Dublin: HSE, p.6.

[36] National Institute of Clinical Excellence (NICE; 2014). Antenatal and postnatal mental health:clinical management and service guidance. NICE UK.

Despite this, there is a significant gap within the Irish health system to meet the mental health needs of this group. Early intervention needs to include a response which places the emotional health and well-being of mothers, infants and families on par with that of their physical health. The absence of specific policy and supporting service provision to address such needs is a gap of huge significance that must be addressed as a matter of priority.

Mental Health Reform has previously identified specific service areas that should be developed in order to enhance capacity in the area of perinatal and infant mental health, including:

- Providing talking therapies in maternity hospitals for parents and families
- Training health and social care staff working in maternity hospitals and public health and practice nurses working in the community setting on perinatal and infant mental health
- Developing 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) and
- Appointing child specific public health nursing posts or the development of children's nurses in the community

Furthermore, the Psychological Society of Ireland has published a draft paper on perinatal and infant mental health, which includes a number of recommendations for enhanced service delivery in this area:

- Define the term perinatal/ infant mental health
- Develop a system of routine universal screening in order to assess family risk factors for perinatal/infant mental health
- Identify quality local pathways to care in order to address care and intervention needs
- Integrate the principles of perinatal and infant mental health into existing services e.g. maternity, primary care, community and mental health services
- Promote perinatal infant mental health among the public, as well as policy makers, mental health professionals, other allied health professionals
- Commission research in order to identify the specific needs of families and children residing in Ireland, in the context of perinatal and infant mental health
- Recognise and support the role of families in promoting, preventing and responding to perinatal/infant mental health issues

To date, some of the local Area-Based Childhood (ABC) programmes have incorporated children's and parent's mental health and wellbeing through early intervention services and supports. Despite such efforts there is a need for continued investment in the development and national roll out of such initiatives.

In 2013, the WHO recommended redirecting mental health spending towards community-based services, including the integration of mental health into maternal and child health, enabling access to better and more cost-effective interventions.[37]

A recent evaluation of a parenting programme in Ireland indicated that for every €1,463 spent per child, a saving of €4,599 per child was realised.[38]

Further research is needed in the Irish context to identify prevalence rates of perinatal and infant mental health issues and appropriate and effective evidence-based interventions. Nonetheless, researchers, clinicians and economists are in agreement that increasing expenditure on mental healthcare services, particularly in the early years of life, through the implementation of promotion, prevention and intervention services result in long-term economic savings, enhanced social capital and individual gains.

The importance of investing in perinatal and infant mental health is also reflected at the national level in the recent publication of the Sláintecare report, which makes a number of recommendations to expand health and well-being services for children, including:

- Ensuring that parents are supported to meet the emotional development needs of their children as well as their physical health needs through supporting the development of the parent-child relationship
- Integrating an infant mental health approach into the Primary Care Child Health and Wellbeing service
- Providing child health and wellbeing services including parenting supports during pregnancy and in the early years of the child's life

[37] World Health Organisation (WHO; 2013). Mental Health Action Plan 2013 – 2020. WHO, Switzerland.
[38] Early Years Strategy (EYS; 2013) Right From the Start: Report of the Expert Advisory Group on the Early Years Strategy. Department of Children and Youth Affairs, Ireland.

RECOMMENDATION FOR THE DEPARTMENT OF HEALTH & THE DEPARTMENT OF HOUSING, PLANNING, COMMUNITY & LOCAL GOVERNMENT

Recommendation 3: The Department of Housing and the Department of Health should jointly provide a national sustainable funding stream for tenancy sustainment supports, where required, for individuals with severe and enduring mental health difficulties (including those transitioning from HSE supported accommodation and for mental health service users living in other types of accommodation in the community) in order to prevent homelessness and promote recovery

The need for tenancy sustainment supports has been evidenced in a number of recent reports and studies. In a review of the Galway/Roscommon community mental health services, published by the HSE in 2014, the review group found that some people in community residences were being over provided with care and that some could have lived independently. Similar findings were identified in earlier reports including the HSE's own Value for Money Review of the efficiency and effectiveness of long-stay residential care for adults within the mental health services in Ireland and the Mental Health Commission's Happy Living Here Study.

Currently, there are approximately 450 residents in HSE medium and low support accommodation who could probably move to independent living given the right support. There are also other individuals living in the community who could benefit from such a tenancy sustainment programme.

Mental Health Reform has welcomed the commitment within the Programme for Government to

"establish dedicated funding supports for tenancy sustainment for people transitioning from HSE supported accommodation and for clients in mental health services living in other types of accommodation in the community".[39]

Similarly, it has welcomed the recommendation by the Oireachtas Committee on Housing and Homelessness to "guarantee funding for visiting tenancy sustainment and support services to help prevent homelessness by working with those with mental health difficulties in their own homes".[40]

However, to date this Programme for Government commitment has not been fulfilled. Agreement between the Departments of Health and Housing on a funding stream which meets the housing needs of individuals in the community, who require it, is needed for 2018 in order to deliver on the aforementioned commitments, in addition to those included in existing housing policies and strategies, such as the National Housing Strategy for People with Disabilities.

