Mental Health Reform

Promoting Improved Mental Health Services

Mind the Gap!

Mental Health Reform Submission to the Independent Monitoring Group

3rd February 2012

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Executive Summary

Mental Health Reform welcomes the continued efforts by staff, service users and family members to modernise the mental health services. Many positive, individual developments occurred during 2011. At a high level, Government's announcement of a Director for Mental Health as part of the new HSE governance structure bodes well for improved governance in future, while the commitment to dedicated funding to build up community mental health teams was also encouraging. At a local level, some services continued to make progress, drawing on the persistence of individual staff, service users and family members.

However, at a national level there was little evidence of a comprehensive, systematic approach to implementation of AVFC either within the mental health services or across Departments that are responsible for welfare, employment, education and housing. Neither is there yet widespread evidence that the recovery principle is being experienced consistently by service users and family members in mental health service delivery.

Mental Health Reform believes that there is an urgent need to bridge the gap between policy and implementation and to fulfil the promise of recent Government commitments, so that by 2016, when *A Vision for Change* is due to be fully implemented, every service user will indeed receive comprehensive, holistic community-based mental health services with a recovery approach.

As the national coalition of organisations promoting improved mental health services, Mental Health Reform welcomes this opportunity to inform the deliberations of the Independent Monitoring Group for *A Vision for Change.* Mental Health Reform makes the following recommendations around three core themes:

1) Implementing the Recovery Ethos
2) Modernising community-based mental health services
3) Transparency, accountability and governance

Implementing the Recovery Ethos

- Mental Health Reform supports the IMG's recommendations on recovery in its Annual Report for 2010. The HSE should specify how they are implementing these recommendations.
- The HSE should implement an on-going programme of cultural change within mental health services.
- The HSE should develop a charter of rights and responsibilities for mental health service users, families/significant others and carers that formalises the core values of recovery and recognises that service users are equal partners in their own care.
- The HSE should implement the Team Coordinator role in Community Mental Health Teams across the country.
- The Department of Health and the HSE should work together to promote service user-led services and service user employment as peer workers.
- The HSE should develop a framework for the involvement and support of family members/significant others and carers.

- Mental health services that link effectively with mainstream social, educational and employment services to provide seamless, coordinated social inclusion support for individuals.
- A cross-departmental implementation plan for the recommendations relevant to Government Departments beyond Health.
- A cross-departmental implementation and monitoring structure at senior level with public access to information comparable to the HSE's HealthStat reporting.
- An employment strategy for the delivery of training, education and employment services for people with mental health conditions.
- Continued, promotion of a greater awareness among people with a mental health condition of their rights under equality legislation and easier access to claiming their equality rights.
- A long-term public anti-prejudice and discrimination strategy with appropriate resources, targets, monitoring framework and indicators for improving attitudes and behaviours towards people with a mental health condition.
- Implementation of the mental health recommendations in the Government's Housing Strategy for People with Disabilities.
- Social inclusion outcome measures as part of mental health service data collection.
- Ratification and implementation of the Convention on the Rights of Persons with Disabilities and its Optional Protocol to ensure equal access to rights and full participation for people with mental health problems. The Government should establish mechanisms to ensure that people with mental health problems have the opportunity to participate in developing, implementing and monitoring Ireland's compliance with its obligations under the Treaty.

Modernising community-based mental health services

- Ensure that the €23 million and 370 posts specified for community mental health teams in the HSE's 2012 National Service Plan are realised, while also ensuring adequate cover for acute services.
- The HSE should fast track recruitment of the community mental health team staff set out in their 2012 National Service Plan.
- The HSE should establish a programme for developing effective CMHT teamworking.
- The HSE should adopt a policy on gatekeeping that ensures service users see the most experienced, highly trained staff from whichever discipline is most appropriate at first point of contact .
- The HSE should incorporate plans to implement 24/7 available community mental health services and a range of alternatives to hospitalisation for people in crisis as part of its near-term implementation planning.
- Government should initiate a programme designed to identify successful innovations in integrating primary care and mental health services such as Dr. Russell's approach in Cavan, evaluate these and systematically disseminate effective solutions.

