Mental Health **Reform**
Promoting Improved Mental Health Services

**Submission**

**for Budget 2015**

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## INTRODUCTION

While the economy is showing some signs of recovery, Ireland's mental health system continues to be under strain. Commenting on a recent international study into the links between suicide and the recession, co-author Prof. David Stuckler said, "Suicides are just the tip of the iceberg. These data reveal a looming mental health crisis in Europe and North America."[1] With the fourth highest suicide rate among young people in Europe, Ireland is certainly not immune to this impact. Supporting this view, the SeeChange survey carried out in 2012 found that people under economic strain were more likely to report both having a mental health difficulty themselves and knowing someone who has a mental health difficulty.[2] The unemployment rate remains high at 11.8% and with almost half of claimants being long-term unemployed,[3] there is a higher risk that they will develop mental health difficulties.

Mental health services in Ireland continue to be under pressure, unable to cope with the demand. The demand on Child & Adolescent Mental Health Services (CAMHS) continues to increase, up 10% from March 2013 to 2014. Once again, waiting times for child and adolescent mental health services have increased, with the overall waiting list having increased by 8% at the end of March 2014 compared to the same period in 2013.[4] The HSE's most recent performance report shows that at the end of March 2014, there were 452 children and adolescents who had been waiting for more than a year for their first appointment.[5] The proportion of children and adolescents admitted to adult psychiatric units has also increased since 2013, with twenty-seven (27) children and adolescents admitted to such units, representing 34% of admissions in the first quarter of 2014.[6]

In this context, Mental Health Reform calls on the Government **to keep its commitment to mental health,** to continue to invest in comprehensive, community-based mental health services and to fund innovative supports that enable individuals recovering from mental health difficulties to live in the community.

Specifically, MHR recommends:

1. **Allocation of an additional €50 million for mental health services in 2015 for community mental health services as promised by the Minister of State responsible for mental health, Kathleen Lynch, TD, to be used in part to ensure that a 24/7 crisis intervention service is available in every area of the country, including:**

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[1] See 'Big Rise in Suicides during Recession', RTE News, Thursday, 12th June, 2014 available at http://www.rte.ie/news/2014/0612/623247-recession-suicides/

[2] http://www.seechange.ie/wp-content/themes/seechange/images/stories/pdf/See_Change_Research_2012_Irish_attitudes_towards_mentl_health_problems.pdf

[3] CSO Live Register report for May 2014.

[4] HSE Performance Monitoring Report December 2012.

[5] HSE Performance Monitoring Report December 2012.

[6] HSE Performance Monitoring Report March 2013.

- **Allocation of innovation funding to invest in implementing the recovery ethos and employ Peer Support Workers in the HSE's mental health services.**

- **Allocation of funding for mental health services for homeless people.**

2. **Ensuring that the 2014 allocation of €20 million is spent during this year on service improvements for mental health.**

3. **Ensure that the Mental Health Commission is adequately staffed to fulfil its functions, including multidisciplinary inspection and the promotion of good quality mental health services.**

4. **Extend free primary care to all people who require long-term mental health treatment.**

5. **Extend the Counselling in Primary Care service to meet the needs of more people.**

6. **Continue to fund the national roll-out of Suicide Crisis Assessment Nurses in primary care, and liaison nurses in A&E units.**

7. **Provision in Budget 2015 to fund a pilot of the Individual Placement and Support model of supported employment.**

8. **The Department of Environment, Community and Local Government should provide funding in Budget 2015 for an additional forty individuals to transition from HSE supported accommodation into mainstream housing in the community.**

9. **Provision of a dedicated funding stream for social support to individuals with a mental health difficulty who require this support to access and maintain accommodation.**

10. **The SOLAS training allowance should be reinstated in Budget 2015 to ensure that people who avail of training courses can meet the costs of attending training.**

## RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

### CURRENT SHORTFALLS IN RESOURCES

Despite the recruitment of 652 new posts to date out of the 2012 and 2013 allocations,[7] there was in fact a net decrease in mental health service staff from January-December 2013, down from 8,909 to 8,906. Total staffing at the end of 2013 was still more than 1,000 full-time posts less than in March 2009, 10% below the March 2009 level.[8] In particular, the services lost 916 nursing posts (17%) between September 2009 and December 2013.[9] This shortfall situation exists within a context in which the Government's mental health policy recommended that more than 1,000 additional staff were needed to implement the policy as of 2006. The situation in Child & Adolescent Mental Health Services (CAMHS) is even more severe, with less than half of the staff required in place, according to the HSE's annual report for CAMHS.