[39] See A Programme for a Partnership Government 2016.
[40] See Report of the Committee on Housing and Homelessness, June 2016.

An on-going difficulty in preventing homelessness and promoting community living 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, who require it. Tenancy sustainment supports can assist individuals to embrace all areas of independent living such as:

- Developing a fuller awareness of his/her potential, skills, interests and talents
- Integrating fully in the community in which they live
- Accessing training, employment and availing of educational opportunities identified through the support planning process
- Identifying and reducing issues related to isolation when they arise by increased socialisation within their community
- Linking with the community mental health team to ensure that they are receiving the correct level of care to maintain their recovery
- Developing the required knowledge of social welfare and other entitlements (including the various utility services)
- Meeting responsibilities in regard to payment of bills; such as rent and utility bills etc.
- Maintaining their home to a reasonable standard and that repairs/faults are reported by the tenant as early as possible
- Understanding their new and enhanced rights as tenants, as outlined in their tenancy agreement which is registered with the Residence Tenancy Board (RTB)
- Fulfilling their responsibilities as detailed in the Tenancy Agreement, especially in regard to being a good neighbour and their responsibilities in relation to visitors

A recent evaluation of Hail's Regional Visiting Support Service (RVSS), a homeless prevention service for people with mental health difficulties highlights the effectiveness of tenancy sustainment supports. The study showed at 12 month follow up (on average) 80% of former clients of the service could be confirmed as remaining housed. 4% had deceased or moved to a nursing home and 16% could not be traced. "These findings indicate that a large majority of those clients whose tenancies are successfully maintained at case closure, perhaps even almost all, are remaining in a tenancy at follow up".

It is imperative that a national sustainable funding stream for tenancy sustainment supports is provided so that the Government's policy of de-institutionalisation is not hindered by a gap in housing support in the community. Fundamentally, it is necessary for promoting the recovery of people with mental health difficulties and in ensuring their social inclusion within the community.

RECOMMENDATION FOR THE DEPARTMENT OF SOCIAL PROTECTION

Recommendation 4: Provide funding to implement the internationally evidence-based approach to supported employment to ensure that all individuals with mental health difficulties, who want to work, are adequately supported to take up and sustain employment

The current system of employment supports for people with mental health disabilities, throughout the country, has not been successful in facilitating access to employment. 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,[41] however, half of adults with a mental health disability who are not at work say they would be interested in starting employment if the circumstances were right.[42]

Yet, people with mental health difficulties continue to experience significant social exclusion through a loss of income, unemployment and a loss of social contacts. Employment has been identified as increasingly important as a route to social inclusion and recovery from a mental health difficulty. In a detailed report on mental health and social inclusion, the National Economic and Social Forum in Ireland concluded that work is the best route to recovery and employment is the best protection against social exclusion. Studies have also indicated that returning to work can lead to clinical improvement and increased social functioning among individuals and improved quality of life.

The Department of Social Protection's (DSP) recent report on its Disability Allowance (DA) Survey identifies significant levels of interest among individuals on DA in taking up employment (including both part time and full-time work). Among those who were not currently working 35% expressed an interest in working part time, while 8% expressed an interest in full time employment, given the right supports.

Interestingly, the survey shows that 50% of participants reported mental health difficulties as the primary reason for being on DA.

The survey also identified that people with disabilities (including mental health disabilities) experience numerous barriers to employment and a range of supports are required to help achieve employment ambitions and goals, including in areas such as being able to retain social welfare payments, supportive work environments, access to transport, mental health supports; adaption of job tasks, flexible hours and flexible work arrangements.

There is strong evidence that the internationally recognised approach to supported employment (Individual Placement Support) is the most effective method of supporting people with severe mental health difficulties to achieve sustainable, competitive employment.[43] It has also been shown to be both cost effective and less costly than

[41] 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

[42] CSO National Disability Survey 2006 – Volume 2, Dublin: The Stationery Office, p.86.

[43] Sixteen randomised controlled trials have demonstrated that Individual Placement and Support achieves far superior outcomes across varying social, political, economic and welfare contexts. These show that 61% of people with serious mental health conditions can gain open competitive employment using Individual Placement and Support as compared with 23% for vocational rehabilitation. Randomised controlled trials in the United States have also shown that IPS

traditional vocational approaches.[44] The IPS approach includes seven key essential principles including integrated mental health and employment supports, intensive, individual support, rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer.[45] The principles of the evidenced based supported employment approach have been strongly endorsed by the UK Government.[46],[47]

In 2015, the Department of Social Protection invested in evidenced-based supported employment by partnering with the HSE and Mental Health Reform on a pilot of the Individual Placement and Support approach in four sites across the country. Early indications are that the sites are able to provide a more integrated supported employment service than has been the case previously through Employability services.