- The Department of Health and the HSE should work together to develop a framework for the integration of specialist mental health and primary care services.
- The HSE should take action to ensure better access to mental health treatment for people with co-occuring mental health problems and problematic drug or alcohol use.
- National, regional and local mental health promotion programmes should be evaluated within the next two years and a plan for implementing effective programmes on a nationwide basis put in place on foot of that evaluation.
- A designated mental health promotion officer should be appointed in each Service Area.
- Government should fulfil its commitment to establish a cross-departmental group to ensure that good mental health is a policy goal across a range of people's life experiences including education, employment and housing.
- All Government policies should be checked for their impact on the mental health of the population (mental health proofing).
- The Department of Health and the HSE should urgently progress establishing regional, appropriate acute inpatient units that can be designated centres under the Criminal Law (Insanity) Act 2006.
- The HSE must demonstrate that it is engaging in specific initiatives to ensure that community mental health services meet the mental health needs of all people living in local communities.
- The HSE must ensure that part 5 of the Mental Health Commission's *Code of Practice on being Admitted, Transferred and Discharged to and from Hospital* is implemented nationally.
- The HSE should set out how it will implement Recommendation 15.6.1 to establish neuropsychiatry services in Ireland by 2016.
- The HSE should ensure that appropriate care planning is undertaken to address the risk factors for people with dementia in inpatient psychiatric units.

Transparency, Accountability and Governance

- Establishment of an executive position within the HSE which is responsible for implementing *A Vision for Change*. This must be led by a Director for Mental Health Services who has executive powers, budgetary control and responsibility to publicly report on progress. The Director must be recruited early in 2012 to oversee the additional investment set out in the HSE's National Service Plan.
- Government should ensure the provision of adequate funding to ensure equitable services across the country. In the short term all Service Areas should receive at least the national average level of funding (national average level adjusted according to the population covered) within three years. This will assure a geographically equitable and harmonised funding distribution at the Service Area level.
- Government should provide adequate funding to allow for the transition from institutions to community services without jeopardising quality of services. In this regard, the allocation of €35 million, if realised in the appointment of community-based mental health service staff while ensuring adequate staffing of inpatient units, is welcome.

- The HSE should publish a detailed implementation plan that contains timelines, detailed costs, measurable targets and designated responsible persons early in 2012.
- The HSE should, as a matter of urgency, develop transparent, reliable financial and performance monitoring systems aligned to AVFC that systematically capture the voice of the service user.
- Government should introduce legislation to underpin implementation of AVFC.

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Introduction

> *"When you are vulnerable, they say what you need to do and they don't listen to how you feel. They will listen to your parents over you."*
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> *"Too much emphasis on medical issues."*
>
> *"It seems like the services don't take family members seriously."*

These three quotes from Mental Health Reform's 2011 consultation with service users, family members and other stakeholders across the country illustrate how far some services still have to go to achieve the vision of this Government's mental health policy. While there are some high quality services and some that have made exemplary steps to improve, as shown by the National Service User Executive's recent awards, there is still too great a gap between those services which are progressing *A Vision for Change* and those lagging behind. There is still no national implementation plan to deliver quality services and supports across the mental health system and this failure is showing itself in the disparity between good and poor service provision across the country. The HSE's National Service Plan for 2012 still shows mental health services at just 5.3% of the overall health service spend, far short of the 8.3% set out in *A Vision for Change.*

In 2013, *A Vision for Change* is due for review and it is vital that these next four years are made to count in delivering the policy in full. As the national coalition of organisations promoting improved mental health services, Mental Health Reform welcomes this opportunity to inform the deliberations of the Independent Monitoring Group for *A Vision for Change.* This submission is structured around three core themes:

1) Implementing the Recovery Ethos
2) Modernising community-based mental health services
3) Transparency, accountability and governance

In making this submission, we have drawn upon our member organisations' experiences, direct feedback from service users, family members and service staff as well as evidence from the Inspector's reports for 2011, the HSE *Vision for Change Survey Results* for July 2011 and other published data.

1. Implementing the Recovery Ethos: Slow Cultural Change

Last year the Independent Monitoring Group made a set of detailed recommendations for implementing the recovery ethos in the mental health services. From the feedback that Mental Health Reform heard during our 2011 consultation, it is evident that there is a widespread lack of real delivery of the recovery ethos in services across the country. We consistently heard that current services are focussed on 'maintenance' rather than recovery; we heard that "the attitude of mental health staff can be anti-recovery" and that recovery is seldom mentioned.

Lack of choice was also identified by service users in many areas. After so many years, it is disappointing to hear that service users still cannot get regular appointments with the same consultant in a way that would

support building a therapeutic relationship, but rather are faced with having to meet a new junior doctor every six months or so. While service users in one area spoke of improved access to counselling, others said there was a need for better access to talking therapies.

