

Mental Health Reform submission on review of A Vision for Change



Mental Health Reform
Promoting Improved Mental Health Services

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Introduction

Eleven years on from publication of our national mental health policy, *A Vision for Change*, there is agreement across the mental health community that its implementation has been incomplete and uneven.

Despite this implementation deficit, the policy has received widespread support from key stakeholders, including people who use the mental health services, their family members and carers, and mental health professionals, in addition to garnering strong political support.

A Vision for Change was hugely innovative in a number of ways in that it:

- sought to be a policy for the mental health of the population, not just a policy for mental health services
- set out a policy on mental health promotion at all stages of the life cycle
- introduced principles of 'recovery', 'citizenship' and 'partnership', which for the first time in national policy clearly recognised the role of the 'service user' in their own mental health care and treatment. The involvement of service users and family members/carers at all levels of the mental health system was acknowledged
- affirmed the importance of advocacy for people with mental health difficulties at all levels of the care system
- incorporated community support and primary care into its framework, and
- highlighted the importance of the social inclusion of people with mental health difficulties

The recommendations of the Expert Group on *A Vision for Change* are still of significant value today and must be realised in full. However, there are important policy areas that were not adequately addressed in 2006 that require urgent attention, including:

- a problematic policy recommendation on services for people with a dual diagnosis of mental health difficulties and addiction, leading to barriers to people with a dual diagnosis accessing integrated care
- inadequate specification of the resources needed for mental health in primary care, leading to undue pressure on specialist services, in particular child and adolescent mental health services and unnecessarily high waiting lists for specialist treatment
- the absence of any policy around gender sensitive mental health services
- under-developed policy around culturally sensitive mental health services, and
- incomplete recommendations to support integrated mental health care that reflects the developmental progression of children through to early adulthood

In addition, there are environmental changes such as the homeless crisis, as well as other emerging issues, for example, an increasingly diverse ethnic population, which were not considered in *A Vision for Change*.

Furthermore, the significant shift in ethos required of the mental health services, reflected in the principle of 'recovery' in *A Vision for Change*, and embodied in ideas of partnership, choice and social inclusion, was not spelled out in the policy. As a result, the HSE has experienced significant resistance in trying to drive recovery-orientated mental health services in parts of the country. In

addition, detailed policy recommendations are required on the nature and role of peer support as a key component of the mental health system, which holds significant potential.

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health recognises that “the recovery approach, when implemented in conformity with human rights, has helped to break down [traditional] power asymmetries, empowering individuals and making them agents of change rather than passive recipients of care”.¹

In his most recent report, the Special Rapporteur acknowledges that power imbalances have dominated the relationship between mental health services and users of services and ultimately this has created an environment where people are undermined in making decisions about their own health, meaning human rights violations can and do occur.

Mental Health Reform has consistently highlighted that people with experience of a mental health difficulty as a group are one of the least protected in terms of their rights. They are also one of the most socially excluded, experiencing prejudice and discrimination in all areas of their life in the community, including employment and housing.

It is in this context that it is imperative that human rights strongly underpin any revised mental health policy, taking into account the evolving human rights framework in mental health. The Special Rapporteur and the World Health Organisation have advocated the implementation of rights-based mental health policies which keep pace with most current human rights law. In particular, the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which was adopted in December 2006 almost a year after *A Vision for Change* was published, has the potential to shift mental health service delivery from a model which has disempowered ‘service users’ to one which is focused on autonomy, empowering people to make their own decisions and achieving the full and effective participation of individuals in society.

The UNCRPD sets out a wide range of rights, including civil and political rights, the right to live in the community, participation and inclusion, education, health, employment and social protection; all of which apply to people with mental health difficulties. The WHO has recognised that “its coming into force marks a major milestone in efforts to promote, protect and ensure the full and equal enjoyment of all human rights of persons with [mental health] disabilities”.²

The right to the highest attainable standard of health also has “much to contribute to advancing this [paradigm shift] and provides a framework for the full realisation of the right of everyone to mental health”.³

MHR echoes the recent call by the Special Rapporteur “for a shift in the paradigm, based on the recurrence of human rights violations in mental health settings and to move towards mental health systems that are based on and compliant with human rights”. In order to achieve this, it is imperative that mental health policy is developed to be inherently rights-based, taking account of the evolving human rights framework.

¹ United Nations General Assembly (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/35/21 (28 March 2017), available from undocs.org.

² World Health Organisation, *Mental health, human rights & legislation: A global human rights emergency in mental health*, available at http://www.who.int/mental_health/policy/legislation/en/.

³ United Nations (2017).

It is also necessary that revised mental health policy keeps pace with legislation that has a bearing on people with (or at risk of) mental health difficulties. The new Assisted Decision-Making (Capacity) Act 2015 presumes that all individuals have decision-making capacity and should be supported to make decisions that affect them, including with respect to mental health care and treatment. Similarly, the Expert Group on the review of the Mental Health Act, 2001, recommended a shift from the Act's guiding principle of 'best interests' to a human rights-based approach, focused on principles of autonomy, choice and respecting the will and preferences of the person.

There is no doubt that there is a requirement for a coherent legal and policy framework, to ensure effective implementation of principles of human rights, autonomy and self-determination. In particular, legislative and policy provisions must focus on individuals being empowered and facilitated to direct their own mental health care.

In addition, family supporters and carers (with the permission of the service user) should also be supported to 1) have their own needs met and 2) be involved in their relative/friend's care. The role of family members/carers is one of the very significant gaps in *A Vision for Change*, despite principles of partnership and recovery underpinning the policy. Family members and carers consistently raise their experiences of disenfranchisement as partners in the mental health system. There is a need to rectify this lacuna in national mental health policy and to fully recognise family members and carers in any reframed policy.

Mental health legislation must support revised mental health policy and vice versa. Of course, national mental health policy must promote such principles; however, individuals must also have such rights placed on a statutory footing.

MHR is also of the view that the mental health system should be driven by policy which advocates a trauma-informed approach. According to US agency Substance Abuse and Mental Health Services Administration (SAMHSA) "a program, organisation, or system that is trauma-informed:⁴

- realises the widespread impact of trauma and understands potential paths for recovery
- recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- responds by fully integrating knowledge about trauma into policies, procedures, and practices, and
- seeks to actively resist re-traumatisation"

Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available, in addition to service user and family/carer engagement, empowerment and collaboration. Fundamental to the trauma-informed approach is for mental health services "to promote the linkage to recovery and resilience for those individuals and families impacted by trauma."⁵

No doubt, a mental health system underpinned by a trauma-informed approach should be complemented by the use of trauma specific interventions, which focus on the relationship between the individual's past trauma and symptoms of such trauma.

⁴ Substance Abuse and Mental Health Services Administration, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

⁵ *Ibid.*, p. 10.

It is Mental Health Reform's position that a full and comprehensive review of *A Vision for Change* is required to address existing gaps in policy. To date, an external evidence and expert review on *A Vision for Change* has been commissioned by Government to determine the parameters of a revision of the policy. This process has been completed and it is expected that an oversight group will be established to oversee the development of a new policy for mental health based on the outcome of the expert review. It is imperative that this review process is conducted in a transparent manner and allows an opportunity for widespread consultation among people who have an interest in Ireland's mental health system.

This submission has been developed on foot of Mental Health Reform's report *A Vision for Change Nine Years On: A Coalition Analysis of Progress*, which reports on the extent to which the policy had been fulfilled between 2006 and 2015. This submission includes key recommendations on the next phase of reform of Ireland's mental health system with a particular focus on issues which were not addressed in *A Vision for Change*.

Mental Health Reform's submission on the review of *A Vision for Change* has been produced based on in-depth consultation with its advisory groups, including its Grassroots Forum (made up of people with self-experience, family members and carers), its member organisations, as well as external experts operating in particular areas of mental health. Evidence was also drawn upon from national and international research, as well as existing Mental Health Reform policy positions.

The submission has been framed based on action-orientated recommendations, with each recommendation supported with sub-actions and a rationale. The review builds on the existing principles and recommendations set out in *A Vision for Change*, which continue to have Mental Health Reform's support. Each chapter of the submission (as set out below) affirms the recommendations of the Expert Group on AVFC (related to that particular chapter) and proceeds to set out new recommendations, with associated actions to be included in any revised policy.

Mental Health Reform's submission sets out key recommendations across ten chapters including in the areas of:

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

MHR would like to thank everyone who provided information and feedback to this submission. We would also like to thank all of the staff in the HSE and other public agencies and the Department of Health and other Government Departments who continue to strive to improve the mental health outcomes of Ireland's population.

Chapter 1: Service user and family supporter/carer involvement

Mental Health Reform recommends that Government uphold the existing recommendations in *A Vision for Change* on the involvement of service users and family supporters/carers in every aspect of mental health service development and delivery.⁶

In addition to the existing recommendations set out in *A Vision for Change*, the revised policy should include the following:

Supports for family supporters/carers

Recommendation 1: Mental health services should routinely offer assessment of the support needs (including informational, emotional and practical) of family supporters/carers, with the permission of the primary service user, and provide appropriate supports. This measure should be introduced as a matter of urgency for family members under the age of 18 years.

Action: The HSE Mental Health Division should develop and implement national standard operating procedures on assessing the support needs of family supporters/carers of individuals engaged in mental health services.

Action: The HSE Mental Health Division should monitor the extent to which mental health services provide mental health supports to family supporters/carers, and collect data on the types of supports and interventions provided.

Action: The HSE Mental Health Division should develop guidance on supporting the specific support needs of children and young people. This may include, for example, the development of child-friendly waiting/visiting areas and child friendly information and literature.

Action: The HSE Mental Health Division should produce an action plan on the development of support groups for family supporters/carers across all parts of the country.

Rationale

It is now widely recognised that family supporters/carers are inevitably impacted by the mental health and social outcomes of relatives/friends with a mental health difficulty^{7,89}, including those children whose parent has a mental health difficulty¹⁰. Despite this recognition, the current mental health policy does not make any specific recommendation for mental health services on assessing and meeting the mental health support needs of family supporters/carers.^{11,12}

⁶ Department of Health (2006) *A Vision for Change*, p. 9.

⁷ Mental Health Reform (2013) *Recovery: What you should expect from a good quality mental health service*, p. 11.

⁸ REFOCUS CPsychI (2013) *Who cares? Listening to the needs and experiences of carers of people with mental illness*, p. 5.

⁹ Kartalova-O'Doherty, K., Doherty, D., Walsh, D. (2006) *Family Support Study: A study of experiences, needs and support requirements of families with enduring mental illness in Ireland*, Health Research Board, Dublin.

¹⁰ Higgins, A., McDaid, S. (eds) (2014) *Mental health in Ireland: Policy, Practice and Law*, Dublin: Gill and MacMillan.

¹¹ *A Vision for Change* sets out some practical measures on supporting the involvement of family members and carers in their loved one's recovery, for example, inclusion in the care planning process with the agreement of the service user, inclusion in the discharge planning process, timely and appropriate information and education, planned respite care, the appointment of a member of the multidisciplinary team to act as a keyworker/designated point of contact with the team and ensuring these services are provided.

In 2013, the REFOCUS group made up of family supporters/carers and service users produced a report, which documented the needs of carers of people with mental health difficulties. It recommends that the “critical role” of carers should be recognised within the mental health system to ensure the well-being of not only the individual, but also the carer(s).¹³ The paper further recommends that mental health services should be aware of the psychological impact on carers when a family member develops a mental health difficulty.¹⁴ An assessment of need for the individual’s family member, including children, or main carer should be carried out routinely, if agreed to by all concerned.¹⁵

This is further reflected in the Guidelines for *Realising a Family Friendly Mental Health Service*, which were published by Shine in 2014. A key principle underpinning the guidelines is the provision of support for family supporters/carers, as the adverse effect of caring for a person with mental health difficulties is significant.¹⁶ Shine identifies that currently there is a limited availability of supports for family members and carers and recommends that support for this group should include a number of elements:¹⁷

- a family liaison officer
- regular contact between mental health services and families
- information about self-help
- support groups and organisations
- family advocacy
- family education and psycho-educational interventions and
- counselling and family therapy

The Mental Health Commission (MHC) also sets out a number of ways for improving family supports, including:¹⁸

- provision of factual information about what services are available, how they work and how to access help in a crisis
- introduction of a complaints mechanism for family members
- counselling and psychotherapy to help family members to handle their own stress and anxiety
- access for family members to a helpline or other supports in a crisis
- access for family members to respite services
- listening to and respecting the views of family members
- the appointment of a key worker or liaison for family members

¹² *Planning for the Future*, 1984, identified that the mental health services should accept some responsibility for the welfare of the family as well as that of the service user. Family support by psychiatric personnel should include education about the nature of the mental health difficulty, advice and guidance on the care of the service user and a facility to relieve the family of the care of the patient for designated periods and in times of crisis.

¹³ REFOCUS CPsychI (2013), p. 4.

¹⁴ *Ibid.*, p. 5.

¹⁵ *Ibid.*

¹⁶ Shine (2014) *Guidelines For Realising A Family Friendly Mental Health Service*, p. 3.

¹⁷ *Ibid.*, p. 4.

¹⁸ Mental Health Commission (2005) *Quality in Mental Health - Your Views: Report on Stakeholder Consultation on Quality in Mental Health Services*, Dublin: MHC.

Despite provision for family/carer supports within policy, it is important that this is developed in a more coherent way and translated into practice. There is no doubt that there is a lack of supports for family members/carers across the country to support their relative/friend and to maintain their own mental health. In a family support study, the majority of participants reported having to rely on informal supports such as other relatives, friends and neighbours, and information resources such as books or television.¹⁹

Research involving Irish children reported that they had little experience of receiving help from any agency to deal with their parent's mental health difficulty and often experienced reluctance from others to discuss issues with them or involve them in any way.²⁰ These findings have been reflected in studies involving psychiatrists²¹ and mental health nurses,²² with both groups expressing concern about the quality of support and information offered to children.

The literature,^{23,24} in addition to consultations with MHR's Grassroots Forum, highlights the need for age-appropriate support groups, and promotion of such groups among younger family members/carers.

Recommendation 2: Mental health services should provide information of a general nature on mental health to family supporters/carers with the permission of the service user. Such information should be provided in a timely and ongoing basis.

Action: The HSE Mental Health Division should develop guidance for mental health services/professionals on providing information of a 'general' nature to family supporters/carers of people using the mental health services. The particular needs of family supporters/carers from different ethnic minority groups should be carefully considered in this context.

Action: The HSE Mental Health Division should ensure that such guidance is published and distributed to all mental health services, is made available to all mental health professionals and that staff are familiar with the guidelines.

Rationale

A Vision for Change recognises that there may be times when family members'/carers' information needs will conflict with the individual's right to privacy.²⁵ In order to address this "a way forward should be agreed to ensure that the needs of the carer and family are also met".²⁶ The policy recommends that "ongoing, timely and appropriate information to service users and carers" is provided by mental health services.²⁷

However, the extent and types of information to be provided to family supporters/carers is not clarified within the policy, often resulting in a lack of information being provided to this group of individuals. While accepting the need to respect 'service users' privacy, family supporters/carers

¹⁹ O'Doherty, K. and Doherty, T. (2009).

²⁰ Somers, 1998 (Higgins and McDaid).

²¹ O Shea, 2004 (Higgins and McDaid).

²² Houlihan et al., 2013 (Higgins and McDaid).

²³ HRB research (Tedstone Doherty et al., 2006).

²⁴ UCC and Family Carers Ireland research report "*A Fine Balance: Mental health and Family caring*" (UCC, 2016). This is a small scale qualitative study which involved 7 carers living in Cork city.

²⁵ AVFC (2006) p. 30.

²⁶ Ibid.

²⁷ Ibid., p. 31.

have expressed concern about the way in which client confidentiality operates to withhold information from them.²⁸

Family supporters/carers often receive poor access to general information about mental health and limited information regarding the well-being and treatment of the person they support.²⁹ They believe that they are often excluded from the process even where it has a significant impact on the family, including at critical times such as admission and discharge from hospital.

A 2002 European survey reported that between 22% and 44% of participant carers were dissatisfied or very dissatisfied with the quality of care provided for their family member or for themselves.³⁰ Most of their dissatisfaction related to wanting more information and advice on how to handle specific problems that arose while supporting their relative/friend. In a study by Higgins et al. in 2012, family members consulted spoke of a lack of information on how to cope with or respond to their family member and a lack of involvement and support when this person was in crisis.³¹

Shine recommends that sharing consented information with family supporters/carers may potentially bring benefits not only to the individual experiencing mental health difficulties but also to the family and the service provider. For example, information on managing behaviours, medication and its effects, and on access to local and national support groups is essential for families/carers.³²

An example of an Irish initiative which aims to empower family supporters/carers through information provision is the Eolas Project. It is unique in that it provides information through peers (service users and family members) and clinicians working together, using knowledge gained by lived experience and clinical expertise. Findings from an evaluation of the programme illustrate that it has a number of positive outcomes, including:³³

- increases in perceived knowledge³⁴, empowerment and support
- evidence from family members that they left the programme with a 'better understanding' of another's mental health difficulty
- the benefit participants got from having a space where they could meet people in similar circumstances and share their personal experiences
- feedback from family member participants on how the programme enabled them to empathise, learn from each other, form social bonds within the group and feel less isolated
- a recommendation from both individuals and their family members that the Eolas project should be made available to everyone when they become engaged with the mental health services

²⁸ MHC (2005) p. 85.