More than eight years after the publication of *A Vision for Change*, mental health services are still not uniformly providing the basic model of care that includes home treatment and 24/7 crisis intervention, with crisis houses, as the norm in all areas. Ireland continues to have a high rate of suicide, while this gap in crisis services is allowed to persist.

**Sandra's Story**

*Sandra describes having to seek help through the Accident & Emergency department of her local hospital.*

"It was a complete nightmare! I had to wait up to five hours in A&E. For people who are feeling suicidal this amount of waiting means they can easily leave and go on to harm themselves."

*On one occasion a doctor agreed that Sandra was suicidal but informed her that there were no beds available.*

"I was sent home with the promise that someone from the A&E department would check in with me the following day. They also said they would inform my Community Mental Health Team what had happened. Neither was done."

*Sandra was also upset by the little regard for her safety as she was leaving hospital.*

"I had arrived in A&E by ambulance. But when I was eventually discharged at five in the morning I had to make my own way home."

*Sandra's name has been changed to protect her identity.

There is a solution to the gap in crisis intervention services. Models of good practice are operating in some mental health services, providing access to help out of hours. The West Cork mental health

[7] See reply by Tánaiste Eamon Gilmore, TD to Parliamentary Question on 23rd May, 2013.
[8] HSE Census of employment April 2013.
[9] HSE Census of employment December 2013.

service operates a 24-hour listening service. The Celbridge community mental health team provides a 7-day-a-week service and also gives service users the telephone number of the acute unit to call out of hours. In the view of Dr. Pat Gibbons, Clinical Director of the Celbridge service, the home care service combined with the keyworker system and a 24/7 phone number gives people a sense of security in the mental health system and helps to reduce hospital admissions. In other areas, crisis services are available, but only during office hours, Monday to Friday. The mental health services need adequate staffing levels to provide 7-day-a-week day hospital services alongside home treatment.

Other aspects of community mental health services that require funding include establishing the Team Co-ordinator position in each community mental health team as set out in *A Vision for Change*. Having clear accountability within community mental health teams is key to consistently good practice and central to this is having a Team Co-ordinator who shares day to day responsibility for the team with a lead consultant. Unfortunately no separate funding has been made for this post, other than some back filling for a small number of posts in each area management team.

Each community mental health team needs access to all of the professional disciplines set out in *A Vision for Change*. There is a history within some areas of prioritising some disciplines while allowing the complete absence of others in teams. In addition, in order to ensure good quality care, all professionals should have access to supervision from a more senior person within their discipline. This requires that all of the relevant grades within each discipline are available across the service.

Mental health services also require dedicated funding for essential training for all mental health professionals, such as in recovery focused practice, effective key working, completing assessments of the bio-psycho-social needs of patients, working effectively with families and carers, and staff supervision.

With regard to innovation, Mental Health Reform welcomes the current HSE initiative to implement the recovery ethos in seven mental health services across the country (the 'Advancing Recovery in Ireland' project). This GENIO-funded project has the potential to generate significant cultural change within the services involved. Mental Health Reform welcomes the appointment of Peer Support Workers in some of these projects through once-off funding. However there is a need to mainstream Peer Support Workers as part of the HSE's workforce as is recommended in *A Vision for Change.* Also, it will be important to sustain the momentum from these projects by continuing to invest in organisational change in 2015.

One area of service delivery that has been particularly neglected in recent years is mental health services for homeless people. The number of homeless people in Ireland has increased dramatically in recent years. During this time, mental health outreach services have not been increased to meet the upsurge in need; instead, homeless services have advised Mental Health Reform that they have severe difficulties in accessing urgent mental health support for their clients.

1. **Recommendation: Government should allocate an additional €50 million for mental health services in 2015 for community mental health services as promised by the Minister of State responsible for mental health, Kathleen Lynch, TD, to be used in part to ensure that a 24/7 crisis intervention service is available in every area of the country. This funding should be used to support:**

- **The continued development of community mental health teams to ensure the Team Coordinator post and all disciplines are available and that adequate staffing at different grades facilitates appropriate, professional supervision.**
- **The development of 24/7 crisis intervention services, including crisis houses, in all mental health service areas.**
- **Allocation of innovation funding to invest in implementing the recovery ethos and employ Peer Support Workers in the HSE's mental health services.**
- **Allocation of funding for mental health services for homeless people.**

MHR continues to be concerned about the risk that the €20 million allocated for 2014 will be used to shore up deficits elsewhere in the HSE. As of May 2014, there is no sign of any of this funding being spent on the appointment of new staff and this is a similar pattern to what occurred in 2012 and 2013.