We understand that a HSE working group is drawing up guidelines on recovery. It is vital that these guidelines are translated into daily practice across the country. Mental Health Reform believes that the below actions can help to embed the recovery ethos in mental health services:

- Developing a service mission statement that reflects recovery values
- Developing service policies that foster hope, listening, partnership and choice
- Developing service procedures that operationalise recovery values such as positive risk management policies that promote self-determination.
- Developing care planning that happens in partnership with service users and families/significant others and provides choice
- Measuring and monitoring fulfilment of recovery values, including measuring achievement of service users' goals, social inclusion and discharge from services
- Supporting service users and families/significant others to link in with local community services and supports
- Recruiting staff based on aptitudes and skills that are congruent with the recovery philosophy
- Training staff in the skills of how to assess capabilities, identify and plan action towards goals and support the development of personal meaning; also including positive service user role models in training
- Employing service users in the delivery of services, including peer support workers (see Slade 2009)
- Supervising staff performance based on fulfilment of recovery values
- Supporting service users to challenge prejudice and discrimination in services and the wider community (Slade 2009, MHC 2008)
- Ensuring that individuals' human rights are protected, respected and fulfilled

(Based on Farkas, Gagne, Anthony and Chamberlin (2005), Slade (2009) and Mental Health Commission (2008)

In addition, both service users' and family members'/significant others' experiences of mental health services would be significantly improved if team-working was structured to ensure that individuals had ongoing contact with a single professional from whichever discipline is most appropriate. Implementation of the Team Coordinator role recommended in *A Vision for Change* would facilitate this type of keyworker arrangement where service users and families/significant others would have a designated staff member as their regular point of contact (see explanatory text supporting Recommendation 9.2). Such an approach is already being operated in both West Cork and Loughrea community mental health services.

Recommendations:

- Mental Health Reform supports the IMG's recommendations on recovery in its Annual Report for 2010. The HSE should specify how they are implementing these recommendations.
- The HSE should implement an on-going programme of cultural change within mental health services.
- The HSE should develop a charter of rights and responsibilities for mental health service users, families/significant others and carers that formalises the core values of recovery and recognises that service users are equal partners in their own care.
- The HSE should implement the Team Coordinator role in Community Mental Health Teams across the country.
- The Department of Health and the HSE should work together to promote service user-led services and service user employment as peer workers.
- The HSE should develop a framework for the involvement and support of family members/significant others and carers.

1.a. Social Inclusion

"Supported Employment [is an] excellent service to aid recovery through employment". (Mental Health Reform public meeting in Waterford)

"We need to find ways of increasing self-confidence. Increase productivity in all areas of life, not just in jobs. Get people involved in the community, in hobbies, etc." (Mental Health Reform public meeting in Newbridge, Co. Kildare)

In Recommendation 4.2, AVFC recognised that combating stigma is an essential component of a modern mental health policy. Good quality mental health services support an individual's integration into the community and help them to combat stigma/prejudice and discrimination. People with mental health conditions also need to be able to access effective income, education, housing and employment supports to enable their social inclusion in local communities. Yet in Ireland there is still an unacceptable level of inequality experienced by people identified as having a mental health condition and attitudes towards people with a mental health condition are still poor. For example, in 2011 the general public was still least comfortable working with a colleague with a mental health difficulty compared to other disabilities (see NDA attitudes survey ((2012)).

The Government's support for the 'See Change' stigma reduction campaign is welcome, as is the leadership being shown by Minister Lynch in publicly advocating for better attitudes about mental health. However, the impact of the See Change campaign at a broad-based, national level has been constrained by its relatively small-scale funding. Given the recent findings that attitudes towards people with mental health difficulties have deteriorated somewhat during the period 2006 to 2011, there is a need to consider whether a more fully-resourced campaign is required to bring about progress on attitudes and discrimination.

Currently there is no specific cross-departmental implementation plan on mental health. Neither are specific mental health actions evidenced in all of the relevant departmental Sectoral Plans under the National Disability Strategy. One positive example has been the dedicated chapter on mental health in the Housing Strategy for People with Disabilities, developed by the Department of Environment, Community and Local Government. The Department of Social Protection has also engaged with Mental Health Reform through the Disability Stakeholders Group. In terms of cross-departmental action on mental health, the Office for Disability and Mental Health facilitates cross-departmental discussion at senior official level. The

cross-departmental working group between the Departments of Health and Justice have also produced successful outcomes in the form of the protocol on criminal justice and mental health and the appointment of designated mental health liaison officers among the Gardai. The Equality Authority has also, on its own initiative published two new leaflets on mental health and equality targeted at people with a mental health condition and employers.

The Programme for Government commitment to "establish a cross-departmental group to ensure that good mental health is a policy goal across a range of people's life experiences including education, employment and housing" is welcome in promising a stronger structure for cross-departmental implementation.

Mental Health Reform supports the Independent Monitoring Group's previous recommendations that the Government develop an overarching implementation plan that covers all relevant Government Departments and that a more structured process of evaluation of implementation across Government Departments is established. Without such tight governance, experience shows that many departments appear to lose focus on their particular role in implementing Ireland's mental health policy.