²⁹ Kartalova-O'Doherty et al. (2006).

³⁰ De Hann et al., (Higgins and McDaid, p. 124).

³¹ Higgins and McDaid, p. 124.

³² Fadden, G. (2013) *Working Collaboratively with Families: Challenges and Opportunities*. The Meriden Family Programme.

³³ Higgins, A., et al., (2012) *The Eolas Project: The design, delivery and evaluation of a peer and clinician led information programme on recovery and mental health difficulties for users of services and family members*, Dublin: Trinity College Dublin, p. 2-3.

³⁴ Family member participants have identified increases in knowledge of mental health conditions, services provided by the mental health team, of managing relapse prevention and increased awareness of self-care and hopefulness as benefits to the programme.

- general agreement that having a user of services/family member as a facilitator on the programme was a positive experience

There is an opportunity for the HSE Mental Health Division to consider the expansion of the Eolas project³⁵ to individuals, including family supporters/carers in all parts of the country, to increase their understanding of mental health, to alleviate their confusion and distress and to support them to be partners in their relative/friend's recovery.³⁶ As recommended in the evaluation of the project, the revised facilitators training programme should be evaluated and accredited by an appropriate professional body.

While the confidentiality and privacy of the individual engaged in mental health services must continue to be respected, it is necessary that family supporters/carers are supported through the provision of general information as called for in Mental Health Reform's campaign on reform of the Mental Health Act, 2001.

Recommendation 3: The HSE Mental Health Division should ensure that in adult services a standardised approach is taken to the involvement of family supporters/carers in recovery planning for their relative/friend who is engaged with mental health services.

Action: The involvement of family supporters/carers in recovery planning should be reflected in HSE Mental Health Division standard operating procedures.

Rationale

Planning for the Future, 1984 identified that "families of patients...should be regarded as part of the psychiatric team".³⁷ "As relatives are centrally involved in caring for the patient, they should be given a role in assessing progress and in planning care. Their knowledge and judgements should be taken into account by the psychiatric team".³⁸

A Vision for Change reiterates the recommendations in *Planning for the Future* that mental health teams should support and engage with families as part of mental health service provision. More specifically, the Expert Group recommended that both service users and carers be involved in every level of mental health service delivery, from individual care planning (ICP) to being members of management teams at local and national level.³⁹

Furthermore, the Mental Health Commission's Quality Framework sets standards for the involvement of family supporters/carers in their relative/friend's care.⁴⁰ Standard 6.1 of the

³⁵ The evaluation report recommends that the revised programme should be further evaluated using a larger cohort of participants to ensure that statistical findings are robust.

³⁶ One of the recommendations in the evaluation report was to consider providing all users of services and family members with relevant written information based on the EOLAS Project handouts immediately when they attend the mental health service, as part of an everyday quality service. It also recommends that consideration should be given to providing family members with information on support groups and accessible counselling services, and appointing a key worker who would act as a 'mediator' between families, users of services and mental health services.

³⁷ Department of Health and Children (1984) *Planning for the Future*, Dublin: The Stationary Office, p. 13.

³⁸ Ibid.

³⁹ AVFC (2006), p. 8.

⁴⁰ The MHC's Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre encourages mental health services to actively engage with family members in the areas of admission, transfer and discharge and that family members should have active involvement in their loved one's treatment, where appropriate. However, the Code is constrained by the requirement to respect the individual's right to privacy.

Framework states that “families, parents and carers are empowered as team members receiving information, advice and support as appropriate”.⁴¹

While the standard reflects an intention to provide for family supporter/carers’ needs and a partnership role, the criteria developed under this standard are limited in their scope. Similarly, *A Vision for Change* is much stronger on the role of service users in their own care and recovery than on family supporter/carer involvement.

This is compounded by the fact that mental health legislation in Ireland has failed to provide a statutory basis for family supporter/carer involvement. Instead it has prioritised the individual’s right to privacy and confidentiality. The Expert Group on the review of the Mental Health Act, 2001 has not made any recommendation to amend the existing legislation to reflect the legal rights of family supporters/carers.

Despite the recognition that family members and carers can be valuable in their relative/friend’s care and recovery,⁴² such individuals continue to report their marginalisation by the mental health system. In Mental Health Reform’s public consultation meetings, 2015, participants identified that family supporters/carers need to be properly informed of their relative/ friend’s mental health condition, there needs to be improved communication and dialogue between family supporters/carers and mental health staff, and they need to be listened to in a meaningful way.

Overall, Mental Health Reform advocates that the involvement of family supporters/carers should be protected in legislation. Families and carers should be provided with the following rights:

- provision of information of a general nature on mental health (with the permission of the primary service user)
- to have their support needs assessed and responded to (with the permission of the primary service user), particularly where family members are under the age of 18 years
- to be involved in discharge planning, where the individual concerned is being discharged to the family supporter/carer home and the individual has given their permission. This may include a discharge planning meeting between family supporters/carers and the community mental health team

The National Carer’s Strategy⁴³ sets out a number of actions to ensure that carers are recognised and respected as key care partners and included in decisions relating to the person that they are caring for. These actions should be considered in progressing the involvement of family supporters/carers in mental health service delivery.

⁴¹ Mental Health Commission (2007) *Quality Framework: Mental Health Services in Ireland*, Dublin: Mental Health Commission, p. 17.

⁴² Family members and carers can provide useful information to mental health services about what triggers the individual’s mental distress, what the usual signs are when the individual is starting to deteriorate and what has helped the individual’s recovery in the past.

⁴³ Department of Health (2012) *National Carers Strategy*, Dublin: Department of Health.

Service user and family supporter/carer engagement structures

Recommendation 4: The recommendations of the Reference Group on family supporter/carer involvement at national, regional and local level should be fully implemented.⁴⁴

Action: The HSE Mental Health Division should develop an implementation plan and allocate funds to ensure the HSE Reference Group's recommendations fully translate into action.

Action: The HSE Mental Health Division should monitor implementation of these recommendations through established mechanisms.

Action: As alluded to in the Reference Group report, the monitoring and reporting of service user and family supporter/carer feedback should be clearly defined at all levels of the mental health system. Similarly, mechanisms for reporting back to individuals and groups as to progress and impact of their feedback should be clearly specified. As part of this process, key performance indicators (KPIs) on the collection, review and reporting of service user and family supporter/carer feedback should be included in the development of any national mental health information system.

Rationale

A *Vision for Change* recommended the development of the National Service User Executive (NSUE) to inform at national level the issues relating to service user involvement and participation in planning, delivering, evaluating and monitoring mental health services.⁴⁵ NSUE is no longer funded by the HSEw therefore it is necessary that new structures are put in place to ensure service user and family supporter/carer involvement at regional and local levels. This should be supported by the National Office and Head of [service user and family supporter/carer] Engagement within the HSE Mental Health Division.

Recommendation 5: Mental health service staff should ensure that they are aware of and inform service users and family supporters/carers about community supports available in the local area.

Action: The HSE Mental Health Division should include a duty on services/staff to inform service users and family supporters/carers about community supports in Clinical Programme guidance and in Standard Operating Procedures.

Action: The HSE Mental Health Division should ensure that all local area management teams provide information to services and staff on community supports operating in the local area, including, for example, community peer support services.

Rationale

One of the key principles in promoting recovery among people with mental health difficulties is supporting individuals to link in with local community services and supports. This is reflected in the New Zealand recovery competencies, which actively supports service users to connect with community supports with the aid of the mental health services.⁴⁶ The Mental Health Commission's

HSE (2019) Recommendations of the Reference Group on Structures and Mechanisms for Service User, Family Member and Carer Engagement, Dublin: HSE.

⁴⁵ AVFC (2006) p. 27.

⁴⁶ Mental Health Commission (New Zealand) (2001) *Recovery Competencies for New Zealand Mental Health Workers*, Wellington, NZ: Mental Health Commission, p. 7.

Standard 2.3 specifies that: “The mental health service promotes mental health and community integration of mental health service users.”⁴⁷ This standard places a responsibility upon mental health professionals to actively work to facilitate service users’ integration into the local community.

The provision of information on local community resources such as support groups, family resource centres and other local services can form a vital part of a person’s recovery network. However, research suggests that mental health professionals, including GPs, may lack basic information about local mental health services, including supports provided by community and voluntary organisations such as peer support groups.⁴⁸ The lack of information provided to families/carers during the waiting period has also been identified as one of the key barriers in accessing appropriate mental health care for children and adolescents in Ireland.⁴⁹ Mental Health Reform has previously recommended that a directory of information on existing supports in their local community should be made available to individuals accessing mental health care.

A Vision for Change clearly identifies ‘community support’, as the first of three layers in its proposed framework for a mental health policy.⁵⁰ The Expert Group acknowledged that the community itself is a valuable resource in dealing with many health difficulties.⁵¹ More specifically, the Expert Group referred to the value of services that use the support of families and communities to improve outcomes in mental health, such as the community-based rehabilitation model.⁵²

In 2007, the National Economic and Social Forum published a report on mental health and social inclusion. The report identifies that there is a strong association between mental health and the provision of social supports in the community.⁵³ In order to ensure a continuum of care from early intervention to recovery, community supports need to be included. Strategic areas identified by the NESF for improving the mental health of local communities include recognition and support for the role of the community and voluntary sector and the provision of social support initiatives in local communities.⁵⁴

Advocacy supports & peer-led services

Recommendation 6: National, statutory and independent advocacy services should be developed so that they are available to both children and adults with mental health difficulties in hospitals, day centres, training centres, clinics, and throughout the community.

Action: Research should be conducted to identify the level and nature of need for advocacy services among both children and adults with mental health difficulties.

Action: The HSE Mental Health Division should develop an action plan, in consultation with key stakeholders and in line with evidence-based practice and research on the development and

⁴⁷ MHC (2007), p. 16.

⁴⁸ Whitford, D.L. and Coptly, M. (2005) “General practice in Ireland: are we equipped to manage mental health?” *Irish Journal of Psychological Medicine* 22:2:40-41.

⁴⁹ Kerin, L. (2015) *National and International Literature Review of Good Practice in Child and Adolescent Mental Health Services*, p. 8.

⁵⁰ AVFC (2006), p. 21.

⁵¹ *Ibid.*, p. 22.

⁵² *Ibid.*

⁵³ National Economic and Social Forum (2007) *Mental Health and Social Inclusion*, Dublin: National Economic and Social Forum.

⁵⁴ *Ibid.*, p. 6.

implementation of advocacy services for both adults and children with mental health difficulties. This should include an agreed time-frame, an allocated budget and key objectives for delivery.⁵⁵

Action: Specific consideration should be given to the advocacy needs of particular groups of individuals, including people from ethnic minority groups and members of the deaf community. This should be done in consultation with key stakeholders, including community and voluntary groups in local areas across the country.

Action: The HSE Mental Health Division should ensure that guidance is included in Clinical Care Programmes and Standard Operating Procedures (SOPs) to inform individuals of existing advocacy services, including community supports.

Rationale

As outlined in Mental Health Reform's *Nine Years On* report, there are significant gaps in existing advocacy supports for people with mental health difficulties. In particular, there appears to be inadequate provision of advocacy services 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."⁵⁶ This right has yet to be realised. While the advocacy needs of people living in the community is not fully known due to a lack of research in this area, it is important that the revised mental health policy recognises that there may be an as of yet undocumented need among this group of individuals across the country.

There are indications that there is unmet need in this area, including a lack of awareness among people with mental health difficulties living in the community of existing advocacy and/or other supports^{57, 58}, reports to MHR of difficulties by people living in the community in making complaints about the mental health services, and reports by the Mental Health Inspectorate about a lack of support for people in supported accommodation to participate fully in community life.^{59,60}

A recent small scale study in one urban area in Ireland investigated the views of mental health service users on independent advocacy supports available in the community. The report identified that 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.^{61,62} Furthermore, a high

⁵⁵ The HSE should recognise that there are multiple areas that an individual may require advocacy supports in, e.g. family and marital relationships, accessing education, accessing and sustaining employment and housing, as well as support with attending medical/therapeutic appointments by having an advocate present during appointments.

⁵⁶ AVFC (2006) p. 25.

⁵⁷ McDaid, S. (2014), op. cit., citing Mac Gabhann, L, et al. (2010) *Hear My Voice: The experience of discrimination by people with mental health problems*. Dublin: Amnesty International Ireland.

⁵⁸ In a DCU study, just 46 of 300 participants identified the Citizens Information Service as a source of support if they felt they were unfairly treated, while only 18 participants mentioned the Equality Authority, showing a very low level of awareness of statutory supports available.

⁵⁹ Inspector of Mental Hospitals 2003, p. 10-11.

⁶⁰ In 2003, the Inspectorate concluded that many community residences were operating as 'mini-institutions', commenting that: "The Inspectorate had been struck by how little rehabilitation took place in community residences and how their management was oriented towards continuing, rather than decreasing dependency".

⁶¹ Mental Health Reform (2017) *The Advocacy Needs of Mental Health Service Users Living in the Community: A Pilot Study*, Dublin: Mental Health Reform.

⁶² 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.

percentage of participants to the study had experienced difficulties in accessing supports and/or entitlements.⁶³

Mental Health Reform is also concerned that the move to community based mental health services and the dispersal of people with long-term mental health difficulties from psychiatric institutions into the community (HSE-supported accommodation, homeless hostels, voluntary housing association supported accommodation, family homes and independent accommodation in the community) may have left some individuals without adequate support to access services and entitlements. A 2010 survey by Mac Gabhann et al. of 300 people with experience of a mental health difficulty in Ireland reported experiences of unfair treatment in every domain of social life, including by friends, neighbours, family, health services staff, the police, and in housing, education, work, public transport and welfare.⁶⁴

The need for a national advocacy service for children under the age of 18 engaged in mental health services was not recognised in *A Vision for Change* and should be acknowledged in the revised policy. This is endorsed in the Mental Health Commission's Quality Framework, which includes an obligation on mental health services to provide access to advocacy supports for both adults and children.⁶⁵ The Children's Mental Health Coalition has also recommended the establishment of a dedicated advocacy service to ensure that the advocacy needs of children with mental health difficulties are met.⁶⁶ In a recent study with young people engaged in mental health services it was identified that a "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".⁶⁷

The rights of children to participate in decisions that affect them is underpinned in both national and international legislation, including the Ombudsman for Children's Act^{68,69}, the national children's framework *Better Outcomes, Brighter Futures*⁷⁰, the National Strategy on Young People's Participation in Decision-Making^{71,72} and the National Youth Strategy⁷³. It is guaranteed in human

⁶³ 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.

⁶⁴ MacGabhann, et al., op cit.

⁶⁵ MHC (2007), p. 32.

⁶⁶ Children's Mental Health Coalition (2015) *Meeting the Mental Health Support Needs of Children and Adolescents: A Coalition Analysis*, Dublin: Mental Health Reform, p. 29.

⁶⁷ Buckley, S. et al. (2012) *Mental health services: the way forward. The perspectives of young people and parents*. St Patrick's University Hospital, Dublin.

⁶⁸ Government of Ireland, *Ombudsman for Children Act, 2002*, Dublin: Government of Ireland. Retrieved from <http://www.irishstatutebook.ie/pdf/2002/en.act.2002.0022.pdf>.

⁶⁹ Under section 7 of the Act, "the Ombudsman for Children shall establish structures to consult regularly with groups of children that he or she considers to be representative of children" for the purposes of promoting the rights and welfare of children. "In consultations under this subsection, the views of a child shall be given due weight in accordance with the age and understanding of the child."

⁷⁰ Minister for Children and Youth Affairs (2014) *Better Outcomes, Brighter Futures: The National Policy Framework for Children & Young People 2014-2020*, Dublin: Department of Children and Youth Affairs.

⁷¹ Department of Children and Youth Affairs (2015) *National Strategy on Children and Young People's Participation in Decision-making, 2015 – 2020*. Dublin: Government Publications.

⁷² Objective 3 of the National Strategy commits to ensuring that children and young people will have a voice in decisions that affect their health and well-being, including on the mental health services delivered to them. Within the Strategy the HSE commits to sharing best practice in adolescent mental health advocacy.