2. **Government must ensure that the €20 million allocated for community mental health services in 2014 is spent in 2014 and incorporated into the on-going budget for mental health services in 2015.**

## RESOURCING THE MENTAL HEALTH COMMISSION TO FULFIL ITS REMIT

Mental Health Reform is concerned that the under-resourcing of the Mental Health Commission is hindering its ability to fulfil its statutory remit. In 2007, the Mental Health Commission had an annual budget of €20.5 million. By the end of 2012, the Commission had spent just €13.1 million during that year, a reduction of 36% in its operating budget.

Mental Health Reform is concerned that the Mental Health Commission does not currently have adequate resources to fulfil its role in promoting good quality mental health services, nor to resource the Inspectorate in order to ensure adequate inspection of mental health services.

3. **Recommendation: the Department of Health should ensure that the Mental Health Commission is adequately staffed to fulfil its functions, including multidisciplinary inspection and the promotion of good quality mental health services.**

## FREE GP CARE FOR PEOPLE REQUIRING LONG-TERM MENTAL HEALTH TREATMENT

Access to free GP care is an important issue for individuals with severe mental or emotional distress who may require long-term treatment in primary care. In the context of Government policy that supports people being deinstitutionalised and living in the community, lack of a medical card can undermine an individual's ability to access mainstream primary care. 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.[10] 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 primary care services. Lack of security about the medical card is also known to be a deterrent to individuals with disabilities who might otherwise take up work.

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

4. **Recommendation: The Department of Health should extend free primary care to all people who require long-term mental health treatment.**

## INVESTING IN MENTAL HEALTH IN PRIMARY CARE

The HSE's Counselling in Primary Care service is a positive early intervention programme that seeks to ensure medical card holders with mild to moderate mental health difficulties have access to up to 8 sessions of counselling. Approximately 15% of the population can be expected to be experiencing anxiety or depression at any one time.[11] The CIPC service received 5,000 referrals in its first six months of operation from July-December 2013, and has a development budget of €3.8 million for 2014 which represents just one-half of one percent of the mental health service budget.[12] This compares to investment of £300 million for the Increasing Access to Psychological Therapies (IAPT) service in the UK which represents 5% of the UK mental health spend.

The CIPC service has the potential to reduce the number of individuals referred on to specialist mental health services as well as improving the number of individuals returning to work who may be off work due to mental or emotional distress. The similar programme running in the UK (the IAPT programme) has been proven to be cost-effective and has increased the number of individuals with mental/emotional distress returning to work. Since October 2008, the IAPT service has treated 1.3 million individuals, and of these 82,000 have moved off of sick pay and benefits.

However, in Ireland the CIPC service is limited to a maximum of 8 sessions and accessible only by GP referral, unlike in the UK which has a ceiling of 20 sessions and also allows self-referral. Also, in Ireland this service is only available to medical card holders, leaving a significant number of people outside coverage.

One positive initiative that has reduced unnecessary usage of costly mental health services are the Suicide Crisis Assessment Nurses who are available to liaise with GPs where the GP is concerned

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[10] Nolan, A. & Nolan B. (2004) *Ireland's Healthcare System: Some issues and challenges,* Dublin: ESRI.
[11] Information taken from the Increasing Access to Psychological Therapies service in the UK NHS.
[12] See HSE Mental Health Division Operational Plan 2014, p.21.

about a patient who may be suicidal, and the piloting of liaison nurses in Accident & Emergency units to support A&E staff responding to individuals with mental health difficulties who have self-harmed. The Suicide Crisis Assessment Nurse (SCAN) project and roll-out of SCAN in sites across the country is an important strand of work that can improve access to crisis and follow-up support for individuals who are at immediate risk of suicide. According to the GPs involved in the evaluation of SCAN, it resulted in significantly better outcomes for patients than traditional mental health services. The evaluation also found that SCAN may result in lower costs or at least better health outcomes at relatively low cost. It would be a welcome step to provide SCAN specifically to liaise with homeless services.[13]

5. **Recommendation: extend the Counselling in Primary Care service to meet the counselling needs of middle-income people with mild to moderate mental health difficulties and increase the ceiling on the number of sessions to 20.**
6. **Recommendation: the Department of Health, through the National Office for Suicide Prevention, should continue to fund the national roll-out of Suicide Crisis Assessment Nurses in primary care.**

## RECOMMENDATIONS FOR THE DEPARTMENT OF SOCIAL PROTECTION

### SUPPORTED EMPLOYMENT

In 2013, Mental Health Reform advised the Department of Social Protection to fund the evidence-based approach to supported employment for people with mental health difficulties. While such funding was not allocated in the 2014 budget, there is now an opportunity for the Department to invest in effective supported employment by piloting the good practice model in the form of Individual Placement and Support.