Despite the key role that social inclusion plays in recovery there is currently no nationwide measurement of the social inclusion outcomes for mental health service users. As the HSE has plans to develop a nationwide mental health information system, it should ensure that indicators for housing, employment, education and income status are collected on a routine basis about people accessing mental health services in order to measure whether service users are achieving improved social and economic outcomes over time.

Recommendations:

- Mental health services that link effectively with mainstream social, educational and employment services to provide seamless, coordinated social inclusion support for individuals
- A cross-departmental implementation plan for the recommendations relevant to Government Departments beyond Health
- A cross-departmental implementation and monitoring structure at senior level with public access to information comparable to the HSE's HealthStat reporting
- An employment strategy for the delivery of training, education and employment services for people with mental health conditions
- Continued, promotion of a greater awareness among people with a mental health condition of their rights under equality legislation and easier access to claiming their equality rights
- A long-term public anti-prejudice and discrimination strategy with appropriate resources, targets, monitoring framework and indicators for improving attitudes and behaviours towards people with a mental health condition
- Implementation of the mental health recommendations in the Government's Housing Strategy for People with Disabilities
- Social inclusion outcome measures as part of mental health service data collection
- Ratification and implementation of the Convention on the Rights of Persons with Disabilities and its Optional Protocol to ensure equal access to rights and full participation for people with mental health problems. The Government should

establish mechanisms to ensure that people with mental health problems have the opportunity to participate in developing, implementing and monitoring Ireland's compliance with its obligations under the Treaty.

2. Modernising the mental health services

2.a. Staffing Multi-disciplinary Teams

It was reported to the Joint Committee on Health and Children that "in October 2010 the HSE had 9,525 staff deployed in mental health but by the end of April 2011 this number had reduced to 9,091. This represent[ed] a 4.5% reduction in the workforce in a six month period."[1] In the Child & Adolescent Mental Health Services there was only a 2% increase in staffing of community teams through September 2011 and these teams had only 42% of the total staffing recommended in AVFC.[2] Mental Health Reform has been concerned to hear reports from services of the impact of combined staffing and budget cuts on community based services, with some withdrawal of community services. For example, a day service in Ennis closed for a week due to a lack of budget to employ agency staff; a service in Dublin reported having to close two high support hostels due to lack of staff and also having difficulty replacing community mental health team staff. The Examiner newspaper also reported that nurses in Kerry, Roscommon, Dublin, Clare and Monaghan were experiencing shortages.[3] Throughout the year reports of between 500 and 1,000 potential staff losses due in early 2012 also generated anxiety in the sector.

"We need more community nurses. They are spread thin. Access to them is hard. A person who made a suicide attempt two weeks ago had no support." (Mental Health Reform's public meeting in Tralee)

In such a context, the allocation of €23M set out in the HSE's National Service Plan 2012 in additional funding for community mental health teams (€16M for adult and €7M for child and adolescent), and the corresponding 370 posts is welcome. It can be expected that the 150 posts allocated for the Community Child & Adolescent Mental Health Teams will have a particularly positive impact in bridging the 58% gap between 2011 staffing levels and those recommended in AVFC. However, there is concern that this commitment could be at risk if substantial further acute service staff losses occur. It will be vital to fast track community team recruitment in 2012 so that the holistic, quality community services that can prevent and/or reduce inpatient admissions can be developed quickly.

Furthermore, additional staff resources will have little effect unless they are used efficiently. Part of the cultural change that needs to happen in the mental health services is the development of a teamwork approach as contrasted with the traditional, hierarchical structure overseen by a consultant psychiatrist. In Ireland, "the traditional medical model is still dominant with the psychiatrist as clinical team leader."[4] There continues to be a "medicalised model" of care provided predominantly by the disciplines of psychiatry and nursing, with relatively low levels of input from psychologists, social workers and occupational therapists.[5]

Having non-medical disciplines as full-time participants in mental health teams is linked to better team

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[1] "National Priority Issues for the Quarterly Meeting with the Minister for Health and the CEO of the Health Services Executive" answers submitted to the Joint Committee on Health and Children, _____

[2] Third Annual Child & Adolescent Mental Health Service Report

[3] *Irish Examiner* 11/10/11 'Mental health staff shortages at crisis levels'.

[4] De Burca, S., Armstrong, C. and Brosnan, P. (2010) *Community Mental Health Teams: Determinants of Effectiveness in an Irish Context*, Limerick: Health Systems Research Centre, p.141.