⁷³ The National Youth Strategy, alongside the National Strategy on Young People's Participation in Decision-Making, promotes young people's voices being heard and acted upon in planning and decision making processes at all levels.

rights legislation under the United Nations Convention on the Rights of the Child (UNCRC)⁷⁴ and General Comment 12 and in other European⁷⁵ and international policy and law.

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 [with mental health difficulties] and accordingly accessible and child-friendly.⁷⁶ The Expert Group on the review of the Mental Health Act, 2001, has also recommended that advocacy services to children and to the families of children in the mental health services should be made available.

Recommendation 7: The role of peer support workers in HSE run or funded services should be specified in national mental health policy.

Action: The HSE Mental Health Division should clearly define the role and function of peer support workers, in consultation with key stakeholders, and ensure the national roll-out of peer support workers in each Community Healthcare Organisation (CHO) area.⁷⁷ This should be complemented by the development of standardised accountability, performance management and support structures for peer support workers in all CHO areas.

Action: The HSE should provide guidance and training for Community Mental Health Teams (CMHTs) on engaging and working collaboratively with peer support workers. The effectiveness of professional disciplines in working with peer support workers should be monitored and evaluated on an ongoing basis.

Action: The (national) recruitment of peer support workers should be advertised widely to ensure that individuals both in and outside of the mental health services have an opportunity to apply for such positions.

Action: The HSE Mental Health Division should consider the development of peer support workers for both service users and family supporters/carers.

Action: The HSE Mental Health Division should commission an independent analysis/review of the first phase of peer support workers in HSE mental health services. This should include a recommendation on the number of peer support workers to be appointed to services across the country.

Action: The HSE Mental Health Division should allocate continued funding for the role of peer support workers in HSE run/funded services.

Action: The HSE Mental Health Division should report on the number of peer support workers operating in mental health services.

⁷⁴ Article 12 of the UNCRC and General Comment 12 on the Right of the Child to be Heard guarantees a child's right to express his/her opinions and for such opinions to be taken into account. This explicitly guarantees children's and adolescents' right to participate fully as service users in mental health service provision.

⁷⁵ European Union, *Charter of Fundamental Rights of the European Union*, 26 October 2012, 2012/C 326/02, available at <http://www.refworld.org/docid/3ae6b3b70.html> [accessed 17 March 2016]

⁷⁶ CRC/C/IRL/CO/3-4.

⁷⁷ HSE (2015) *Mental Health Division Operational Plan 2015*, p. 17.

Rationale

Mental Health Reform has previously called for the allocation of funding to support teams to implement the recovery ethos and employ peer support workers in the HSE's mental health services. The recovery ethos promotes the idea of bringing people with mental health difficulties into contact with those who are in recovery as an effective means of fostering hope. Patricia Deegan acknowledges the "gift" that "disabled people have to give to each other", which manifests in the form of hope, strength and experience as lived in the recovery process.⁷⁸ The presence of other recovering persons can challenge individuals' despair through example.

The importance of peer support workers is strengthened through Article 26 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD).⁷⁹ This article clearly advocates the role of peer support by including this among the measures that governments are required to implement.

A growing evidence base points to the effectiveness of peer involvement in supporting people with mental health difficulties. A report produced by the Canadian Mental Health Association found that peer support is associated with:⁸⁰

- reductions in hospitalisations for mental health difficulties
- reductions in 'symptom' distress
- improvements in social support
- improvements in people's quality of life

Further research has shown that peer support is effective, with strong evidence for peer/mutual help groups as well as growing positive evidence for other types of peer initiative such as consumer-run organisations and peer support workers in mainstream settings.⁸¹

In addition, it is recommended that family members/carers of people with mental health difficulties be supported through peer support. An evaluation of the FRIENDS PROJECT has "highlighted the benefits of peer support as a method of service provision for the family members of those with mental health difficulties. Not only does peer support empower family members with crucial life experience, it also represents value for money".⁸²

As outlined in MHR's *Nine Years On* report, in recent years, peer support workers have been introduced to a small number of mental health services. While the HSE has committed to

⁷⁸ Deegan, P.E. (1988) "Recovery: the lived experience of rehabilitation", *Psychosocial Rehabilitation Journal* vol.11, issue 4.

⁷⁹ UN General Assembly, *Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly*, 24 January 2007, A/RES/61/106, available at <http://www.refworld.org/docid/45f973632.html> [accessed 17 March 2016].

⁸⁰ Canadian Mental Health Association, Ontario, Centre for Addiction and Mental Health, Ontario Federation of Community Mental Health and Addiction Programs, & Ontario Peer Development Initiative (2005) *Consumer/Survivor Initiatives: Impact, outcome, and effectiveness*, Toronto, ON: Ontario Federation of Community Mental Health and Addiction Programs.

⁸¹ O'Hagan, M., Cyr, C., McKee, H. and Priest, R. (2010) *Making the Case for Peer Support: Report to the Mental Health Commission of Canada*: Mental Health Peer Support Project Committee, available at <http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Peer%20Support/Service%20Systems%20AC%20-%20Peer%20support%20report%20EN.pdf>, p.10.

⁸² Brennan, A. (2016) *FRIENDS PROJECT EVALUATION, Dublin: FRIENDS project*.

implementing the peer support worker role in mental health services throughout the country, it is imperative that the definition of this role is clearly set out in national mental health policy.⁸³

Recommendation 8: The establishment of a dedicated funding stream to be made available for the development and sustainment of community peer initiatives. This should be supported through inter-departmental collaboration.

Action: The HSE Mental Health Division should allocate dedicated funding for the development and continuation of new and existing peer-led services for people with mental health difficulties across the country. This should be complemented by a set of standard guidelines on the allocation of funding for peer-led projects, including the equal distribution of funding across CHO areas and the appointment of a designated staff member within the Division with lead responsibility for funding applications.

Action: Government should resource peer-led and peer-run community development projects for people with mental health difficulties as a way of fostering recovery from mental health difficulties and promoting social inclusion of people with a mental health disability.

Action: The Department of Health and the HSE Mental Health Division should commit to the implementation of the recommendations in the evaluation report of Áras Folláin & Gateway (peer-led support services) and develop an action plan and timeframe for implementation of same.⁸⁴

Rationale

A *Vision for Change* includes a recommendation that “innovative methods of involving service users and carers should be developed by local services, including the mainstream funding and integration of services organised and run by service users and carers of service users”.⁸⁵

The National Economic and Social Forum highlighted the role that community development can play as a “key strategy in building social capital, particularly in facilitating communities in a self-help approach to providing solutions to collective problems such as ill-health”.⁸⁶ The NESF recommended that community development and local support networks be further developed and resourced and that innovative approaches to community development be fostered.

During the past decade a handful of local community projects have been developed by people who use mental health services and their family members. Two of the most well-established are the Áras Folláin centre in Nenagh, Co. Tipperary, and the Gateway project in Rathmines, Dublin. These projects provide a vital space for individuals to support each other to recover from mental distress. They also provide training and self-development programmes and work to engage people who use mental health services in local community activities. These types of programmes have the

⁸³ As of July 2016 and following a training and recruitment programme that was in train at that time, it was anticipated that 40 part-time peer support workers would be appointed to seven identified mental health services across five of the CHO areas that were ready to host peer support workers. It was expected that each service would have between 2 and 5 peer support workers. Local services were given the responsibility of developing local implementation plans that would set out line management and supervision support.

⁸⁴ Murphy, R., Lindenau, A., Corrigan, C., Downes, C., and Higgins, A. (2016). *Development and impact of peer-led mental health support in the community: A review of Áras Folláin and Gateway*. Dublin: Mental Health Ireland.

⁸⁵ AVFC (2006), p. 27.

⁸⁶ NESF (2007), p. 5.

potential to reduce hospitalisation and improve social inclusion of people with severe mental health difficulties.⁸⁷

However, these types of initiatives, as recommended in *A Vision for Change*, remain sparse. They have been particularly vulnerable to funding cuts during the economic crisis and have failed to achieve a secure funding base. In addition, peer supports, specific to children and young people should be developed and delivered across mental health services (including community, public and private sectors).

Recommendation 9: An independent complaints mechanism to receive, investigate and resolve complaints about mental health service delivery should be established.

Action: The Department of Health should identify a direct route to an independent complaints mechanism for people who use mental health services.

Action: The HSE should ensure implementation of the recommendations of the Ombudsman's report *Learning to Get Better*,⁸⁸ which looks at how public hospitals (including mental health facilities) in Ireland handle complaints about their services. In particular, it looks at how well the HSE and public hospitals listen to feedback and complaints and whether the HSE and public hospitals are learning from complaints to improve the services they provide.

Action: The HSE should provide information to all service users (and family supporters/carers) about available advocacy support in order to make a complaint, particularly where the individual needs support to exercise their capacity.

Action: Mental health services should ensure that all individuals accessing services are made aware of the Office of the Confidential Recipient and provided with information on the processes involved in making a complaint.

Action: Similarly, individuals should be made aware of the processes involved in making a complaint to the Office of the Ombudsman. This information should be advertised widely, including through mental health services. Individuals should also be informed that the Ombudsman will receive complaints directly, in exceptional circumstances.

Rationale

In the Ombudsman's *Learning to Get Better* report, key findings included that individuals and their family supporters/carers often do not know how to make a complaint about a hospital service and are not aware of the support available to help them to do so. This includes the right to escalate the complaint to the Ombudsman's Office.⁸⁹

The main barriers to giving feedback or making a complaint were identified as a fear of repercussions for individuals' or their relatives' treatment and a lack of confidence that anything would change as a result of complaining.⁹⁰

In *Mental Health Reform's* report on the advocacy needs of people with mental health difficulties

⁸⁷ living in the community, the following was reported: Higgins, A. (2016).

⁸⁸ Office of the Ombudsman (2015) *Learning to Get Better*, Dublin: Office of the Ombudsman.

⁸⁹ Ibid.

⁹⁰ Ibid.

- 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
- 41% of participants were not confident at all in making a complaint to the HSE

A number of key findings have been identified from the Mental Health Commission's report on service users' views of inpatient services in 2011.⁹² These include that:

- more than half of service users (53%) were not aware that they could access the complaints procedure in the hospital
- 56% stated that they were not provided with any written information regarding their rights when entering hospital
- the majority (68.7%) of service users did not wish to make a complaint about an area of dissatisfaction, although 31.3% of respondents reported that they did
- of those respondents who answered the question: If you did have a complaint, with whom did you discuss it? 28.7% of those reported that they would not discuss their grievance
- one third (33.3%) of respondents reported that their complaint was investigated within a reasonable timeframe; however, 43.1% disagreed
- of those who complained, 24.6% (31/126) of respondents stated that they were satisfied with the way their complaint was dealt with, while 51.6% (65/126) were not
- a similar proportion was not satisfied with the outcome of their complaint (54.4%)

According to the Mental Health Commission's annual report 2015, 15% of the 61 approved centres are non-compliant with the complaints regulations.⁹³

The Ombudsman has made a number of recommendations in his report *Learning to Get Better*, including that:

- multiple methods of making a complaint should be available and easily understood, both during and after treatment
- independent advocacy services should be sufficiently supported and signposted to assist individuals and their families in raising concerns
- the HSE and hospitals should highlight complaint outcomes which lead to improvements and changes in procedures (including among the public)

In addition to such recommendations, Mental Health Reform is of the position that there is a need for an independent body to be given a direct role in receiving, investigating and resolving complaints about mental health service delivery.⁹⁴

⁹¹ Mental Health Reform (2017).

⁹² Mental Health Commission (2011) *Your Views of Mental Health Inpatient Services: Inpatient Survey 2011*, Dublin: MHC.

⁹³ MHC (2016) Mental Health Commission Annual Report 2015, Dublin: MHC.

⁹⁴ MHR's briefing paper on improving the system for making a complaint about mental health services sets out the concerns about the existing system in detail and makes specific recommendations (available at

Currently, there is no statutory independent complaints route for people engaged in mental health services in Ireland who must, in the first instance, complain to the public mental health service provider. Only after having made a complaint to the HSE and having received a dissatisfactory response, can an individual then seek redress through the Office of the Ombudsman. This is a highly problematic situation given that mental health service users, unlike other health service users, can be involuntarily detained in health services. In many cases there is a perceived threat of involuntary detention that makes people fearful of complaining, in case detention is used as a form of retribution.

Recovery ethos

Recommendation 10: The HSE Mental Health Division, including mental health service management team members across the country, should demonstrate leadership at national, regional and local level to progress organisational change in order to instil the recovery ethos in all mental health services.

Action: The HSE should allocate additional resources to support capacity-building of staff, service users and family supporters/carers in 'recovery'.

Action: The HSE should monitor the recovery orientation of mental health services through soliciting regular feedback from service users and family supporters/carers.

Action: The HSE's publication on advancing the recovery ethos should be used as a tool to implement the principles of recovery in mental health services across the country. The discussion paper focuses on building capacity, fostering change, measuring change and sustaining change to ensure the delivery of 'recovery orientated mental health services'.^{95, 96}

Action: The recovery ethos should be strongly embedded in the HSE National Standards for Mental Health Services.

Action: Key performance indicators that monitor delivery of a recovery-oriented mental health service, in addition to recovery focused outcomes for individuals, should be designed and included in any national mental health information system.

Rationale

The Expert Group identified 'recovery' as a key principle in guiding the national mental health policy *A Vision for Change*. "A recovery orientation should inform every aspect of service delivery and service users should be partners in their own care".⁹⁷

<https://www.mentalhealthreform.ie/mhr-position-paper-on-improving-the-complaints-system-for-the-mental-health-services/>.

⁹⁵ Collins, P. & Naughton, L., (2015) *Advancing Recovery in Ireland. A National Conversation: Opening Thoughts*. National Office for Advancing Recovery in Ireland. HSE: Mental Health Division. Dublin.

⁹⁶ Among the measures discussed to advance the recovery ethos in this paper include the development of recovery partnerships which focus on collaboration between the individual and the service provider; enabling the voice of the individual, whereby the needs of the latter are prioritised; enabling the voice of family members; encouraging recovery 'champions' at all levels of the system; building partnerships with local community organisations; measuring change based on outcomes that are relevant to the individual, including experience of care; recognition and promotion of existing good practices and initiatives in recovery; sharing of information; inclusion of recovery principles in recruitment process and continuous professional development in recovery.

⁹⁷ AVFC (2006) p. 9.

In recent years, the Advancing Recovery in Ireland pilot programme was initiated in seven mental health service sites across the country. The initiative represented the first systematic approach to developing recovery-oriented services at a national level, using a comprehensive organisational change methodology.⁹⁸ Prior to this, efforts to progress the concept of recovery in service delivery had been slow and fragmented, driven by keen individuals seeking change, as opposed to a systematic, nationwide approach.

An evaluation of the recovery initiative identified that, despite each site being unique in its level of recovery capacity, a number of conditions and principles existed that increased the potential for organisational change.⁹⁹ These include:

- the involvement of senior management and senior medical personnel
- fidelity to the Implementing Recovery through Organisational Change (ImROC) methodology
- an appreciation of the benefits of open dialogue
- the inclusion of service users and family members
- good communication and coordination of different recovery initiatives
- the inclusion of different organisations and disciplines as champions of recovery

Collectively, the seven sites selected to participate in this programme have evidenced many creative recovery initiatives, with ARI projects continuing to emerge in various pockets of the country. Mental Health Reform has previously welcomed the HSE's commitment to instil the recovery ethos in all mental health services. However, such organisational change requires continued leadership and commitment, including the provision of adequate resources, education and training in order to sustain progress made to date. It is imperative that the recovery ethos is instilled at all levels of the mental health system, in every part of the country.

⁹⁸ The initiative was based on and guided by principles of the Implementing Recovery through Organizational Change (ImROC) methodology, a framework for service transformation outlining ten key organisational challenges which mental health services must address if they are to become more recovery-oriented (Shepherd et al. 2010).

⁹⁹ Watts, M., Downes, C. & Higgins, A. (2014) *Building Capacity in Mental Health Services to Support Recovery. An exploration of stakeholder perspectives pre and post intervention*. Dublin: School of Nursing and Midwifery Trinity College Dublin, p. 8.

Chapter 2: Social inclusion

Mental Health Reform recommends that Government uphold the existing recommendations in *A Vision for Change* to support the social inclusion of people with mental health difficulties.¹⁰⁰

In addition to the existing recommendations set out in *A Vision for Change*, the revised policy should reflect the following recommendations:

Employment

Recommendation 1: Government should 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.

This recommendation should be read in line with the Government’s Comprehensive Employment Strategy.^{101,102}

Action: The Department of Social Protection should develop the current supported employment service in Ireland to fulfil the internationally evidence-based approach to supported employment.

Rationale

The current system of employment supports for people with mental health disabilities throughout the country has manifestly failed to facilitate 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.¹⁰³ 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.¹⁰⁴

The Department of Social Protection’s (DSP) recent 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).¹⁰⁵ Interestingly, the survey shows that 50% of participants reported mental health difficulties as the primary reason for being on DA.