The commitment by the Department of Social Protection to invest in the pilot of the IPS approach to supported employment is very welcome by Mental Health Reform. However, it is important that this commitment continues and the IPS approach is rolled out across the country to ensure that all individuals with mental health disabilities who want to work are provided with effective support into employment.

Failure by the Irish Government to adopt this approach is likely to result in people with mental health disabilities, who could work with the appropriate support, remaining outside the labour market. This, ultimately, will adversely impact on an individual's recovery, exacerbate their exclusion within society and have continued negative implications for the Irish economy.

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participants have much better employment outcomes than people supported by more traditional approaches of providing vocational training and job preparation before undertaking the search for competitive employment.

[44] Researchers conclude that "compared to standard vocational rehabilitation services, IPS is, therefore, probably cost-saving and almost certainly more cost-effective as a way to help people with severe mental health difficulties into competitive employment."In a report for the UK Department of Work and Pensions, the authors calculated that for every pound invested in the supported employment approach there was an expected saving of £1.51.The OECD has also identified that IPS produced better outcomes than alternative vocational services at a lower cost overall to the health and social care systems.

[45] Perkins, R Farmer, P and Litchfield, P, Realising ambitions: Better employment support for people with a mental health condition, 2009, London: The Stationery Office Ltd, p.63-64.

[46]Department of Health (2006a) From segregation to inclusion: Commissioning guidance on day services for people with mental health problems. London: Department of Health.

[47] Department of Health (2006b) Vocational services for people with severe mental health problems: Commissioning guidance. London: Department of Health / Care Services Improvement Partnership.

RECOMMENDATION FOR THE DEPARTMENT OF EDUCATION & SKILLS

Recommendation 5: The necessary resources should be allocated to implement a nationwide schools programme on mental health promotion and well-being for both primary and post primary schools

In its report on effective interventions for the prevention of mental health difficulties, the WHO identifies that there is ample evidence that school based programmes can influence positive mental health and reduce risk factors and emotional and behavioural problems through social–emotional learning and ecological interventions. A number of outcomes have been identified from existing school based programmes, including "academic improvement, increased problem-solving skills and social competence as well as reductions in internalising and externalising problems such as depressive symptoms, anxiety, bullying, substance use and aggressive and delinquent behaviour".[48]

There is also compelling evidence on the value of a 'whole school' approach to social and emotional learning, which every level of education would benefit from.[49] In the context of mental health, the whole school approach builds the capacity of the school community to promote a sense of wellbeing, address the common emotional needs of young people and prevent the development of mental health difficulties. It seeks to make changes to the schools' social and learning environments, strengthen the structures within each school for addressing mental health promotion and promote links between the school and its community.

The implementation of the Incredible Years Programme in Ballymun has shown the benefits of implementing a whole school approach to social and emotional learning. Pre and post test monitoring data demonstrates significant improvements in children's social and emotional well-being (as measured by the Strengths and Difficulties Questionnaire) associated with participation in the programme. Such outcomes were also reflected in the parenting programme.[50] Parents who participated in the programme reported significantly reduced levels of stress (measured by Parental Stress Index) and depression (measured by the Beck Depression Index).

Schools can also act as an early identification and referral point for students experiencing mental health difficulties. Where timely and appropriate supports are provided for young people with mental health difficulties, there is clear evidence that many will recover, or at least develop coping strategies to manage their difficulties more effectively.[51] There are also obvious economic benefits to addressing the issue of mental health in education. Mental health difficulties in childhood not only negatively affect a child's ability to learn, but can lead to more serious mental health difficulties in adulthood, particularly if the child is not supported to recover.

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[48] WHO (2004) Prevention of mental disorders: effective interventions and policy options, Geneva: WHO.

[49] 4 Elias, M.J., Zins, J.E., Weissberg, R.P., & Greenberg, M.T. (2003) Promoting social and emotional learning: Guidelines for educators. Alexandria, VA: AFSP.

[50] Morgan, M. & K. Espey (2012) Whole-school implementation of Incredible Years: An Action Research Study, Dublin: Young Ballymun.

[51] D Evans, E Foa, R Gur (Eds.) et al., (2005) Treating and preventing adolescent mental health disorders: what we know and what we don't know, Oxford University Press, New York.

It must be acknowledged that in Ireland a new subject on wellbeing will be introduced to students starting the first year of secondary school in September 2017 under a revised timetable for the roll out of junior cycle reforms. This is a positive initiative that should be welcomed, however, it is imperative that a school programme on mental health promotion and well-being is rolled out nationally and is available to all children and young people in both primary and post primary schools.

About Us

Mental Health Reform is the national coalition promoting improved mental health services and the social inclusion of people with mental health difficulties. The coalition currently has 59 member organisations. See www.mentalhealthreform.ie for more details. Mental Health Reform acknowledges the support of the Department of the Environment, Community and Local Government's Scheme to Support National Organisations 2016-2019.

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