[5] Ibid., p.101.

processes. This in turn leads to better service quality, clinical effectiveness and service management.[6] Well-functioning multidisciplinary teams accept collective responsibility for service quality and outcomes. Good team working is also cost effective.[7] Case management and/or a key worker system are an accepted part of effective multidisciplinary teamworking in other jurisdictions.[8]

Furthermore, there is a systemic flaw in the current system in that trainee doctors, who are often the least experienced within the system, are charged with the most important initial assessment function. This may lead to extremely poor initial experiences on the part of service users and the lowest level of diagnostic/assessment capacity at the most important point of contact, i.e. the first point of contact. It also fails to draw upon the breadth of disciplines that could be involved in assessment. The system needs to change so that priority is given to service users being met by the most experienced, most highly trained and wisest mental health practitioners of the most relevant discipline at first point of contact.

Mental Health Reform believes that attention must be paid both within the health services and in professional training programmes to developing effective multidisciplinary teamworking processes. Mental Health Reform supports the recommendation made by De Burca, Armstrong and Brosnan that a programme of Community Mental Health Team development be undertaken.[9] The Mental Health Commission has produced valuable guidance on teamworking which can be used by health services to develop and monitor their team practices.[10]

Recommendations:

- Ensure that the €23 million and 370 posts specified for community mental health teams in the HSE's 2012 National Service Plan are realised, while also ensuring adequate cover for acute services
- The HSE should fast track recruitment of the community mental health team staff set out in their 2012 National Service Plan
- The HSE should establish a programme for developing effective CMHT teamworking
- The HSE should adopt a policy on gatekeeping that ensures service users see the most experienced, highly trained staff from whichever discipline is most appropriate at first point of contact

2.b Access to support during a crisis

People in mental health crisis experience difficulties when accessing support. Currently, the norm is that a person in crisis has no alternative but to attend an A&E Department where they are competing for assessment and support alongside people with physical trauma and other critical health concerns. *A Vision for Change* recommended both that community mental health services be available on a 24/7 basis and that thirteen crisis houses be available, one per every 300,000 population (Recommendation 11.11). A small number of services across the country have extended their availability to seven days per week, but again, this is not yet widespread practice. There has been almost no development of alternatives to hospitalisation for people in crisis yet.

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[6] (De Burca, et al., p. 118).

[7] (Byrne & Onyett (2010), p.7).

[8] See MHC (2006) *Multidisciplinary Team Working: From Theory to Practice: Discussion Paper*, Dublin: MHC.

[9] Ibid.

[10] Byrne & Onyett (2010).

Recommendation: The HSE should incorporate plans to implement 24/7 available community mental health services and a range of alternatives to hospitalisation for people in crisis as part of its near-term implementation planning.

2.c. Integration between primary care and mental health services

Mental Health Reform has been encouraged to see local initiatives to increase mental health specialist support into primary care. The collaborative care model operated by Dr. Vincent Russell in Cavan, while not necessarily a replicable model, points the way to how specialist mental health services can provide support to primary care teams in a way that benefits service users, primary care and mental health services. In this mode Dr. Russell provides indirect consultation for patients seen by GPs in primary care centres, occasional direct consultations within primary care centres and regular meetings with primary care staff. Dr. Russell has reported that the arrangement resulted in much better communication between primary care and mental health service staff and as a result of better communication, fewer referrals to the mental health services and fewer hospital admissions. Mental Health Reform is also aware that the DETECT early intervention programme works through establishing good liaison with local GPs. DETECT's work with the ICGP to develop GP workshops as part of the GP Continuous Medical Education programme along with the publication of Early Psychosis Guidelines for Primary Care has been bearing fruit, with over 600 medical professionals having attended workshops.[11] The joint forum between the Irish College of General Practitioners and the College of Psychiatry Ireland is also a promising development.

The HSE's own initiatives to implement the primary care chapter of *A Vision for Change* have had limited impact to date with a small number of GPs having received training through the DCU programme.

What is now needed is to build on the good examples in Ireland and international good practice and, working with the Joint Forum, to develop a coherent, national programme to provide integrated care to the service user through primary care with specialist mental health support as required. This programme must ensure that GPs are trained in the recovery ethos which provides a very different paradigm than the traditional medical approach that would form the cornerstone of GP education.

Mental Health Reform also welcomes the allocation of €6 million in funding for access to psychological therapies through primary care. This initiative reflects how *A Vision for Change* is not just a mental health service strategy, but a policy for the mental health of the whole population. Given the strong message from service users that they want greater choice in mental health care and services that provide more listening support, MHR believes that individuals with an assessed need should have timely, affordable access to psychological therapy at the lowest level of care possible.

Recommendation:

- Government should initiate a programme designed to identify successful innovations in integrating primary care and mental health services such as Dr. Russell's approach in Cavan, evaluate these and systematically disseminate effective solutions.

- The Department of Health and the HSE should work together to develop a framework for the integration of specialist mental health and primary care services.