Among those who were not currently working 35% expressed an interest in working part-time, while a further 8% expressed an interest in full time employment, given the right supports.¹⁰⁶

The survey also identified that people with disabilities (including mental health disabilities)

¹⁰⁰ AVFC (2006) p. 43.

¹⁰¹ Government of Ireland (2015) *Comprehensive Employment Strategy for People with Disabilities 2015-2024*, Dublin: Government of Ireland.

¹⁰² Action 2.4 of the Comprehensive Employment Strategy recommends “using the Individual placement support model as part of a rehabilitation process [for those with mental health difficulties] that includes coordinated support for employers and employees at local level by job coaches and community mental health teams.

¹⁰³ 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.

¹⁰⁴ CSO National Disability Survey 2006 – Volume 2, Dublin: The Stationery Office, p. 86.

¹⁰⁵ Judge, C., Rossi, E., Hardiman, S. and Oman, C. (2016) Department of Social Protection Report on Disability Allowance Survey 2015, Dublin: Department of Social Protection.

¹⁰⁶ *Ibid.*

experience numerous barriers to employment and that 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; adaptation of job tasks, flexible hours and flexible work arrangements.

There is strong evidence that the internationally recognised approach to supported employment (Individual Placement Support (IPS)) is the most effective method of supporting people with severe mental health difficulties to achieve sustainable, competitive employment.¹⁰⁷ It has also been shown to be both cost effective and less costly than traditional vocational approaches.¹⁰⁸ This approach includes seven key essential principles including integrated mental health and employment supports, intensive individual support, rapid job search (based on the person's employment interests and preferences) followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer.¹⁰⁹ The principles of the evidenced based supported employment approach have been strongly endorsed by the UK Government.^{110, 111}

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 from society and have continued negative implications for the Irish economy.

¹⁰⁷ 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 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.

¹⁰⁸ 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.

¹⁰⁹ 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.

¹¹⁰ Department of Health (2006a) *From segregation to inclusion: Commissioning guidance on day services for people with mental health problems*. London: Department of Health.

¹¹¹ Department of Health (2006b) *Vocational services for people with severe mental health problems: Commissioning guidance*. London: Department of Health / Care Services Improvement Partnership.

Social welfare

Recommendation 2: The Government should reform sickness and welfare benefits so that they can provide flexible, secure income support for people's ongoing recovery from a mental health difficulty.

Action: The benefits system (including the new Partial Capacity Benefit (PCB))¹¹² should ensure that individuals can automatically revert to full benefits during periods where they are not working, where the individual has a history of a mental health difficulty. This should be time unlimited.

Action: DSP should promote public awareness that individuals will not be at risk of losing existing benefits should they undergo assessment of PCB.

Action: DSP should provide ongoing guidance and training to ensure that all Intreo staff (including any new staff) can support individuals with mental health difficulties to access appropriate benefits and supports. The translation of such training into practice should be closely monitored and evaluated on an ongoing basis.

Action: The Department of Social Protection and the Department of Health (in addition to relevant government agencies) should develop clear protocols for enhanced coordination between health and social welfare supports, in order to facilitate individuals' recovery from mental health difficulties.

Rationale

It is evident that people residing in Ireland with long-term mental health difficulties who are on disability or illness benefits are under severe economic strain due to social welfare and related cuts. This is further compounded by the inadequacy of rent supplement compared to escalating rents.¹¹³ The additional stress put on people with mental health disabilities due to the lack of recognition of the impact of the economic crisis on those on disability benefits is likely to continue to negatively impact on their mental health.

Furthermore, there has been a lack of recognition of individuals with mental health difficulties who may have fluctuating work capacity and fall in and out of work numerous times while of working age.

In MHR's public consultation meetings 2015, individuals with self-experience of mental health difficulties reported that the greatest barrier to recovery is the difficulty in accessing social welfare payments. Individuals expressed concerns about the administration of benefits, which often prevent people from participating in the workforce for fear of losing their benefits, inadequate information on citizen's entitlements to social welfare payments, and inexperienced staff working in social welfare offices.

In the Department of Social Protection's recent review of Disability Allowance, fear of losing social welfare benefits and fear of losing the medical card were most highly reported as barriers to achieving individual employment goals.

¹¹² The current Partial Capacity Benefit Scheme often discourages people with a mental health disability from taking up work because they must undergo a review of work capacity that can result in removal of their existing disability benefit.

¹¹³ Focus Ireland (2015) *Submission to Department of Social Protection in advance of the Pre-Budget 2016 Forum*, p. 1.

In the UK, the Green Party has developed a position on ‘basic income’, a guaranteed, non-means-tested income, sufficient to cover basic needs, payable to all individuals in the UK. The Party proposes that a number of existing benefits would be abolished under this system, however, individuals with a disability would be paid a supplement [in addition to their basic income] to ensure that no person would receive less than they did under the old system.¹¹⁴

A broad principle of ‘basic income’ is that people who have a disability or are not capable of work will be provided with an adequate income. Basic income will be provided regardless if individuals are in employment or not. Furthermore, if an individual takes up employment, they are not at risk of losing their basic income, as is often the case under the current disability benefits system in Ireland. Mental Health Reform recommends that the Irish Government consider the principles of the ‘basic income’ approach so that all individuals with a mental health difficulty are guaranteed a basic income, regardless of their capacity to work.

Overall it is important that the benefits system is made more flexible to fit in line with the recovery principle in *A Vision for Change* so that it fosters individuals’ recovery and enables people to fall in and out of the labour market, as their mental health improves or deteriorates.

The Programme for Partnership states that Government will “seek to introduce flexibility and support in the social welfare system for people with severe and enduring mental health difficulties to transition into employment by ensuring a seamless return of their entitlements should a particular employment opportunity prove unsuitable.” It is imperative that this commitment is implemented in practice so as to have a real and meaningful impact on the lives of people with mental health disabilities.

Training/vocational education & social inclusion support

Recommendation 3: The Department of Health should reconfigure day support services for people with a mental health difficulty who are unable to work, in accordance with the New Directions Report for Adult Day Services¹¹⁵. This should be complemented by the development of a range of community (mental health) services, including peer-led supports.

Action: The HSE should provide a funding stream for the reconfiguring of adult day support services for people with mental health difficulties, to be carried out in accordance with the New Directions policy. Funding should be provided for both peer-run and professionally-run peer-involved services.

Rationale

According to international evidence, approximately half of participants in supported employment programmes with mental health disabilities do not find competitive employment. This leaves a significant group who require other rehabilitative and vocational support in order to ensure that they do not become socially excluded.

The National Learning Network (NLN) has expressed concerns that in many communities NLN services are the only supports available to people with mental health disabilities. Furthermore in

¹¹⁴ Green Party of England and Wales (2015) *Basic Income: a detailed proposal*, England: Green Party of England and Wales.

¹¹⁵ HSE (2012) *New Directions: Review of HSE Day Services and Implementation Plan 2012 – 2016*, Dublin: HSE.

MHR's report on the value of NLN rehabilitative and vocational training, a dearth of progression options for those not entering the labour market was identified.¹¹⁶

The HSE's proposed new approach to adult day services, *New Directions*, includes a commitment to developing services that are "person-centred", that support the social inclusion of individuals in their community and that build personal capacity and competencies.¹¹⁷ Participants involved in the development of the report identified that "training and support in day services vary from clearly planned programmes to situations where people spend time with nothing to do or engage in repetitive activities, which they see as of little use or value".¹¹⁸ There was also strong criticism of the lack of choice in activities at many day services.

Service users and providers talked about an existing ethos of care that promotes dependence and an overemphasis on a medical model delivered in a clinical environment. They argued for choice and for programmes and activities that are interesting, meaningful and strengthen capacity for independence.

The report also recognises the need for the implementation of quality assurance systems and common standards to ensure consistency and quality of care across adult day services. In order to move away from current practices, which often limit the role of individuals, there is a requirement for a "strong national vision, cultural change among providers and funders, support for innovation, funding systems that facilitate individual choice, and an expanded array of demand-led, individualised services that let service users exercise choice and control over decision-making about their service".¹¹⁹

With more than 7,000 people with mental health difficulties using adult day activation services,¹²⁰ it is imperative that ongoing activation and social inclusion supports are developed to ensure standardised services across the country that are underpinned by principles of equality, participation, choice and independence.

Housing

In accordance with each of the recommendations set out below, the housing design guidelines to promote independent living and mental health recovery (published by the HSE and the Housing Agency) should be considered.¹²¹

¹¹⁶ Mental Health Reform (2013) *Final Report to National Learning Network: Research into the Value of Rehabilitative and Vocational Training and Support Services for People with Mental Health Issues*, unpublished research report.

¹¹⁷ HSE (2012), p. 15.

¹¹⁸ Ibid.

¹¹⁹ Ibid.

¹²⁰ Ibid., p. 77.

¹²¹ The guidelines highlight best practice in home design for people with mental health difficulties to help facilitate independent living. The aim is to help overcome some of the obstacles to and reduce the amount of assistance required for a person with an enduring mental health difficulty to maintain and run their home. Key recommendations highlighted in the report include:

- Choice – a person's choice of where to live is a foremost consideration.
- Design participation – involving a person in the design process and fully understanding their needs is essential.
- Cognition – a well-designed environment using principles of universal design and assistive technology can help people with cognitive disability to overcome some of their specific difficulties.
- Physical Health – Many people with mental health conditions have also got co-existing physical ailments. Therefore, creating accessible environments to meet the totality of the person's needs is important.
- Social Factors – Staying connected with friends and family are essential to a person's circle of support. Access to amenities and services is vital. Housing should not be separate from other housing in a community, balanced with protecting a person's anonymity and privacy in individual circumstances.

Recommendation 4: The Departments of Health and Housing 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.

Action: The Departments of Health and Housing, in consultation with key stakeholders, should develop a joint protocol to ensure the effective transition of individuals from HSE (mental health service) supported accommodation to community living. It is imperative that mental health services, local authorities and voluntary housing bodies work collaboratively to support the tenancy sustainment needs of people with mental health difficulties.

Action: The Departments of Health and Housing should commission specialist housing agencies to provide visiting supports for mental health service users living in the community, based on their identified need.

Rationale

Article 19 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) states that people with disabilities shall be given the “equal right to live in the community, with choices equal to others” and state parties “shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community”,¹²² including by ensuring that:

- persons with disabilities have the opportunity to choose their place of residence, and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement
- persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community
- community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs

At a national level, the Expert Group on *A Vision for Change* recommended that “opportunities for independent housing should be provided by appropriate authorities, with flexible tenancy agreements being drawn up in accordance with each service user’s needs”. “Arrangements that

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- Environmental Factors – it is widely recognised that colour and works of art can be mood enhancing and lessen anxiety in healthcare settings. Natural light should be prioritised and integrated into any design for mental health service users.
 - Maximising daylight, reducing noise exposure in the built environment (all of which can exacerbate mental health issues if not designed into homes).
 - Ensuring natural elements such as plants and views of the natural environment from windows (can reduce stress and diminish cognitive fatigue).
 - Low maintenance accommodation and gardens (reducing need for additional support).
 - Monitored smoke, gas, heat, CO2 detector alarms (also controls with audio and touch based clues for ease of use).
 - Use of appliances that are undemanding and straightforward to operate, e.g. one action to turn on and off.
 - Ensuring homes are located in diverse, active communities close to essential amenities and support services.

¹²² UN General Assembly (2007).

best enable service users to move from high-support to low-support and independent accommodation need to be considered".¹²³

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.¹²⁴

The Housing Agency's report on housing options for people with mental health difficulties points to international and national literature that demonstrates the importance of independent living that encompasses choice for the individual, in addition to stable, affordable and good quality accommodation. "Housing arrangements that combine support for everyday living and a suitable social environment, are most likely to maximise independent living".¹²⁵

There are a number of non-governmental organisations that provide supports for independent living in the community for people with severe and enduring mental health difficulties, including Focus Ireland, Cork Mental Health Housing Association and HAIL Housing Association. For example, HAIL provides accommodation for families and individuals with a range of housing needs, but primarily for those with mental health difficulties who require additional support to live independently in the community. Strong links between HAIL, local authority housing officers, homeless services (including homeless forums) and local community mental health services help individuals to link in with specific services necessary to ensure their recovery and enable a possible transition to independent living.

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 and 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 the 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.

¹²³ AVFC (2006) p. 110.

¹²⁴ The *Happy Living Here* report recommends a reduction in the amount of high-support accommodation, noting that the recovery of individuals would be better provided in their own environment. The authors recommend that local authorities should assume responsibility for some HSE supported accommodation (primarily low support) and work in partnership with local mental health teams in order to support independent living among individuals with mental health difficulties.

¹²⁵ Carroll, S. and Cotter, N. (2010) *Review of the Housing and Support Options for People with Mental Health Related Housing Needs*, Dublin: Housing Agency.

- maintaining their home to a reasonable standard and ensuring 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 Residential Tenancies 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% were deceased or had 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".

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".¹²⁶

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".¹²⁷ Similar commitments have been made in Rebuilding Ireland, the Government's action plan on housing and homelessness.

Agreement between the Departments of Health and Housing on this funding stream should be clearly set out in national policy 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. Clear protocols must also be established between the two Departments and their relevant agencies on supporting the effective transition of individuals to community living, in addition to tenancy sustainment.

It is important that such funding 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, in ensuring their social inclusion within the community and upholding their human rights (including to choice, respect and dignity) on a par with individuals without mental health difficulties. The Australian Human Rights and Equal Opportunities Commission found that one of the biggest obstacles in the lives of people with mental health difficulties is the absence of adequate, affordable and secure accommodation.

¹²⁶ Department of the Taoiseach (2016) Programme for a Partnership Government, Dublin: Department of the Taoiseach.

¹²⁷ Oireachtas Committee on Housing and Homelessness (2016) Report of the Committee on Housing and Homelessness, Dublin: Houses of the Oireachtas.

Recommendation 5: Dedicated funding should be allocated for the capital costs of providing social housing for people with a mental health difficulty transitioning from HSE supported accommodation and/or acute care.

Action: The Department of Housing should ensure that the commitments in the Strategic Plan on Housing Persons with Disabilities as they relate to people with mental health difficulties are implemented as a matter of priority.¹²⁸

Action: The Department of Housing should collaborate with the HSE Mental Health Division in planning for the timely allocation of appropriate housing for people with mental health difficulties. Such planning should take account of housing needs assessments carried out by all Local Authorities.

Action: The Department of Housing should ensure that every local authority reports on the housing needs of people with mental health difficulties who come to their attention. Work is currently underway on the collection of such data via the Housing Agency.

Rationale

The Strategic Plan for Housing Persons with Disabilities recommends that local authorities ensure that a proportion of social housing is allocated to people with mental health difficulties in each local area. Given that the vast bulk of mental health care is delivered in the community, there will be a small but regular flow of individuals with a mental health disability who will require social housing support. HSE guidance on addressing the housing needs of people with mental health difficulties states that:

“They [mental health services and local authorities] need to engage in estimating and planning for the provision of an adequate stock of suitable living accommodation for mental health service users who have special needs in relation to their living environment and the development of mechanisms to ensure equity of access for people with a mental illness to the housing allocations process”.¹²⁹

A recent study conducted in the Tallaght mental health services found that 98% of long-stay/delayed discharge patients had a housing-related need. In order to prevent inappropriate and costly long-term stays in acute mental health units, it is vital that people who are in inpatient care and who have a housing need can access social housing quickly. This means that the planning mechanisms used by local authorities to estimate current and future housing need, must take account of individuals with severe mental health difficulties who will need social housing support. Of course, this extends beyond those in hospital, and includes people with mental health difficulties who are homeless. It is imperative that the Department of Health and the HSE work collaboratively with the relevant housing agencies throughout this process.

It is also important that individuals are provided with appropriate housing in order to support their recovery. Feedback from Mental Health Reform’s Homeless Sector Advisory Group highlights that people with mental health difficulties are often placed in inappropriate accommodation, which can

¹²⁸ Department of Environment, Community and Local Government & Department of Health (2011) *National Housing Strategy for People with a Disability 2011 -2016*, Dublin: Department of Environment, Community and Local Government.

¹²⁹ HSE (2012) *Addressing the Housing Needs of People using Mental Health Services: A Guidance Paper*, available at www.hse.ie/eng/services/Publications/Mentalhealth/housingdocument.pdf

exacerbate existing mental health difficulties. Mental Health Reform's Grassroots Forum has recommended that people with mental health difficulties be housed in communities with infrastructure that supports improved living standards, including good transport links and community supports for the individuals' recovery. Members of the Forum expressed concern that placing people with mental health difficulties in areas where there is little community service provision may have an adverse effect on the person's mental health and recovery.