- People with a mental health disability[14] in Ireland are nine times more likely to be out of the labour force than those of working age without a disability[15], the highest rate for any disability group.
- Only 43.8% of the working age population of people with a mental health disability are in the labour force compared to 61.9% of the overall population.
- The unemployment rate for people with a mental health disability is 41.4%.[16]

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

[14] Mental health disability is defined by the Irish Census as having both a long-lasting psychological or emotional condition and having a difficulty with an activity of daily living. See http://www.census.ie/The-Census-Form/Each-question-in-detail.109.1.aspx to read the census questions on disability.

[15] 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.

- 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.[17]

In the UK, Government policy supports provision of the Individual Placement and Support (IPS) model of supported employment which has been proven to be more effective at getting people with mental health disabilities into work than traditional vocational training approaches.[18] It has been reported that:

> "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."[19]

IPS has also been shown to be both cost effective and less costly than traditional vocational approaches. Looking across six European sites, researchers have found that the IPS model "produced better outcomes than alternative vocational services at lower cost overall to the health and social care systems." Furthermore, the researchers found that IPS is probably cost-saving and "almost certainly more cost effective" than other vocational services at helping people with severe mental health disabilities to get into open employment. The 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 problems into competitive employment."[20] 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.[21]

Ireland's current Supported Employment programme does not fulfil the IPS model in three key ways: Firstly, FÁS's Supported Employment Programme requires that the individual is 'job ready' in order to participate in the programme. Experts say that it is not possible to tell in advance whether someone with a mental health disability will be able to obtain competitive employment.[22] Secondly, the support on the FÁS Supported Employment programme is limited to 18 months, except in exceptional cases. The IPS model incorporates indefinite support.

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

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

[18] For a description of the IPS model, see Appendix 1 to this submission.

[19] Perkins, R., Farmer, P. and Litchfield, P. (2009) *Realising ambitions: Better employment support for people with a mental health condition,* London: The Stationery Office Ltd, p.60.

[20] Knapp, et al. (2013) 'Supported Employment: Cost-effectiveness across six European sites', *World Psychiatry* vol. 12, pp.60-68.

[21] Perkins, et al., p.75.

[22] See Mueser, K. and Bond, G. (2012) 'Supported Employment' in Hunter L. McQuistion, Wesley E. Sowers, Jules L. Ranz and Jacqueline Maus Feldman, editors, *Handbook of Community Psychiatry,* New York: Springer.

In 2007 there were approximately 2,000 people on FÁS's Supported Employment Programme at any one time[23] with approximately one third of these participants having a mental health disability.[24] Given that there are approximately 20,000 people with a mental health disability on Disability Allowance, it can be seen that there is a large gap between the need for Supported Employment and current provision.

It is evident that the Government's current Supported Employment programme for people with a mental health condition does not follow international evidence on effective supported employment programmes. This is likely to result in people who could work with support being kept out of the labour market.

7. **Provision in Budget 2014 to fund a pilot of the Individual Placement and Support model of supported employment.**

## RECOMMENDATIONS FOR THE DEPARTMENT OF ENVIRONMENT, COMMUNITY AND LOCAL GOVERNMENT

The Government's commitment in Budget 2013 to fund forty places for individuals in mental health service housing to transfer into mainstream housing in the community, at a cost of €0.35 million, was welcomed by Mental Health Reform. Further funding will be required in 2015 to continue the transfer of individuals who are currently inappropriately placed in HSE supported accommodation and who could live in mainstream housing in the community.

8. **Recommendation: The Department of Environment, Community and Local Government should provide funding in Budget 2015 for an additional forty individuals to transition from HSE supported accommodation into mainstream housing in the community.**

An on-going difficulty in preventing homelessness and promoting deinstitutionalisation is the lack of a dedicated funding stream to provide medium and long-term tenancy sustainment support to individuals with long-term mental health difficulties. The Implementation Framework for the National Housing Strategy for People with Disabilities recognises that the HSE will be required to continue to provide health and personal social services for people transitioning from mental health service accommodation.[25] The interim protocol agreed as part of the Housing Strategy for People with Disabilities states with regard to people transitioning from institutional settings that:

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

[23] WRC Social and Economic Consultants (2008) *Research Report on the Operations and Effectiveness of the Supported Employment Programme*, *Final Report*, available at www.fas.ie, p.26.