2.d. Integration between Addiction and Mental Health Services

[11] DETECT, 'Report on the DETECT Service: An Irish Early Intervention for Psychosis Service: Five Year Progress, Plans for the Future: 2006-2011' available at DETECT: Avila House, Block 5, Blackrock Business Park, Carysfort Avenue, Blackrock, Co. Dublin.

While there is little systematic Irish evidence yet on the prevalence of co-occurring problematic drug and alcohol use and mental health problems in Ireland, evidence in the UK would suggest that such 'co-morbidity' is widespread among both addiction and mental health service users. A UK study published in 2003 found that 44% of mental health service users had previous year problem drug use or harmful alcohol use, while 75% of drug service users and 85% of alcohol service users had a 'past-year psychiatric disorder'.[12]

Workshops conducted by Dual Diagnosis Ireland in 2010 found that staff from the addiction services experienced frustration in trying to get their service users' mental health needs met, a lack of coordination between addiction and mental health services and a perceived "lack of respect for addiction professionals by CMHT staff."[13] More recently, in a meeting with homeless sector staff from the Dublin region, Mental Health Reform heard that service providers continue to have difficulty getting mental health treatment for their service users if the individual concerned has problematic drug or alcohol use. This lack of effective service delivery for people with both conditions is likely to be resulting in higher than necessary costs.

Recommendation:

- The HSE should take action to ensure better access to mental health treatment for people with co-occuring mental health problems and problematic drug or alcohol use.

2.e. Mental health promotion

A Vision for Change concerns more than improving mental health service delivery – it is a policy for improving the mental health of the population. However, the mental health promotion recommendations of AVFC have been relatively neglected to date. The HSE has reported previously on its national advertising campaign on mental health and operates the www.yourmentalhealth.ie website. The NOSP has funded various local mental health promotion initiatives, but the most recent HSE survey results show that only 1 of the 13 Expanded Catchment Areas (ECA) was involved in setting and evaluating targets for mental health promotion programmes, while only 2 ECAs had a designated mental health promotion officer.[14] Beyond the HSE, there is still a need to make mental health education problems widely available in schools and workplaces.

One practice that might improve cross-departmental action is to have all Government policies checked for their impact on the mental health of the population (this is called 'mental health proofing'), for example, policies in the areas of housing, access to work, education and social protection. Mental Health Reform supports the IMG's recommendation in its annual report for 2010 that mental health proofing of Government policies take place.

Recommendations:

- National, regional and local mental health promotion programmes should be evaluated within the next two years and a plan for implementing effective programmes on a nationwide basis put in place on foot of that evaluation

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

[13] MacGabhann, L., Moore, A. and Moore, C. (2010) 'Dual diagnosis: Evolving policy and practice in the Irish healthcare system', *Advances in Dual Diagnosis* 3:3:17-28.

[14] Health Service Executive (July, 2011) *Vision for change survey results* available at http://www.hse.ie/eng/services/Publications/services/Mentalhealth/A_Vision_for_Change_Survey_Results_July_2011.pdf

- A designated mental health promotion officer should be appointed in each Service Area
- Government should fulfil its commitment to establish a cross-departmental group to ensure that good mental health is a policy goal across a range of people's life experiences including education, employment and housing.
- All Government policies should be checked for their impact on the mental health of the population (mental health proofing)

2.f. Ensuring mental health services serve the whole community

Community mental health services have a duty to meet the mental health needs of all members of the community, including those in the traveller community, asylum seekers, members of the LGBT community, people who are deaf, people who are homeless, etc. Members of these groups are at higher risk of developing a mental health condition than the population at large. For example, among users of Simon Community homeless services, 52% had at least one mental health diagnosis in 2010.[15] Mental Health Reform is concerned that the HSE is not giving adequate priority to ensuring that mental health services are serving the whole of the population. Under the international human rights framework, Government has an obligation to ensure that the health of vulnerable groups is protected through targeted programmes.[16]

> *"What frightens me are services not being culturally appropriate. .. services never reach out to traveller organisations."* (Consultation meeting at Pavee Point)

> *"There is a reluctance among [mental health] professionals to acknowledge the impact of sexual identity."* (Conversation with a BeLonG To Youth Services staff member)

> *"There are more than 5,000 deaf people in Ireland but they still have no right to an interpreter. They are being turned away from casualty."* (Dublin public meeting).

> *"People are still being discharged to homelessness."* (Consultation with Dublin homeless agencies).

> *"In custody people can be stabilised but then upon release, it can be difficult to get services to be available in the community."* (Consultation with the Probation Service).

2.g. Forensic mental health services

The lack of modern, regional forensic mental health service as envisaged in *A Vision for Change* continues to result in a lack of appropriate mental health support for people involved in the criminal justice system. In his

[15] Simon Communities of Ireland (2010) 'Health and Homelessness: Health Snapshot Study of People Using Simon Services and Projects in Ireland', Dublin: Simon Communities of Ireland, p.31.