Mental Health Reform recommends that the Department of Housing, in its plans to build social housing, should include a proportion of social housing to be allocated to people with a mental health disability who are identified by the mental health services and/or through local authority housing need assessments. Effective collaboration from HSE mental health services is fundamental to this process.

Recommendation 6: Government should commission an annual independent review of rent supplement rates (including Housing Assistance Payments (HAP)) to ensure that they keep pace with the private rental market. This will ensure that individuals in receipt of such benefits, including people with mental health difficulties, have a realistic chance of securing appropriate accommodation.

Rationale

The increases made available since July 2016 to the maximum rent limits under the HAP scheme, in addition to the roll out of HAP to all local authorities since March 2017, must be acknowledged.

However, it must also be recognised that rates of homelessness are steadily increasing¹³⁰ and the disparity between rent supplement and private rental market rates has previously been reported as one of the key contributors to individuals and families losing their homes.^{131,132} There is no doubt that people with mental health difficulties (in receipt of rent benefits) are at increased risk of homelessness due to the continued difficulties they experience in accessing secure accommodation within the private rented sector.

In 2015, Mental Health Reform consulted with mental health social workers operating in mental health services across the country in relation to rent supplement rates and how such rates are impacting on people with mental health difficulties in securing appropriate housing. Overall, the social workers consulted agreed that one of the key obstacles for individuals in receipt of rent benefits in securing accommodation is rent supplement and housing assistance payments being out of line with increasing private rental costs.

Despite such information being provided prior to the revised rent supplement rates, a new study carried out by the Simon Community has found that the supply of housing for people receiving rent

¹³⁰ Between December 2014 and December 2015 there was a net increase of 1,700 people in the number of people recorded as homeless, an increase of 43%. This upward trend continued into 2016, and in December of last year, 7,148 were accessing emergency accommodation in Ireland, an increase of 36% from the previous December of 2015.

¹³¹ Focus Ireland (2017) Why are so many people becoming homeless? Retrieved from <https://www.focusireland.ie/resource-hub/about-homelessness/>.

¹³² According to Focus Ireland research and analysis, the crisis in the private rental sector is the immediate cause of homelessness for the overwhelming number of families, i.e. landlords selling up or being repossessed, shortage of properties to rent, scarcity of properties accepting rent supplement, and high/increasing rents. Focus Ireland continues to report that some families are becoming homeless as Rent Supplement payments fail to cover the rent. Overall Focus Ireland is of the view that "the single largest cause of homelessness is now property being taken out of the rental market".

benefits is extremely low. During a three-day long 'snapshot' study of the market, the study looked at 600 properties in 11 areas across the country and found that 88% of the rental properties looked at were beyond the reach of Rent Supplement and the Housing Assistant Payments scheme.¹³³

Niamh Randall, National Spokesperson for the Simon Communities, has commented that “the once off increase in Rent Supplement/HAP limits in July last year (2016) has meant that the payments have not kept pace with rising rental payments. There has been a decrease in the number of properties available to people within these limits.”¹³⁴

In addition to barriers to housing related to rent supplement rates, measures which target the stigma experienced by people with mental health difficulties in securing accommodation in the private rental market must also be addressed as a matter of priority.

Recommendation 7: In accordance with the Expert Group report on review of the Mental Health Act, 2001, the revised mental health policy should take account of the need for the extended remit of the Mental Health Commission to regulate community based services,¹³⁵ and for the Inspector of Mental Health Services to conduct annual inspections of all 24-hour staffed community residences.

Action: The HSE Mental Health Division should ensure that recommendations as set out in the HSE 2008 evaluation on the efficiency and effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services in Ireland are implemented. This includes a recommendation that performance indicators for community residences be put in place and monitored.

Action: The HSE Mental Health Division should submit periodic progress reports to the Department of Health on the implementation of the findings/recommendations of the above mentioned review. This was previously recommended by the Department; however, since the publication of the review, there has been no implementation plan for these recommendations and little evidence that the recommendations have been implemented.

Action: The HSE Mental Health Division should ensure implementation of the recommendations as set out in the ‘Happy Living Here’ study on improved standards for individuals residing in community residences.

Rationale

Under the current Mental Health Act, 2001, the Inspector of Mental Health Services can visit community residences, report on his or her findings and request that the service provide a quality improvement plan. However, under current legislation, these residences are not subject to inspection or regulation by the Mental Health Commission. This means that the MHC has no statutory powers over these residences, unlike inpatient units which can be closed down by the MHC if they breach certain standards of care.

¹³³ Simon Community (2017) Locked Out of the Market VII: The gap between rent supplement/hap limits and market rents snapshot study, Dublin: Simon Community.

¹³⁴ Conroy, J. (16 May 2017) “Rising rents are leaving people homeless”. Newstalk. Available at <http://www.newstalk.com/Rising-rents-are-leaving-people-homeless>.

¹³⁵ The Expert Group established to review the Mental Health Act 2001 made the following recommendation: The new Act should give the Mental Health Commission specific powers to make standards in respect of all mental health services and to inspect against those standards. The Standards should be made by way of regulations and the regulations should be underpinned by way of primary legislation.

Of additional concern is the existing environment and practices of care in such community residences. Following inspections of 20 community residences in 2015, the Mental Health Commission stated that “many of the residences inspected were too big, in poor condition and institutional in nature”.¹³⁶ In addition:

- there was limited multidisciplinary input in over 50% of residences inspected
- some residents had no care plans or any meaningful activities to occupy them during the day
- 40% of residences inspected by the Inspector of Mental Health Services in 2015 had more than 13 beds despite recommendations in national policy on transitioning people from congregated settings stating that “home sharing arrangements should be confined to no more than four residents in total and that those sharing accommodation have, as far as possible, chosen to live with the other three people”
- some residences are not providing adequate physical healthcare, including screening and referral

Overall, many 24-hour supervised residences were failing to provide opportunities for the optimal recovery and rehabilitation of their client population, as outlined for them in *A Vision for Change*, which is now 11 years in operation.

It is important to note that individuals living in these residences are particularly vulnerable, as many have been living with long term mental health difficulties and within institutional settings for most of their lives. This vulnerability is further exacerbated by the fact that there is no statutory oversight in terms of regulation and inspection of community residences.

In addition, there is a fundamental need to identify precisely the number of residences and people living in such residences. Without this, there is no clear picture of the number of residents subject to institutional conditions in the community. To date, there has been conflicting figures provided on the number of residences in operation.

The Expert Group established to review the Mental Health Act, 2001, recommended that revised legislation should give the Mental Health Commission “specific powers to make standards in respect of all mental health services and to inspect against those standards”.¹³⁷ “The Standards should be made by way of regulations and the regulations should be underpinned by way of primary legislation”.¹³⁸ Provision for such recommendations should be made in the revised mental health policy.

Tackling stigma and discrimination

Recommendation 8: The Government should develop an evidence-based, multi-annual national stigma/discrimination reduction campaign targeted at reducing prejudice and discrimination against people with severe mental health difficulties, and among disadvantaged and at-risk groups.

¹³⁶ Mental Health Commission (2016).

¹³⁷ Expert Group (2015) Report of the Expert Group on the Review of the Mental Health Act, 2001, Dublin: Department of Health.

¹³⁸ Ibid.

Action: The Department of Health should review the impact of the See Change campaign and develop a well-resourced national, evidence-based, multi-annual stigma/discrimination reduction plan targeted at reducing prejudice and discrimination against people with severe mental health difficulties, and at reducing stigma about mental health within particular disadvantaged socio-economic and at-risk groups.

Action: A strand of this campaign should be designed specifically for staff within the mental health services. Service users and family supporters/carers continue to report that a cultural shift is required within the services with respect to how some mental health professionals communicate with and interact with individuals.

Action: The National Disability Authority should be resourced to conduct an up-to-date survey of national attitudes towards people with (mental health) disabilities.

Rationale

The See Change stigma reduction partnership has been an important means of stimulating public discussion about mental health and has begun to have an impact in reducing negative attitudes towards people with mental health difficulties. The See Change Attitudes Survey 2012 showed some improvement in attitudes towards people with mental health difficulties generally since 2010.¹³⁹ However, attitudes towards people with severe mental health difficulties do not appear to have improved,¹⁴⁰ leading to their continued social exclusion and hindering their recovery. Attitudinal and behavioural change is a slow, long-term process that requires sustained support.

In September 2015, findings from a study conducted by St. Patrick's Mental Health Services illustrated that only 21% of individuals surveyed believed that Irish employers would be comfortable employing someone with a mental health difficulty and 9% claim that they would not want to live next door to someone who previously had a mental health difficulty, with 16% uncertain.¹⁴¹

The high prevalence of mental health difficulties among particular disadvantaged groups, such as people from ethnic minorities, members of the deaf community, LGBTI and homeless people as well as individuals with addiction problems illustrates the need for targeted stigma reduction and mental health promotion campaigns. Mental Health Reform has heard from the National Traveller Suicide Awareness Project, for example, that members of the Traveller community do not feel that current national mental health and stigma reduction campaigns are relevant to them or aimed at their minority group. Similarly, Mental Health Reform's Ethnic Minorities and Mental Health advisory group recommended that the See Change campaign incorporate a specific strand of work targeted at reducing the stigma around accessing mental health services among people from ethnic minority communities, including the Traveller community.

The new suicide prevention framework *Connecting for Life* makes a clear commitment to reducing stigmatising attitudes to mental health and suicidal behaviour within priority groups.¹⁴²

¹³⁹ See Change (2012) *Irish attitudes towards mental health* available at http://www.seechange.ie/wpcontent/themes/seechange/images/stories/pdf/See_Change_Research_2012_Irish_attitudes_towards_mental_health_problems.pdf.

¹⁴⁰ Ibid.

¹⁴¹ St. Patrick's Mental Health Services (2015) Survey: Only 53% agree people with a mental health difficulty are trustworthy, available at <https://www.stpatricks.ie/survey-only-53-agree-people-mental-health-difficulty-are-trustworthy>.

¹⁴² National Office for Suicide Prevention (2015) *Connecting for Life: report of the research advisory group for the national framework for suicide prevention strategy*, Dublin: HSE, p. 30.

Recommendation 9: Government should review Ireland’s employment equality legislation to ensure that it is adequately protecting people with mental health difficulties from discrimination.

Action: The Department of Justice should commit to undertaking this review of employment equality legislation.

Rationale

The Employment Equality Acts 1998-2008 expressly prohibit discrimination on the grounds of a mental health disability. However, in a study by DCU, 36% of participants reported having experienced unfair treatment in finding a job and 43% in keeping a job.¹⁴³ Amnesty International Ireland concluded that it is likely that discrimination by employers against people with a mental health disability is occurring in Ireland.¹⁴⁴

In the National Disability Authority’s Attitudes Survey 2011, respondents reported relatively higher comfort levels with having a work colleague with a physical, hearing or vision disability compared with a colleague with a mental health disability.¹⁴⁵

Recommendation 10: An awareness raising campaign on the rights of people with mental health difficulties under employment equality legislation and under the Workplace Relations Commission (WRC) should be delivered across the country.

Action: The Irish Human Rights and Equality Commission (IHREC) should actively promote people’s rights under employment equality legislation and the Workplace Relations Commission. Information materials should be disseminated across mental health services, to employers, and to non-governmental and community based groups working with people with mental health difficulties.

Action: IHREC should deliver targeted campaigns and outreach to people with a mental health difficulty in order to raise awareness of their rights in employment.

Action: Mental health services should inform service users, family members and carers of their rights under the equality legislation and the Workplace Relations Commission.

Rationale

There is anecdotal evidence to suggest that there are many individuals with experience of mental health difficulties who are unaware of equality legislation and of their rights under the WRC.

Culturally competent mental health services

Recommendation 11: The HSE Mental Health Division should establish a national programme to develop culturally competent mental health services in order to appropriately meet the needs of individuals from ethnic minority groups.

¹⁴³ MacGabhann, et al. (2010), p. 26.

¹⁴⁴ Amnesty International Ireland (2010) *Hear my voice: challenging mental health prejudice and discrimination*, Dublin: Amnesty International Ireland, p. 49.

¹⁴⁵ National Disability Authority (2011) Public Attitudes to Disability in 2011 available at https://www.ucd.ie/t4cms/Public_Atitudes_to_Disability_in_Irelandfinal%20Report%202011.pdf.

Mental Health Reform’s recently published guidelines for mental health services and staff on working with people from ethnic minority groups should be considered in this context.¹⁴⁶

Action: The HSE Mental Health Division should disseminate guidance on culturally competent mental health care across all mental health services in Ireland. Mental health services should ensure that all staff have access to this information.

Such guidance should reflect the following principles:

- mental health services and staff should respect the diverse beliefs and values of people from ethnic minority groups and deliver care and treatment in a manner that takes account of such beliefs¹⁴⁷
- mental health services and staff should identify the communication and language assistance needs of people from ethnic minority communities, provide information in ways that are accessible and provide appropriate interpretation services, where necessary¹⁴⁸
- mental health services should improve accessibility to mental health services for people from ethnic minority communities
- mental health services should provide opportunities for family/advocate involvement and support for individuals from ethnic minority communities. This should include enhanced collaboration with mental health advocates and ethnic minority groups in the community
- mental health staff should be appropriately aware, skilled, experienced and knowledgeable in order to meet the care needs of people from ethnic minority communities
- mental health services should undergo systematic evaluation and review to ensure that the mental health needs of people from ethnic minority groups are being adequately met

Action: The HSE Mental Health Division should allocate funding for the training of mental health professionals in culturally competent mental health care.

Action: Such training should also be provided to interpreters working with individuals from ethnic minority groups.

Action: Professional associations should ensure that training in ‘cultural competency’ is included in the core curriculum of trainees and in continuous professional development programmes.

Action: The HSE Mental Health Division should commission an evaluation of existing mental health supports provided by ethnic minority groups in the community. Based on this analysis, an action plan should be developed to adequately resource and support such groups in responding to the mental health needs of people from ethnic minority groups in their communities. One way in which this could be achieved is through the appointment of mental health workers for ethnic minority communities.

Action: The HSE Mental Health Division should commission research on the specific mental health needs of people from ethnic minority groups, including rates of prevalence, and experiences of the mental health services.

¹⁴⁶ Mental Health Reform (2016) Ethnic Minorities and Mental Health: Guidelines for mental health services and staff on working with people from ethnic minority communities, Dublin: MHR.

¹⁴⁷ MHC (2007), p. 26.

¹⁴⁸ Ibid. p. 27, 30 & 38.

Rationale

Internationally, the most widely-cited definition of cultural competence is “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.”¹⁴⁹

While current policy documents *A Vision for Change*¹⁵⁰ and the National Intercultural Health Strategy 2007-2012¹⁵¹ refer to the need for culturally competent mental health services, a more developed framework for the implementation of cultural competency is required. This framework should define the scope and meaning of the ‘culturally sensitive’ mental health services referred to in *A Vision for Change*.

National programmes to develop cultural competence and remove barriers to access have been undertaken internationally. In the UK the Delivering Race Equality in Mental Health Care Action Plan¹⁵² has been produced and national standards for Culturally and Linguistically Appropriate Services in healthcare (CLAS) have been published in the US.¹⁵³ These are a blueprint to assist service providers and individuals in implementing culturally appropriate services. The principal standard is to “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.”¹⁵⁴ In Australia, the Mental Health Commission funded the development of a National Cultural Competency Tool (NCCT) for the mental health sector which is a self-assessment tool to assist services in meeting the National Standards for Mental Health Services.¹⁵⁵

Mental Health Reform’s report on ethnic minorities and mental health identifies numerous barriers for ethnic minority communities in accessing mental health services in Ireland. Such barriers include a lack of understanding among mental health professionals of the social and cultural context for people’s mental health difficulties, a lack of awareness among ethnic minority communities on how to access services, experiences of stigma and discrimination, and communication and language barriers.¹⁵⁶

It is important to recognise that mental health services have been designed and developed in a way that reflects a majority culture. For example, standard assessment tools may reflect the dominant culture and mental health professionals may be unaware of this cultural bias. The development of cultural competence among (mental) health professionals is central to measures to improve ethnic minorities’ access to services, and ultimately improve their mental health outcomes.

¹⁴⁹ Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989) *Towards A Culturally Competent System of Care*, Volume I, Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, cited at <http://www.ncccurrricula.info/culturalcompetence.html>.

¹⁵⁰ AVFC (2006), p. 40.

¹⁵¹ HSE (2009) *National Intercultural Health Strategy 2007-2012*, Dublin: HSE.

¹⁵² Department of Health (UK) (2005) *Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside Services*, London: Department of Health.

¹⁵³ US Department of Health and Human Services, Office of Minority Health (5/3/2013) ‘The National CLAS Standards’ available at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.

¹⁵⁴ *Ibid.*, p. 13.