[24] WRC (2008), p.35.

[25] Department of Environment, Community and Local Government (2012) *National Housing Strategy for People with a Disability 2011-2016: National Implementation Framework*, p.11.

the HSE/Service Provider to ensure that the appropriate supports are maintained for the individual."[26]

However, there is currently no dedicated funding stream within either the HSE's or the Department of Environment, Community and Local Government's budgets for tenancy sustainment support. The HSE's recently published guidance paper *Addressing the Housing Needs of People using Mental Health Services* illustrates a range of housing and housing support models currently in operation which emphasise and underpin the requirement for tenancy sustainment support for those transitioning from mental health service accommodation. It is important that a dedicated funding stream for tenancy sustainment support is provided so that the Government's policy of deinstitutionalisation is not hindered by a gap in housing support in the community.

9. **Recommendation: The Department of Environment, Community and Local Government and the Department of Health should agree a way to jointly provide a dedicated funding stream for tenancy sustainment support to individuals with a mental health difficulty who require this support to access and maintain accommodation.**

## RECOMMENDATIONS FOR THE DEPARTMENT OF EDUCATION AND SKILLS

### SOLAS TRAINING ALLOWANCE

Budget 2014 introduced the removal of the €20 per week training allowance payment made to long-term unemployed participants and Disability Allowance recipients in SOLAS courses, the Vocational Training Opportunities Scheme (VTOS) and Youthreach, for new participants from the 1st January 2014.

Many of these courses are accessed by people with mental health difficulties throughout the country. Difficulties are arising now for people who are finishing up programmes and who want to progress to higher level training (for example from HSE-funded Rehabilitative Training to SOLAS-funded Vocational Training), or for people who wish to take up training for the first time. It is having a major, negative impact on the activation opportunities available to people with mental health difficulties in their local community, opportunities that are vital to supporting their recovery.

The €20 per week payment (which was €31.80 until it was reduced in 2011) allowed people to meet some of the additional costs of attending training such as meals, childcare, clothing and other expenses which are incurred when taking part in activities. The training allowance can be viewed as similar to the €50 allowance paid to JobBridge participants who take up JobBridge internships, in that it recognises that taking up such an activation opportunity can involve additional costs.

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[26] Department of Environment, Community and Local Government (2013) *Protocol for the Provision of Housing Support to People with Disabilities* (draft).

With the removal of the allowance there is no longer a financial support to take up training. Trainees are now financially worse-off in training because they still have to meet the additional costs of participating in training but must do so from their basic social welfare payment. Those that find they can no longer take up training are likely to become further isolated in their community and bored, leading to poorer mental health.

10. **Recommendation: The SOLAS training allowance should be reinstated in Budget 2015 to ensure that people who avail of training courses can meet the costs of attending training.**

## CONCLUSION

Mental Health Reform recognises that the Government faces difficult choices in Budget 2015 in order to maintain control over the country's finances. It is important to recognise that individuals' mental health is a positive asset that will support the country's economic and social recovery. Our recommendations are based on cost-effective solutions that can help Government services for people with a mental health condition to be more efficient and at the same time can fulfil the Government's policy commitments on mental health.

Mental Health Reform's recommendations recognise the cross-departmental nature of mental health concerns. They point to the need for 'joined-up thinking' on approaches to mental health between Government Departments in order to bring about awareness of the multi-layered causes of mental distress, and to ensure coherence in interventions from various services and constructive networking between health practitioners, educational bodies, and social workers on issues such as housing, mental health in the education system, social welfare, employment and vocational training. An urgent example is the need to address the negative impact of direct provision on the mental health of asylum-seekers.

We call on Government to incorporate these recommendations into Budget 2015.

## ABOUT MENTAL HEALTH REFORM

Mental Health Reform is the national coalition of 45 organisations working to promote improved mental health services and the implementation of *A Vision for Change*.