[16] The UN Committee on Economic, Social and Cultural Rights' General Comment No.14 on the Right to the Highest Attainable Standard of Health states that "even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programme." (See Article 12).

Judgment in D.P.P. v. B[17], Justice Sheehan noted in 2011 that the Central Mental Hospital is the only designated centre under the Criminal Law (Insanity) Act 2006. The fact that the CMH continues to be the only designated centre in the country means that prisoners from distant prisons must be transferred to Dublin for treatment, removing them from proximity to any social supports they may have such as family and friends. The human rights principle of community-based treatment must apply to prisoners as to any other patients and this includes having inpatient treatment within a reasonable distance to one's own community. There is an urgent need to establish other designated centres to enable a wider range of options for treating individuals within the criminal justice system.

Recommendation:

- The Department of Health and the HSE should urgently progress establishing regional, appropriate acute inpatient units that can be designated centres under the Criminal Law (Insanity) Act 2006.

2.f. Deinstitutionalisation

Mental Health Reform welcomes the continued progress that occurred in 2011 to replace outdated, inappropriate psychiatric hospitals with community-based mental health services. St. Ita's, Portrane closed to new admissions in March, 2011. In November, 2011 the HSE reported that the new psychiatric inpatient and rehabilitation facilities had opened in Letterkenny. During 2011, the HSE also progressed plans to move services in Clonmel into the community.

Recommendation:

- The HSE must demonstrate that it is engaging in specific initiatives to ensure that community mental health services meet the mental health needs of all people living in local communities.
- The HSE must ensure that part 5 of the Mental Health Commission's *Code of Practice on being Admitted, Transferred and Discharged to and from Hospital* is implemented nationally.

2.g. Services for people with Dementia

There are currently approximately 44,000 people under age 65 with dementia in Ireland. This is a population which is currently almost completely without access to appropriate specialist services. These rarer types of dementia may be difficult to diagnose, frequently misdiagnosed (often as schizophrenia or depression) and may give rise to very difficult behavioural symptoms. Families affected report delays of many years in getting a correct diagnosis, often preceded and followed by periods of hospitalisation in psychiatric settings triggered by crisis situations. Depending on circumstances, people under age 65 may find themselves ineligible for referral to dementia specific services, or in other cases forced to fit in to services where the majority of users are much older. Common sense suggests that the lack of timely diagnosis and referral services for this client group is likely to be resulting in increased costs due to people being inappropriately placed in acute psychiatric units.

There is an urgent need for the implementation of the recommendation in *A Vision for Change* for two specialist neuropsychiatric teams, one in Dublin and one in Cork, who could diagnose promptly, treat appropriately and refer to appropriate community supports.

Also, when inpatient psychiatric units are providing care for people with dementia, it is particularly important that robust care planning is undertaken that addresses risk factors, and attempts as far as possible to identify and address their needs in terms of quality of life. Psychiatric settings are rarely set up

[17] D.P.P. v. B. [2011] IECCC 1 at [5.18].

to offer appropriate dementia specific care. Design is recognised as a key factor in quality of life for people with dementia and a psychiatric unit is very unlikely to meet dementia design criteria. Environmental factors may increase the person with dementia's distress and confusion, which in turn may lead to over-medication.

Recommendations:

- The HSE should set out how it will implement Recommendation 15.6.1 to establish neuropsychiatry services in Ireland by 2016.
- The HSE should ensure that appropriate care planning is undertaken to address the risk factors for people with dementia in inpatient psychiatric units.

3. Increasing Accountability, Transparency and Governance

In 2011, the HSE's National Service Plan allocated €5 million in additional funding for mental health, including €1 million for suicide prevention, €3.8 million for child & adolescent inpatient units and €1.2 million for a forensic high support hostel. This is far short of the €21.5 million annual development funding recommended in AVFC; no additional funding was allocated to general adult mental health services nor to other 'special services' such as intellectual disability and eating disorder which have seen little development since AVFC was published.

Total mental health service funding allocated in the HSE's 2011 Service Plan was €708 million which was intended to represent no more than a 1.8% cut to the budget. Government's commitment to protect mental health services in the 2011 budget had been welcome, however as of November, 2011 the mental health services suffered a de-facto cut of more than €8 million[18], reflecting continued staff losses and a deeper cut than had been promised. (As of the date of this submission, year-end financial information has not been published by the HSE.)