¹⁵⁵ Multicultural Mental Health Australia (2010) *National Cultural Competency Tool (NCCT) For Mental Health Services* Parramatta, NSW, Australia: Multicultural Mental Health Australia.

¹⁵⁶ Mental Health Reform (2014) *Ethnic Minorities and Mental Health: A Position Paper*, Dublin: Mental Health Reform.

Gender mainstreaming in mental health services

Recommendation 12: Gender sensitive mental health services should be developed and rolled out across the mental health system to ensure that the gender specific [mental health] needs of both men and women are addressed.

Action: The HSE Mental Health Division should develop guidance on delivering gender sensitive mental health services. This should be supported with the necessary resources to ensure its delivery.

Action: The HSE Mental Health Division should measure compliance with the delivery of gender sensitive mental health services through the development and monitoring of key performance indicators.

Action: The HSE Mental Health Division should ensure that staff are appropriately knowledgeable, skilled and trained in the planning and delivery of gender sensitive mental health care.

Action: The HSE should ensure that every mental health strategy, plan, policy and service undergo a gender impact assessment to ensure that it is meeting the needs of both women and men in terms of access to and experience of mental health services. Once a gender impact assessment has been completed, priorities will need to be set to address existing inequalities and resources allocated to meet these priorities.

Action: The HSE should carry out regular consultations with service users, health care professionals and staff when creating gender-sensitive mental health services. With this participation, mental health services can be more responsive to the actual experiences of women and men.

Action: The HSE should allocate funding to conduct gender mainstreaming action projects in mental health services for the purpose of integrating the learning into all mental health services.

Rationale

The United Nations Economic and Social Council has defined gender mainstreaming as

“The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality.”¹⁵⁷

National and international experts have identified the powerful impact gender has on mental health and on people’s experiences of the mental health services. Gender shapes:

- life experiences
- socio-economic realities

¹⁵⁷ UN (1997) Report of the Economic and Social Council for 1997 United Nations General Assembly. 52nd session A/52/3.

- expressions of mental distress
- pathways into (mental health) services
- (mental health) service needs and responses

For example, risk factors that impact on mental health in women include poverty, inequality in the home and at work, and domestic and sexual violence. Symptoms associated with depression, anxiety, eating disorders and self-harm are much more prevalent in women than in men and women also experience perinatal mental health difficulties. Pathways into services for women are predominantly utilised through primary care, community and maternity services. In addition, in terms of meeting the specific needs of women, services should ensure safety, including through the provision of women only services, listen to women accessing their services and work with women to identify the root cause or context for their mental distress.¹⁵⁸

The risk factors that impact on mental health in men include accidents, being victims or perpetrators of violence, social isolation, homelessness and prison. Men are more likely to experience symptoms associated with early onset psychosis, substance misuse, anti-social personality disorder and have higher rates of suicide than women. It is also worth noting that men are more inclined to seek support through crisis services such as A&E, drug and alcohol related services and through the criminal justice system. Among the particular support needs identified for men are activity-based services, assertive outreach and early intervention.¹⁵⁹

Overall, the specific elements identified for gender mainstreaming include:¹⁶⁰

- combining a dual strategy of gender mainstreaming with targeted actions for gender equality
- implementing leadership and accountability mechanisms for monitoring progress
- identifying issues and problems across the genders, including the use of sex disaggregated data to understand gender differences and disparities
- training staff to deliver gender-sensitive services (staff should be supported by gender specialists)
- supporting women's decision-making and empowerment

In the UK, the importance of gender mainstreaming has garnered much attention. Despite the challenges associated with its implementation, there have been a number of developments in the provision of gender-sensitive service provision, many of which should be considered by the Irish Government. Some of these include:¹⁶¹

- developing a network of women's mental health leads
- establishing a reference group of women 'service users'
- providing women-only sleeping, bathing facilities and spaces in in-patient facilities

¹⁵⁸ Davies, J. and Waterhouse, S. (2005) Do women need specific services? In Nasser, M. et al. (eds.). *The Female Body in Mind*. Hove: Routledge.

¹⁵⁹ Information provided by the National Women's Council of Ireland.

¹⁶⁰ Moser, C., & Moser, A. (2005). "Gender mainstreaming since Beijing: a review of success and limitations in international institutions". *Gender & Development*, 13(2), 11-22.

¹⁶¹ Newbigging, K. "Gender and Mental Health". Presentation, National Women's Council of Ireland Roundtable event, Dublin, 16 November 2016.

- delivery of awareness raising and training on gender-sensitive mental health services
- developing a gender-sensitive approach focused on relational security (i.e. safety in acute inpatient care)
- supporting women using mental health services to disclose their histories of trauma and abuse
- increasing access to effective therapeutic help, including the management of self-harm
- providing community alternatives to prison

Karen Newbigging, University of Birmingham, identifies that there is much learning to draw upon in the development of gender-sensitive mental health services. Among Dr. Newbigging's recommendations, she sets out that in addressing gender in mental health policy and service design and delivery:¹⁶²

- the process must be inclusive
- existing data and expertise within communities should be utilised
- practical initiatives should be supported
- organisational change and development should be addressed through training and consultancy and
- the learning from what works and what does not should be evaluated

¹⁶² Ibid.

Chapter 3: Promoting mental health and well-being in the whole population

This chapter should be read in line with the suicide prevention framework *Connecting for Life*, the Healthy Ireland framework and the National Economic and Social Forum's report *Mental Health & Social Inclusion*.

The WHO has described a healthy city as "one that is continually creating and improving the physical and social environments and expanding the community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential".¹⁶³ *A Vision for Change* identifies the importance of social supports and community development initiatives in protecting against poor mental health, as well as supporting people to recover from stressful life events.¹⁶⁴ A community development approach recognises the socio-economic influences on health, including mental health and also recognises that the context in which people live directly influences health status.¹⁶⁵

It is recognised that the development of community supports, including the provision of key social and community activities, can promote social inclusion and enhance positive mental health. For example, arts projects can make a unique contribution to enhancing well-being and self-esteem,¹⁶⁶ as can community sports activities. The physical environment also has a role in stress reduction and the promotion of well-being.¹⁶⁷

The NESF report on mental health and social inclusion highlights a number of ways in which communities should be strengthened in order to promote positive mental health, including:¹⁶⁸

- the community and voluntary sector should be formally recognised and appropriately resourced in the provision of mental health supports
- youth organisations should be adequately resourced and trained in mental health promotion and suicide prevention, specifically targeted at children and young people
- civic engagement should be promoted in order to enhance the positive mental health of members of the community. Research shows that high rates of civic participation are associated with better health outcomes.¹⁶⁹

The report also acknowledges that community development is a positive approach in terms of supporting the mental health and well-being of individuals with pre-existing difficulties. A range of community supports should be provided to this group of individuals to ensure that they are not

¹⁶³ WHO, What is a healthy city? Available at <http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network/what-is-a-healthy-city>.

¹⁶⁴ AVFC (2006) p. 117.

¹⁶⁵ Black Report (1980) *Inequalities in Health: Report of the Research Working Group*. London: HMSO.

¹⁶⁶ Cohen, G. (2005) *The Creativity and Aging Study Final Report: The Impact of Professionally Conducted Cultural Programs on Older Adults*. NEA Study. Brooklyn, NY: National Centre for Creating Aging.

¹⁶⁷ Department of Health (UK) (2001) *Making it Happen: A Guide to Delivering Mental Health Promotion*. London: HMSO, p. 108.

¹⁶⁸ NESF (2007) p. 139, 149, 162.

¹⁶⁹ The report of the Taskforce on Active Citizenship, 2007, identified that levels of volunteering and involvement in a community group were much lower for the unemployed and those with a disability/illness (16.5%), than compared with the total sample (29%). This suggests that people with experience of mental ill-health, as part of the disability sample, would also be less likely to be actively involved in the community, a finding also supported by research in England (Social Exclusion Unit, 2004).

removed from their communities because of having to avail of services elsewhere and/or that they engage in services for longer than necessary. Burton and Harrison identified that the community development approach can enable people who do not normally access services and supports to access them.¹⁷⁰

The report concludes that strengthening communities is essential to supporting positive mental health. This should include sufficient and effective resources for community-wide initiatives, as well as offering integrated supports for those experiencing mental health difficulties.

The Expert Group was innovative in making *A Vision for Change* a whole-of-population mental health policy and incorporating a full chapter on mental health promotion. Mental Health Reform recommends that Government build on the existing recommendations in *A Vision for Change* on mental health promotion and well-being, including the Expert Group's principles of early intervention, protective factors and mental health promotion across the life stages, as well as identifying particular groups at risk.¹⁷¹

However, the mental health promotion recommendations in *A Vision for Change* were less specific than those in other chapters of the policy and have suffered from lack of implementation. There will always be a pull on mental health resources and services towards meeting existing mental health needs, but in order to have an effective mental health system, it is essential that the balance of effort shifts towards promoting mental health and well-being and preventing mental health difficulties from arising. For this reason, it is important that at this juncture, a more developed positive mental health and well-being strategy be put in place.

The WHO's European Mental Health Action Plan 2013-2020, to which Ireland is a party, sets one of its four core objectives as follows:

“everyone has an equal opportunity to realise mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk”.¹⁷²

The Plan further states that:

“Mental well-being provides a foundation for resilience, strengthening hope for the future, and builds the capacity to adapt to change and cope with adversity.”

The European Mental Health Action Plan builds on evidence presented in WHO Europe's report *Mental Health, Resilience and Inequalities*. On behalf of WHO Europe, Friedli states that:

“... levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological well-being. While psychosocial stress is not the only route through which disadvantage affects outcomes, it does appear to be pivotal.”¹⁷³

The link between socio-economic inequalities and inequalities in mental health is made quite clear by the recent Irish national health survey. This survey looked at mental health in the context of the

¹⁷⁰ Burton, P. and Harrison, L. (1996) *Identifying Local Health Needs: New Community-Based Approaches*. Bristol: Policy Press.

¹⁷¹ AVFC (2006) p. 41-51.

¹⁷² WHO (2013) *Mental Health Action Plan 2013–2020*. Geneva: WHO, p. 3.

¹⁷³ Friedli, L. (2009) *Mental Health, Resilience and Inequalities, Copenhagen*: WHO Regional Office for Europe, p.iii.

deprivation index and found that there is a distinct association between negative mental health and social and economic disadvantage. “Probable mental health problems” (PMHP) are considerably more likely to be detected among those in the highest deprivation deciles.¹⁷⁴ A PMHP was indicated by 13% of those living within the most deprived areas, compared with 5% of those living within the least deprived areas.¹⁷⁵ Differences based on social class are less visible, though 9% of those within lower social classes were identified as having a PMHP, compared with 7% of those in the higher social classes.¹⁷⁶ Additional risk factors for mental health difficulties, as identified in the survey, include a lack of physical activity and a lack of social connectedness. Social connectedness is considered to have positive benefits for both physical and mental health and well-being. It is also worth noting that the survey identified younger women and older men as most at risk of a ‘probable mental health problem’.

Positive mental health has a fundamental role in improving a whole range of life outcomes, and conversely, relative social and economic disadvantage has a profoundly negative influence on mental health. The logical consequence of this relationship is that policy to promote mental health must, at its core, be concerned with reducing social and economic inequalities. WHO Europe recommends the following priority areas for action to improve the mental health of the population:¹⁷⁷

- social, cultural and economic conditions that support family and community life
- education that equips children to flourish both economically and emotionally
- employment opportunities and workplace pay and conditions that promote and protect mental health
- partnerships between health and other sectors to address social and economic problems that are a catalyst for psychological distress, and
- reducing policy and environmental barriers to social contact

It is clear that action in these areas extends far beyond the remit of the Department of Health to Government Departments responsible for social, cultural and economic policy, education, employment and housing, among others.

The review of *A Vision for Change* should develop specific policy towards achieving Objective 1 of the European Mental Health Action Plan 2013-2020.

The updated mental health policy should also reflect the following recommendations:

Early years

Recommendation 1: The recommendations outlined in *A Vision for Change* on perinatal mental health services should be reflected in the revised mental health policy and should be developed based on the NICE guidelines on antenatal and postnatal mental health^{178, 179} and the UK Guidance for Commissioners of perinatal mental health services.

¹⁷⁴ Department of Health (2015) *Healthy Ireland survey 2015: summary of findings*, Dublin: Department of Health, p. 50.

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.

¹⁷⁷ Friedli (2009).

¹⁷⁸ The guidelines make recommendations for the recognition, assessment, care and treatment of mental health difficulties in women during pregnancy and the postnatal period (up to 1 year after childbirth) and in women who are planning a pregnancy.

Recommendation 2: Government should commit to building capacity within 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.

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

- provision of talking therapies in maternity hospitals for parents and families
- training on perinatal and infant mental health for health and social care staff working in maternity hospitals, in addition to public health nurses and practice nurses operating in the community setting
- development of primary care psychology¹⁸⁰ (primary care psychology is also well placed to offer intervention to adults in the community to address pre-natal and post-natal issues) and
- the appointment of child specific public health nursing (PHN) posts or the development of children's nurses in the community

Action: The Department of Health and the HSE should recognise infants and toddlers as a distinct care group to ensure that their mental health needs (social and emotional) are identified and adequately addressed.¹⁸¹

Action: The HSE Mental Health Division, in collaboration with the Department of Health and other sections of the HSE, should promote awareness of perinatal and infant mental health among the general population¹⁸² through targeted information campaigns.¹⁸³

¹⁷⁹ Specifically, the guidelines make recommendations on the following:

- Services should be patient centred and all treatment and care should take account of the individual woman's needs and preferences
- Women should have the opportunity to make informed decisions about their care and treatment
- Health professionals should provide detailed advice about the possible risks of mental health difficulties and the benefits and harms of treatment in pregnancy and in the postnatal period, taking into account individual circumstances
- Services should provide integrated care planning for women with mental health difficulties in pregnancy and the postnatal period (that sets out the care and treatment for the mental health difficulty, the roles of all healthcare professionals, including who is responsible for coordinating the care plan, the schedule for monitoring and providing the interventions and agreeing the outcomes with the woman)
- Services should consider the mental health and well-being of the woman during pregnancy and in the postnatal period
- Services should acknowledge the woman's role in caring for her baby and support her to do this
- Services should provide culturally relevant information on mental health difficulties in pregnancy and in the post-natal period
- Services should ensure there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment
- Services should implement clear referral protocols for services, to ensure effective transfer of information and continuity of care. It is also important that education programmes for maternity staff are delivered to ensure that they are appropriately placed to identify and address mental health issues.

¹⁸⁰ There are a small number of examples of primary care psychology and other child services offering assessment and therapeutic services to the 0-3 age group, using an Infant Mental Health framework, e.g., HSE North Cork and South Tipperary. However, the vast majority of child services in the Republic of Ireland do not provide infant mental health assessment or intervention.

¹⁸¹ Information provided by the Irish Association of Infant Mental Health.

¹⁸² Ibid.

¹⁸³ Ibid.

Action: The Department of Health, in collaboration with the Department of Children and Youth Affairs, and other relevant departments and agencies, should develop a national action plan on perinatal and infant mental health.¹⁸⁴

Action: The HSE should ensure that health and social care professionals have been appropriately trained in responding to the mental health needs of pregnant women, parents, infants and young children.^{185 186}

Action: Associations for (mental) health and social care professionals, in addition to academic institutions, should include perinatal and infant mental health in the curricula of training courses.¹⁸⁷

Action: A universal approach to responding to the mental health needs of infants and young children should be developed, ensuring that the wider community, including child care professionals, GPs, PHNs and family support services and programmes, are equipped to support such needs.

Rationale

The National Maternity Strategy recognises the prevalence of mental health difficulties during the perinatal period and the increased risk for women with a prior history of mental health difficulties.¹⁸⁸ It further identifies that perinatal mental health difficulties not only negatively impact on mothers' mental and physical health but adversely affect mother-infant interaction and infants' neurodevelopment, as well as the wider family.¹⁸⁹

The literature shows that mental well-being during infancy is underpinned by a secure attachment between a baby and a primary caregiving adult. Neuroscience continues to demonstrate the predisposed nature of the infant's brain to develop relationships with their primary caregivers.^{190,191} Therefore, when infants are exposed to chronic stress in early childhood, there is a detrimental disruption in the optimal development of the brain,¹⁹² which may lead to psychological difficulties.^{193,194}

There is a growing body of evidence demonstrating that women who experience untreated perinatal mental health difficulties are at a higher risk of experiencing a disruption of the maternal-infant bond, leading to emotional, behavioural and even physical disturbance in infants.¹⁹⁵ Despite recent commitments by the HSE Mental Health Division to enhance perinatal mental health services,¹⁹⁶ to date such services have remained largely underdeveloped. As of February

¹⁸⁴ Ibid.

¹⁸⁵ Ibid.