Mental Health Reform is available to discuss the above recommendations. Please contact Dr. Shari McDaid, Director at 01 874 9468 or via email at smcdaid@mentalhealthreform.ie

**Appendix I: The Individual Placement and Support Model of Supported Employment**

Individual Placement and Support (IPS) is a form of supported employment in which the assessment of a person's vocational skills and work preferences occurs relatively quickly upon coming into contact with mental health services. Rapid job searching is a key feature with an 'employment first' approach. There is no eligibility criteria for the programme based on 'job readiness'; any person with a mental health condition who wants to work is eligible for IPS. The person may then enter the workforce in a setting that is suitable for them, thus allowing them to develop their skills within the work environment while receiving on-going support. IPS involves seven essential principles:

1. Competitive employment is the primary goal
2. Everyone is eligible – there is no 'eligibility' criterion
3. Job search is consistent with individual preferences
4. Job search is rapid, normally within one month
5. Employment specialists and clinical teams should be integrated and co-located
6. Support is time-unlimited and individualised to both the employer and the employee
7. Social welfare discussions support the person through the transition from benefits to work.[27]

[27] Summarised from Perkins, R., Farmer, P. and Litchfield, P. (2009) *Realising ambitions: Better employment support for people with a mental health condition,* London: The Stationery Office Ltd., p.63.

**Appendix 2: The Individual Placement and Support Model of Supported Employment**

**Mental Health Reform Submission to the HSE on medical card eligibility based on medical conditions**

Access to free GP care is an important issue for individuals with severe mental or emotional distress who may require long-term treatment in the community, either through primary care or community-based mental health services. In the context of Government policy that supports people with long-term mental disorders being de-institutionalised and living in the community, lack of a medical card could significantly undermine this policy, deterring individuals from being discharged from hospital and/or community mental health services.

It can be estimated that 2.6% of the adult population of Ireland has a severe and persistent mental health difficulty at any one time, equating to approximately 89,000 adults in Ireland. Conditions included under this category are schizophrenia, bipolar disorder, and other severe forms of depression, panic disorder, and obsessive-compulsive disorder. The diagnosis of schizophrenia, one of these severe mental health difficulties, is known to be one of the top ten causes of disability in developed countries worldwide. In Ireland, 20,000 people are on Disability Allowance due to a mental health disability.

People who have been receiving some of their mental health treatment free of charge from community-based mental health services may hesitate to be discharged to their GP if they think their out-of-pocket costs will increase. Irish research has found that those with low incomes but without a medical card are less likely to visit a GP.[1] 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. For example, the Inspector of Mental Health Services has found that among individuals in 24-hour supervised residences, almost half were on more than one anti-psychotic medication at the same time and many of these individuals would also have been prescribed another medication such as an anti-depressant or benzodiazepine. Thus people with severe mental health difficulties are likely to require multiple, regular prescriptions of medication.

People with severe mental health difficulties who are in employment are more likely to have periodic breaks in employment due to periods of ill-health and are, therefore, likely to have lower incomes than other groups who are in employment. This can make it difficult for them to meet the additional costs associated with their mental health difficulty. However, their means may place them slightly over the income thresholds for a medical card. They could therefore be at risk of poverty because of the medical costs they incur as a result of their mental health difficulty. This would only contribute further to their distress, with consequent poorer health outcomes.

A sudden stoppage of medication due to concerns about the cost, 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 primary care services. If medication for schizophrenia is discontinued, the relapse rate is about 80 percent within 2 years. With continued drug treatment, only about 40 percent of recovered patients will suffer relapses. Lack of security about the medical card is also known to be a deterrent to individuals with disabilities who might otherwise take up work.

Mental Health Reform considers that it will be important to provide people with long-term mental health conditions, including those diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, and severe forms of depression, panic disorder, and obsessive-compulsive disorder a medical card to enable free access to GP care, including free prescriptions, in order to help prevent relapse and support their ability to live in the community. Also, a review of eligibility for a medical card can be very stressful for a person with a severe mental health difficulty. Access to a discretionary medical card which would be subject to less frequent review would help to alleviate some of the anxiety that occurs as a result of frequent reviews to ascertain any changes in means.

It can be reasonably estimated that the number of additional medical cards such a proposal would entail would be relatively small. This is based on the following assumptions:

- It is generally estimated that 85% of people with severe mental health difficulties are not in work.
- With 89,000 adults with a severe mental health difficulty in Ireland, this equates to a conservative estimate of 76,000 adults who could be expected to already have a medical card, leaving just 13,000 who would require a new medical card.

In conclusion, Mental Health Reform recommends that a medical card be extended to all people with severe mental health difficulties who require long-term mental health treatment.

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