The Government's commitments to an additional €35 million in funding from within the health budget in 2012 and a Director for mental health within the new governance structures HSE are welcome, but it is vital that implementation of *A Vision for Change* is understood as a long-term commitment to transform Ireland's approach to mental health. The HSE's National Service Plan for 2012 still shows mental health services at just 5.3% of the overall health service spend, far short of the 8.3% set out in *A Vision for Change.*

The establishment of a Directorate under the authority of a national Director for mental health may, for the first time since the establishment of the HSE, provide the necessary governance structure to enable accountability for delivery of A Vision for Change. It is vital that the Director is recruited immediately to ensure that the €35 million invested into mental health is used for its intended purpose. It is important that this Director be given executive powers, budgetary control and responsibility to publicly report on progress. The establishment of the Executive Clinical Director structure is also a welcome step. AVFC recommended a multidisciplinary management structure and while this is partially in place in some areas of the country, it is important that the HSE meets its objective in the 2012 National Service Plan to "complete multidisciplinary mental health services management teams."

The persistent Government failure to produce an implementation plan for *A Vision for Change* shows that there is a need for some formal, statutory driver for planning and reporting. Mental Health Reform notes that the Department of Health itself concluded that:

> "Programme efficiency can be improved with the above mentioned additional €35m as well as proposals that the HSE prepare an implementation plan to identify specific recommendations of *A*

[18] HSE Supplementary Report 2011, p.47.

> *Vision for Change* and *Reach Out* to be progressed over the next three years, with timelines, detailed costs and person(s) responsible for implementation."[19]

At an event marking the anniversary of *A Vision for Change* in 2011, Cathal Magee also stated that an 'accountable plan' with 'specifications' was required. TCD's Centre for Health Policy & Management produced an analysis of implementation of *A Vision for Change* in 2011 that included a set of recommendations on implementation planning (see Annex 1).

In 2011, the Department of Health acknowledged that efficiencies could be generated in the public mental health services through the development of a national mental health information system as recommended in AVFC.[20] Two such systems have already been developed: the COMCAR database created by the Health Research Board and the WISDOM database developed and piloted jointly by the HRB and the HSE. The failure of either of these systems to progress to full implementation is a serious disappointment. The lack of reliable, national, public information on community-based adult mental health service delivery and outcomes continues to hinder implementation as it is impossible to tell with confidence which services are actually delivering improved outcomes for service users. In contrast with the adult services, child and adolescent mental health services have been publishing valuable data on service performance regularly for the past three years. The Child & Adolescent Mental Health Service Annual Reports demonstrate the feasibility and benefit of having good quality data against key performance indicators that is published regularly.

Recommendations:

- Establishment of an executive position within the HSE which is responsible for implementing *A Vision for Change*. This must be led by a Director for Mental Health Services who has executive powers, budgetary control and responsibility to publicly report on progress. The Director must be recruited early in 2012 to oversee the additional investment set out in the HSE's National Service Plan.
- Government should ensure the provision of adequate funding to ensure equitable services across the country. In the short term all Service Areas should receive at least the national average level of funding (national average level adjusted according to the population covered) within three years. This will assure a geographically equitable and harmonised funding distribution at the Service Area level.
- Government should provide adequate funding to allow for the transition from institutions to community services without jeopardising quality of services. In this regard, the allocation of €35 million, if realised in the appointment of community-based mental health service staff while ensuring adequate staffing of inpatient units, is welcome.
- The HSE should publish a detailed implementation plan that contains timelines, detailed costs, measurable targets and designated responsible persons early in 2012.
- The HSE should, as a matter of urgency, develop transparent, reliable financial and performance monitoring systems aligned to AVFC that systematically capture the voice of the service user.
- Government should introduce legislation to underpin implementation of AVFC.

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[19] Department of Health Comprehensive Review of Expenditure: September, 2011, p.111)

[20] Ibid., p.110.

Conclusion

Mental Health Reform welcomes the continued efforts by staff, service users and family members to modernise the mental health services. Many positive, individual developments occurred during 2011 as highlighted in this submission and elsewhere. At a high level, Government's announcement of a Director for Mental Health as part of the new HSE governance structure bodes well for improved governance in future, while the commitment to dedicated funding to build up community mental health teams was also encouraging. At a local level, some services continued to make progress, drawing on the persistence of individual staff, service users and family members.

However, at a national level there was little evidence of a comprehensive, systematic approach to implementation of AVFC either within the mental health services or across Departments that are responsible for welfare, employment, education and housing. Neither is there yet widespread evidence that the recovery principle is being experienced consistently by service users and family members in mental health service delivery.

Mental Health Reform believes that there is an urgent need to bridge the gap between policy and implementation and to fulfil the promise of recent Government commitments, so that by 2016, when *A Vision for Change* is due to be fully implemented, every service user will indeed receive comprehensive, holistic community-based mental health services with a recovery approach.