¹⁸⁶ In some areas of the country, e.g., South Tipperary, basic training in infant mental health has been provided for HSE staff and staff working in the voluntary sector.

¹⁸⁷ Teaching on infant mental health is now on the curriculum for the Doctorate in Clinical Psychology in UCD, UL, and NUIG, and the Doctorate in Counselling Psychology in TCD.

¹⁸⁸ Department of Health (2016) *Creating a Better Future Together: National Maternity Strategy 2016-2026*. Dublin: DoH.

¹⁸⁹ Ibid.

¹⁹⁰ Lyman, D.R., Holt, W. and Doherty, R.H. (2010)

¹⁹¹ Zero to Three (2012). *Making it Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health*.

National Center for Infants, Toddlers and Families, USA.

¹⁹² Ibid.

¹⁹³ Mihalopoulos C., Vos T., Pirkis J., Carter. (2012) "The Population cost-effectiveness of interventions designed to prevent childhood depression". *Pediatrics*, 129(3), 723 – 730.

¹⁹⁴ Nelson, F. & Mann, T. (2011). "Opportunities in Public Policy to Support Infant and Early Childhood Mental Health: The Role of Psychologists and Policymakers". *American Psychologist*, 66(2), 129 – 139.

¹⁹⁵ OCECYMH (2014)

¹⁹⁶ See HSE Mental Health Division Operational Plan, 2017.

2017, there were only three perinatal psychiatrists, with one based at each of the Dublin maternity hospitals, on a part time basis with services under significant pressure.¹⁹⁷ There is no specialist perinatal mental health service outside the Dublin area. In addition, there are no mother and baby units on the Island of Ireland. In contrast, there are approximately 20 such units in the UK.¹⁹⁸

According to a recent article in the Irish Medical Times, a report by the National Group on Specialist Perinatal Mental Health Service Design will provide recommendations to the HSE on the development of perinatal mental health services in Ireland. It is expected that the report will “look at the need for maternity liaison teams, specialist perinatal mental health teams, mother and baby units and the interface with secondary care mental health services (general adult psychiatry community mental health teams)”.¹⁹⁹

There is no doubt, that while there is a requirement for the development of specialist perinatal mental health services, there is also a need to develop the capacity of the wider health and social sector to respond to such needs. The National Maternity Strategy recognises the need for better and more accessible mental health support pre, during and post pregnancy at various levels of the system. More specifically it recommends:²⁰⁰

- access to specialist perinatal mental health services (on a tertiary basis) should be standardised, and as a minimum provided on a maternity network basis
- mother-baby bonding should be facilitated and supported at all times, and as such, every effort should be made to keep the mother and baby together, if clinically appropriate
- maternity and mental health services should work collaboratively to ensure the best possible care for women and their babies. Women with a previous history of a mental health condition should be identified early
- all health care professionals involved in antenatal and postnatal care should be trained to identify women at risk of developing or experiencing emotional or mental health difficulties, including an exacerbation of previous mental health issues, in the perinatal period. A multidisciplinary approach to assessment and support should be adopted

In addition, 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. Such recommendations include the following:²⁰¹

- 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

¹⁹⁷ See Oireachtas Joint Committee on Health, National Maternity Strategy Discussion, available at <https://www.kildarestreet.com/committees/?id=2017-02-16a.994>

¹⁹⁸ Ibid.

¹⁹⁹ Shannon, J. (29 March 2017) “Expert Group to recommend new mother and baby unit.” Irish Medical Times. Available at <https://www.imt.ie/news/expert-group-to-recommend-new-mother-and-baby-unit-29-03-2017/>

²⁰⁰ Department of Health (2016).

²⁰¹ Menton, A. (2015) Perinatal and Infant Mental Health: Draft Position Paper & Recommendations. Dublin: The Psychological Society of Ireland (PSI) Perinatal and Infant Mental Health Special Interest Group (SIG).

- develop and deliver specialist perinatal/infant mental health services, to be complemented by specialist staff
- 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. Such research should assess the efficacy of early intervention programmes, in addition to its cost effectiveness. Cross departmental and inter-agency response to perinatal and infant mental health due to its inter-disciplinary nature is required
- recognise and support the role of families in promoting, preventing and responding to perinatal infant mental health issues²⁰²

A number of international strategy documents have stated²⁰³ that the perinatal (and early years) period provides a unique opportunity for the prevention of mental health difficulties, in addition to early intervention in mental health challenges with which mothers and infants may present. 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 a 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.

Recommendation 3: Early intervention programmes for families and children which promote positive mental health and well-being should be developed and rolled out in communities across the country.²⁰⁴

Action: The Department of Children and Youth Affairs should allocate funding for the continued investment in early intervention programmes, with a particular focus on supporting the mental health and well-being of infants and their parents.

Action: The Department of Children and Youth Affairs should invest in specialist intervention services such as parent-infant psychotherapy and other specialist psychological assessment and interventions for families where mental health difficulties have already emerged.²⁰⁵

Action: The Department of Children and Youth Affairs, in collaboration with the HSE, TUSLA (the Child and Family Agency) and other relevant agencies should ensure early identification of at-risk families and the provision of relevant support. This includes families living in poverty, families living in direct provision or hotel type accommodation, those living with domestic violence, drug or alcohol misuse, families where parents are presenting with mental health difficulties as well as those impacted by other types of trauma.

²⁰² Menton, A. (2015).

²⁰³ National Institute of Clinical Excellence (NICE; 2014). *Antenatal and postnatal mental health: clinical management and service guidance*. NICE UK.

²⁰⁴ For example, Young Ballymun is a 10-year initiative aimed at improving emotional well-being and learning outcomes for children living in the Ballymun area of Dublin. In partnership with the HSE and community services, they provide an infant mental health strategy spanning the antenatal period through three years of age.

²⁰⁵ Information provided by the Irish Association on Infant Mental Health.

Rationale

Reflecting the growing body of research focused on the early years of life, the National Center for Infants, Toddlers and Families coined the term ‘infant-early childhood mental health’ (I-ECMH) to refer to the developing capacity of children from birth to five years to develop close and secure relationships, experience and manage a full range of emotions and explore and learn from their environments in the context of their family, community and culture.²⁰⁶

It is now widely accepted that the foundation for good psychological, social and emotional health across the life span is developed in infancy and early childhood. A number of well-conducted longitudinal studies demonstrate that the risk of mental health difficulties such as depression and anxiety is related to adverse early life experiences.²⁰⁷

Infants raised in environments where parental mental health difficulties exist, in addition to issues such as co-morbid drug and alcohol use, social issues (including family violence) and inter-generational issues, have poorer social and emotional developmental trajectories^{208,209} that continue into adulthood²¹⁰ and are more likely to be in receipt of services, including primary care, child and adolescent psychiatry and disability services.

The Area-Based Childhood (ABC) Programme (funded by the Department of Children and Youth Affairs and The Atlantic Philanthropies) targets investment in evidence-based and evidence-informed programmes and services to improve the outcomes for children and families living in areas of disadvantage.

Many of the ABC areas aim to improve children’s and parents’ mental health and well-being through a range of early intervention services and supports. Programmes aimed at enhancing the social and emotional development of children and young people include the Incredible Years programmes, the PAX Good Behaviour Game, and Roots of Empathy. Many areas are also delivering parenting programmes that support parental mental health and well-being, including the Preparing for Life home-visiting programme, the Parents Plus programme, and Triple P. Some ABC areas deliver initiatives that more directly address the mental health of infants and parents, including:

- Limerick City ABC Start Right programme, which promotes a wraparound model of service delivery for all children from ante-natal to three years, incorporating referrals to art therapy and psychology services for children and parents
- the development of an infant mental health strategy in Louth
- training and capacity building in infant mental health to support professionals to focus on the social and emotional well-being of babies and toddlers in Ballymun and Knocknaheeny and

²⁰⁶ Zero to Three (2012).

²⁰⁷ D’Alton, P. (2015, June 25th) “We need to recognise that emotional well-being is linked to early childhood experiences”. *Journal.ie*.

²⁰⁸ BeyondBlue (2008). *National Action Plan for Perinatal Mental Health 2008-2010: Full Report*. BeyondBlue: The National Depression Initiative & Perinatal Mental Health Consortium, Australia.

²⁰⁹ Lyman, D. R., Holt, W., & Dougherty, R. H. (2010). *State Case Studies of Infant and Early Childhood Mental Health Systems: Strategies for Change*. DMA Health Strategies

²¹⁰ Ontario Center of Excellence for Child and Youth Mental Health (OCECYMH; 2014). *Supporting Ontario’s youngest minds: Investing in the mental health of children under 6*. Ontario, Canada.

- infant mental health therapeutic support through one-to-one home visiting services in Ballymun and Knocknaheeny²¹¹

Despite a number of existing early intervention programmes which have been funded by Government there is a need for continued investment in the development and national roll out of early intervention services which specifically target the mental health needs of infants and their parents.

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.²¹² Economists and researchers unanimously agree that investing in perinatal and infant mental health services yield long-term savings, as opposed to short-term relief.^{213,214,215,216} 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.²¹⁷

The financial impact on wider society, by neglecting to invest in perinatal and infant mental health strategies, has also been identified, including “future perinatal mental health difficulties, suicide, infanticide, child abuse and neglect, obesity, fostering and residential care, marital breakdown, economic disadvantage, delays in motor function, language acquisition and cognitive skills, disrupted attachment relationships, emotional dysregulation, social and behavioural problems, academic underachievement, substance abuse, juvenile delinquency and intergenerational effects”^{218,219} The Nobel Prize-winning economist James Joseph Heckman has demonstrated that returns on investment for early intervention programmes for perinatal and infant mental health can be as high as AUS\$17 per dollar invested (based on a reduction in costs to the health, education, child safety and criminal justice systems over the life of the child from birth to early adulthood).²²⁰

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

Whole-school approach

Recommendation 4: The implementation of a nationwide schools programme on mental health promotion and well-being for both primary and post primary schools.

²¹¹ Information provided by the Department of Children and Youth Affairs.

²¹² World Health Organisation (WHO; 2013).

²¹³ Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems*. Centre for Mental Health and London School of Economics.

²¹⁴ Lyman, Holt, & Dougherty (2010).

²¹⁵ Mihalopoulos et al., (2012).

²¹⁶ Nelson & Mann (2011).

²¹⁷ 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.

²¹⁸ Mihalopoulos et al., (2012).

²¹⁹ NICE (2014).

²²⁰ Queensland Mental Health Commission (QMHC; 2014). *Perinatal and Infant Mental Health Service Enhancement: Discussion Paper*. Children’s Health Queensland Hospital and Health Service.

Action: The Department of Education should develop an implementation plan, complemented by adequate resourcing for a nationwide schools programme on mental health promotion and well-being. The existing national guidelines should be considered in this context.

Action: The Department of Education should commit to providing basic training for teachers on their role in the promotion of mental well-being and the prevention of mental health difficulties. Teachers should also be trained to identify where a child may be experiencing a mental health, emotional or behavioural difficulty that warrants intervention and their role in responding to this and/or linking in with relevant supports.

Action: The Department of Education should appoint a senior official to drive the effective implementation of a nationwide schools programme.

Action: The Department of Education should monitor the implementation of any schools programme and evaluate its effectiveness on an ongoing basis.

Action: The Department of Education should take a lead in developing a national protocol for effective inter-agency working between schools and Child and Adolescent Mental Health Services (CAMHS), as well as schools and other relevant bodies such as the National Educational Psychological Service (NEPS).

Rationale

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.²²¹ 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”.²²² International evidence demonstrates that school-based mental health promotion programmes, when implemented effectively, can lead to long term benefits for young people by improving social and emotional functioning and improved academic performance.²²³

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.²²⁴ In the context of mental health, the whole-school approach builds the capacity of the school community to promote a sense of well-being, address the common emotional needs of young people and prevent the development of mental health difficulties. It seeks to make changes to the school’s 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. An evaluation of the programme shows significant improvements in children’s social and emotional well-being (as

²²¹ WHO (2004) *Prevention of mental disorders: effective interventions and policy options*, Geneva: WHO.

²²² Ibid.

²²³ Clarke, A., O’Sullivan, M. & Barry, M., (2010) *Context matters in programme implementation* Health Education, Vol 110 (4), p. 273-293.

²²⁴ Elias, M.J., Zins, J.E., Weissberg, R.P., & Greenberg, M.T., (2003) *Promoting social and emotional learning: Guidelines for educators*. Alexandria, VA: AFSP.

measured by the Strengths and Difficulties Questionnaire).²²⁵ Such outcomes were also reflected in the parenting programme. 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).²²⁶

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.²²⁷ There are also obvious economic benefits to addressing the issue of mental health in education.²²⁸ Mental health difficulties in childhood not only negatively affect a child's ability to learn, but can also lead to more serious mental health difficulties in adulthood, particularly if the child is not supported to recover.

It must be acknowledged that in Ireland a new subject on well-being 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.

Recommendation 5: Mental health supports, including mental health promotion initiatives, should be developed for students in third level education.

Action: Additional ring-fenced funding should be allocated to the provision of mental health supports for students attending third level education. Such supports should include the further development of counselling services.²²⁹

Action: The National Office for Suicide Prevention should proactively engage with and increase its delivery of suicide prevention training to Student Union Officers across the country, including in SafeTalk and ASIST (Applied Suicide Intervention and Skills Training).²³⁰

Action: In consultation with key stakeholders, e.g. the Union of Students in Ireland (USI), national guidelines on mental health promotion and well-being should be developed for third level education. Such guidelines should be complemented by a comprehensive implementation plan, in addition to allocated resources, to ensure the guidelines translate into practice.²³¹

Rationale

Broderick describes "the college years [as being] a key development stage in the life cycle. The experience of college can present several challenges to student's mental health and well-being as they cope with a new environment, a new social network and in some cases living alone for the first time and managing finances and household tasks. It is a time of transitioning from

²²⁵ Morgan, M. & K. Espey (2012) *Whole-school implementation of Incredible Years: An Action Research Study*, Dublin: Young Ballymun.

²²⁶ Ibid.

²²⁷ 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.

²²⁸ Ibid.

²²⁹ Union of Students in Ireland (2015) *Pre-budget submission 2015*, Dublin: USI.

²³⁰ Ibid.

²³¹ Ibid.

dependence to independence, with greater responsibility and competing new academic requirements".²³²

Between 2006 and 2013 the numbers of students presenting with mental health difficulties in universities and colleges across the country have steadily increased. Anxiety disorders have increased from 19% to 32%, depression from 9% to 24%, relationship problems from 11% to 24% and academic-related issues from 19% to 29%.²³³ A number of third level institutions have reported that 80% of students accessing services are presenting with "clinically significant" mental health difficulties.²³⁴ This is further supported by the My World Survey which found that 43% of a student sample have felt at some point that their life is not worth living, 40% suffer from depression, 38% suffer from anxiety, 21% have engaged in deliberate self-harm and 7% have attempted suicide.²³⁵

Furthermore, additional recent research suggests that "while the number of students with mental health difficulties who present in Higher Education Institution (HEI) support services is increasing, this group of students is at the same time the most vulnerable to dropping out of college."²³⁶ "Students with mental health difficulties had the lowest retention rate across all nine third level institutions participating in the study".²³⁷ The report recommends the need to target students with mental health difficulties, particularly in first year, when the highest withdrawals occur".²³⁸

The National Office for Suicide Prevention funds a range of initiatives promoting mental health, including its Please Talk campaign for 3rd level students, in addition to offering ASIST training for student union officers. The Irish Association of University and College Counsellors (IAUCC) previously reported that counsellors offer a range of therapeutic interventions to students in the form of one to one and group counselling and, where possible, support and advice to staff who are concerned about their students.²³⁹ Several services offer training and workshops (including suicide awareness) for students and staff, as well as a range of written and online psycho-educational materials.

A recent report on mental health supports in higher education identified that "there are excellent services, initiatives and mental health awareness within the HEI sector. For example, all colleges report having counselling and Disability Support Services and chaplaincy. A number of institutions reported specialised initiatives in response to the need to support students with diagnosed mental health difficulties".²⁴⁰

"However, findings also show that services have been considerably undermined by recent cutbacks to staffing, a factor which impacts on this vulnerable group of students making them more likely to drop out than other students. Services such as counselling have been badly hit by reductions in staffing, resulting in six month waiting lists in many institutions, and this at a time of a

²³² Broderick, B. (2013) *Addressing the mental health needs of third level students*. Education Matters Yearbook 2013

²³³ Ibid., p. 2-3.

²³⁴ Ibid., p. 3.

²³⁵ Dooley, B., Fitzgerald, A. (2012) *My World Survey: National Study of Youth Mental Health in Ireland*, Dublin: Headstrong and UCD School of Psychology.

²³⁶ Twomey, O., Amberson, J., and Brennan, A. (2010) *Pathways to Education: Students with disabilities tracking report – 2005 intake. An analysis of their progression, retention and success through Higher Education Institutions*.

<http://www.pathwayscork.ie/wp-content/uploads/2010/09/Students-with-Disabilities.pdf>.

²³⁷ Ibid.

²³⁸ Ibid.

²³⁹ Broderick (2013).

²⁴⁰ Murphy, E. (2016) *Mental Health Matters: Mapping Best Practices in Higher Education*. Dublin: AHEAD Educational Press.

greatly increasing level of referrals to the service...." "One institution in particular noted a 41% increase in students seeking counselling in the past 3 years".²⁴¹

Broderick describes the increasing number of student registrations and demand on counselling services against the backdrop of under-resourced and overstretched services.²⁴² "The result is that services are seriously overstretched and long waiting lists are common. While the demand for counselling has never been greater, the majority of counselling services can no longer respond in a timely and adequate manner to their distressed students".²⁴³

A report by the Royal College of Psychiatrists on the mental health of students in higher education has recommended that long established systems for student support such as counselling be maintained, and where possible, expanded. It also emphasised the need for students to be seen quickly for initial assessment in order to avoid significant disruption to academic progress.²⁴⁴

There is no doubt that students require access to supports in promoting their mental health and well-being, in addition to counselling services, where necessary. Outcome measures used by counselling services consistently demonstrate that counselling is effective in significantly reducing levels of depression, anxiety, interpersonal sensitivity and somatic distress in those who attended for 4-5 sessions.²⁴⁵ In 2012, the IAUCC produced a study which found that 75% of students considered counselling to have helped them stay at college, improved their academic achievement and their overall experience of college, and helped them develop employability skills.²⁴⁶

Recommendation 6: Enhance the mental health outcomes of the working age population through targeted interventions aimed at mental health promotion in the workplace, in addition to improved working conditions.

Action: The HSE Mental Health Division should invest in mental health promotion initiatives, including supports for people with existing mental health difficulties in the workplace.

Action: A cross-Governmental approach should be taken to implement the recommendations as set out in the ESRI's report on mental health in the workplace.²⁴⁷

Action: Cross-Governmental collaboration should be developed to improve positive mental health and well-being among vulnerable groups of the working age population, including those individuals who are unemployed.

Action: Voluntary groups should be supported to build their capacity to promote mental health among their client groups, particularly for those organisations working with vulnerable individuals who are not in employment.

²⁴¹ Ibid.

²⁴² Between 2006 and 2013, student registrations had increased by 16%, while the numbers attending counselling had increased by 33%.

²⁴³ Broderick, B. (2013).

²⁴⁴ Royal College of Psychiatrists London (2011) *Mental Health of Students in Higher Education*, London: RCP, p. 12-13.

²⁴⁵ Broderick (2013).

²⁴⁶ Ibid.

²⁴⁷ Russell, H., B. Maître & D. Watson (2016) *Work-related Musculoskeletal Disorders and Stress, Anxiety and Depression in Ireland: Evidence from the QNHS*. Dublin: ESRI. 2002–2013.

Rationale

Research published by the Economic and Social Research Institute in 2016 identified the two most common types of work related illness, musculoskeletal disorders (MSD) and work related stress, anxiety and depression (SAD). In Ireland, SAD accounts for almost 20% of work-related illness.²⁴⁸

In the UK, research has shown that stress, anxiety and depression combined are the single greatest cause of absence from work.²⁴⁹ This is not solely attributed to diagnosed mental health difficulties but extends to issues relating to less than optimum mental health.

The evidence that is available suggests that 'presenteeism' (functioning at less than optimum capacity while at work) has a significantly larger impact on productivity than absenteeism. It is double the cost to the economy as it accounts for 1.5 times as much working time lost as absenteeism.²⁵⁰ A UK study estimated costs of £15.1 billion a year in reduced productivity due to 'presenteeism'.²⁵¹

In Ireland, the CIPD (Chartered Institute of Personnel and Development) has reported that stress, anxiety and depression are the leading causes of long term absence among non-manual workers. In 2008, the Mental Health Commission estimated the direct annual cost of poor mental health in Ireland at €3 billion. These costs are largely attributed to:²⁵²

- loss of potential labour supply
- unemployment
- absenteeism
- presenteeism
- reduced productivity in the workplace
- poor performance
- reduced morale and low motivation
- reduced productivity
- reduced efficiency
- faulty decision making
- poor industrial relations
- high staff turnover
- early retirement
- management time to deal with issues
- providing temporary cover
- complaints and litigation associated with problems

²⁴⁸ Ibid.

²⁴⁹ Friedli, L. (2009) p. 18.

²⁵⁰ Sainsbury Centre for Mental Health (2007) *Mental Health at Work: Developing the business case*, London: SCM (http://www.scmh.org.uk/80256FBD004F3555/vWeb/flKHAL79TMEC/\$file/mental_health_at_work.pdf).

²⁵¹ Ibid.

²⁵² Kennelly, B., O'Shea, E. (2008) *The Economics of Mental Health Care in Ireland*, Dublin: Mental Health Commission.

It is likely that the costs associated with absenteeism and presenteesim due to mental health difficulties in Ireland are significantly higher than that reported in 2008.

Other studies show that improved well-being reduces sickness absence and increases performance/productivity.²⁵³ No doubt, there is an opportunity to promote positive mental health and well-being among the working age population through targeted interventions in the workplace. See Change, the national stigma reduction partnership (aimed at bringing about positive change in public attitudes and behaviour towards people with mental health difficulties) has identified that creating workplace environments which allow for open discussion about mental health, including people's own personal experiences, can promote overall organisational and individual well-being.²⁵⁴

See Change has developed a dedicated programme to assist Irish employers in promoting mental health in the workplace, challenging mental health stigma and in effect enhancing the mental health outcomes of employees. Similar programmes have been developed by organisations such as Mental Health Ireland. IBEC (the Irish Business and Employers Confederation) has also produced guidance for employers in promoting mental well-being and understanding and supporting employees experiencing mental health difficulties while in the workplace.²⁵⁵

Such interventions must, however, be complemented by improved working conditions across the work force. Ferrie (2007) found that factors attributable to well-being in the workplace included social support, job security and control, and greater effort/reward balance.²⁵⁶ The WHO has reflected the need to improve such conditions in order to promote and protect mental health, in addition to providing early referral to workplace based support for individuals experiencing mental health difficulties or personal crises.²⁵⁷ Evidence from Sweden shows how changing employment conditions towards less job security and control is impacting upon people's health and well-being, influencing rates of cardiovascular disease, alcohol misuse and suicide.^{258,259}

The OECD has identified the high costs of mental health difficulties, not only to the individual, but to the employer and the economy. The OECD recognises that in order to address such costs, mental health difficulties must become a priority for the employment sector and every branch of social policy, including unemployment and disability.²⁶⁰ The OECD recommends an integrated approach which addresses these key issues:

²⁵³ Harter et al. 2003; Cropanzano and Wright 1999; Wright and Staw 1999; Lyubomirsky et al. 2005; Pelled and Xin 1999; Keyes 2005.

²⁵⁴ In addition to promoting overall well-being, work place initiatives can result in reduced absenteeism, enhance employee stress management skills, reduce cost associated with absenteeism, employee relations issues, enhance talent retention and acquisition and can assist employers in developing systems to support the 1 in 4 employees who may experience mental health difficulties at a given point.

²⁵⁵ IBEC (2016) Mental health and wellbeing: A line manager's guide. Dublin: IBEC.

²⁵⁶ Ferrie, J.E. (ed.) (2007) *Work, stress and health: Findings from the Whitehall II study*. London, Cabinet Office/University College London.

²⁵⁷ Friedli, L. (2009).

²⁵⁸ Commission on Social Determinants of Health (CSDH) (2007) *Achieving health equity: from root causes to fair outcomes*: interim statement Geneva, CSDH (http://www.who.int/social_determinants/resources/interim_statement/en/index.html).

²⁵⁹ In terms of good practice, in France, Electricite de France and Gaz de France have implemented the APRAND programme (Action de Prévention des Rechutes des troubles Anxieux et Dépressifs). This programme focuses on action to promote mental health and prevent relapse of depression and anxiety disorders. For early identification of people at risk, individuals on sick leave were asked to meet with company occupational health physicians. Individuals meeting screening criteria were placed on a health promotion programme involving the provision of information on "their mental health condition" and a recommendation to consult with their general practitioner, occupational physician or psychiatrist. Overall this group had a significantly higher rate of recovery as compared with individuals in a control group.

²⁶⁰ OECD (2015) *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, Mental Health and Work, Paris: OECD Publishing.

- early intervention is required. Interventions often come too late and should be focused on keeping individuals in education and employment as opposed to intervening after people have left the labour market. Sickness and unemployment schemes also need to respond in a timely manner to help people who are out of work get back into employment
- integrated service provision between education, employment and health is required. People with mental health difficulties often have interlinked social and economic problems which require an integrated response. Currently, supports and services are often delivered in silos
- sectors, services and professionals operating outside of specialist mental health services have a key role to play in improving the employment outcomes of people with mental health difficulties

The OECD Mental Health and Work Policy Framework provides a series of general policy conclusions for all OECD countries, including recommendations to:²⁶¹

- help young people through mental health awareness and education policies
- strive for an employment orientated mental health care system
- improve workplace policies and employer supports and incentives
- make benefits and employment services fit for people with mental health difficulties

In effect, an integrated, early intervention approach is required in order to 1) improve the employment outcomes of people with mental health difficulties and 2) improve the mental health outcomes of employees.

Vulnerable groups of individuals, including those who are unemployed, should also be targeted through mental health promotion programmes. The WHO has identified the relationship between mental health [difficulties], deprivation and inequality, which requires a targeted approach.²⁶²

Mental health difficulties are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education, low income, or material standard of living, in addition to poor physical health and adverse life events.²⁶³ At a European level, 26% of the population living in poverty (measured in terms of low income and multiple deprivation of necessities) has the highest prevalence of anxiety and depression.²⁶⁴

There is a need to develop mental health promotion programmes that target individuals from disadvantaged groups, including individuals who are unemployed and experience low levels of income and deprivation. In the development of such programmes, it is of fundamental importance that individual mental health difficulties are considered in the context of social and economic circumstances. The relationship between mental well being and wider health determinants such as housing, employment, education and income must be taken into account. Evidence to this effect must inform the design of mental health promotion, prevention and care across the spectrum of mental health difficulties.

²⁶¹ OECD (2015) OECD High-Level Policy Forum on Mental Health and Work Bridging Employment and Health Policies. Paris: OECD Publishing.

²⁶² Friedli, L. (2009), p.iii.

²⁶³ Ibid.

²⁶⁴ Melzer D, Fryers T, Jenkins R. (2004) *Social Inequalities and the Distribution of Common Mental Disorders*. Maudsley Monographs Hove, Psychology Press.

Connecting for Life identifies specific groups of individuals, including people who are unemployed, as at increased risk of suicide. It includes a commitment to the continued development of mental health promotion programmes with and for priority groups, and to increase awareness of mental health services and supports among such individuals.²⁶⁵ At a broader level, the strategy includes a commitment to develop and implement a national mental health and well-being plan and to deliver coordinated communication campaigns (such as the Little Things campaign, 2014) for the promotion of mental health and well-being among the whole population, with a focus on protective health behaviours and consistent signposting to relevant support services.²⁶⁶

There is evidence to suggest that reducing social inequalities can have a positive impact on health outcomes, including mental health outcomes. A preliminary analysis suggests that higher national levels of income inequality are linked to a higher prevalence of mental health difficulties.²⁶⁷

Therefore, in addition to developing mental health promotion programmes which take account of social and economic factors, a whole-of-Government approach is required to improve quality of life for disadvantaged groups and reduce inequality. The WHO has identified priorities for action for improving mental health and well-being across the population, as set out at the beginning of this chapter.²⁶⁸

Recommendation 7: All Government policy should be ‘mental health proofed’ to ensure that it protects and promotes the mental health of Ireland’s population, and in effect improves mental health outcomes.

Rationale

The Independent Monitoring Group on *A Vision for Change* recommended that “significant memoranda to Government should be mental health proofed to ensure that the proposals do not adversely affect people with mental health difficulties”.²⁶⁹

Indeed, Government should consult with the Department of Health, the HSE Mental Health Division and other relevant agencies and stakeholders on the development of policy and legislation to ensure that it adequately considers the mental health impact on the whole population.

The WHO recognises that mental health influences a very wide range of outcomes for individuals and communities, including educational attainment, general health and employment. It is both a cause and a consequence of social and economic status. The WHO further identifies that in order to improve the mental health outcomes of the population, Government must focus on facilitating a “policy sea change” in which “policy makers across all sectors think in terms of mental health impact”.²⁷⁰ The social, cultural and economic determinants of mental health must be addressed through wider national policy and legislation, including in areas such as housing, employment, education, justice and social protection, in order to make improvements to mental health outcomes.

²⁶⁵ National Office of Suicide Prevention (2015).

²⁶⁶ Ibid.

²⁶⁷ Pickett, K.E., James, O.W., Wilkinson, R.G. (2006) *Income inequality and the prevalence of mental illness: a preliminary international analysis*. *Journal of Epidemiology and Community Health* 60;646-647.

²⁶⁸ Friedli, L. (2009).

²⁶⁹ The Independent Monitoring Group (2011) *A Vision for Change – the report of the Expert Group on Mental Health Policy. Fifth annual report on implementation 2010*, Dublin: Department of Health, p. 67.

²⁷⁰ Friedli, L. (2009), p. iv.

The EU Joint Action for Mental Health and Well-being has recently identified the Mental Health in All Policies (MHiAP) approach as one of its key priorities.²⁷¹ It defines MHiAP as follows:

“Mental health in all policies (MHiAP) is an approach to promote population mental health and well-being by initiating and facilitating action within different non-health public policy areas. MHiAP emphasises the impacts of public policies on mental health determinants, strives to reduce mental health inequalities, aims to highlight the opportunities offered by mental health to different policy areas, and reinforces the accountability of policy-makers for mental health impact”.²⁷²

Of fundamental importance is that the MHiAP approach promotes:

- positive mental health and well-being
- the prevention of mental health difficulties
- early intervention and
- support for the recovery of individuals with existing mental health difficulties

This approach is further endorsed in the European Framework for Action on Mental Health and Well-being 2016. A key objective of the framework is to:

“Develop mental health promotion and prevention and early intervention programmes, through integration of mental health in all policies and multi-sectoral cooperation”. In line with the WHO, the Joint Action Group has concluded that in order to improve the mental health outcomes of the population “mental health needs to be incorporated in all [Government] policies and at all levels”.²⁷³

This approach is clearly reflected in Together for Mental Health - A Strategy for Mental Health and Well-being in Wales. The strategy identifies a range of protective factors for mental health and well-being, in addition to a number of risk factors for mental health difficulties. In the UK, work is being developed on the MHiAP approach following on from the Government’s report No Health Without Mental Health.

A number of measures have been recommended at European level to support the implementation of the MHiAP approach. These include the development of tools for implementation of MHiAP, such as mental health impact assessments.

There is no doubt that mental health is a growing health, social and economic issue. The WHO’s Commission on Social Determinants of Health stated that ‘depressive mental illnesses’ will be the leading cause of disease in high income countries by 2030.²⁷⁴ Ultimately what is required is a “shift in consciousness and a recognition that mental health is a precious resource to be promoted and protected at all levels of policy and practice”.²⁷⁵ This is crucial in order to improve positive mental health outcomes among Ireland’s population and to reduce the direct and indirect costs associated with mental health difficulties.

²⁷¹ Joint Action on Mental Health and Well-being (2015) Mental Health in All Policies: Situation analysis and recommendations for action. Available at <http://www.mentalhealthandwellbeing.eu/publications>.

²⁷² Ibid.

²⁷³ Joint Action on Mental Health and Well-being (2015).

²⁷⁴ CSDH (2008) Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

²⁷⁵ Friedli, L. (2009).

Recommendation 8: In relation to mental health promotion, an audit is required of all HSE health services to measure the extent to which they incorporate mental health promotion. This should help to identify the gaps in links between physical and mental health care within the physical health services. An evaluation of the mental health promotion services provided by HSE suicide prevention and health promotion officers, in addition to other HSE led/funded programmes is also required.

Chapter 4: Mental health in primary care

The WHO has recognised that mental health in primary care is “fundamental”,²⁷⁶ that it is the first level of care within the formal health system and the “most viable way of closing the treatment gap and ensuring that people get the mental health care they need”.²⁷⁷ Services at the primary care level are generally the most accessible, affordable and acceptable for communities. Where mental health is integrated as part of these services, access is improved, mental health difficulties are more likely to be identified and treated, and co-morbid physical and mental health difficulties managed in a seamless way.

The Expert Group on *A Vision for Change* recognised that the primary care sector holds responsibility for the delivery of 90% of mental health care and that most people who experience a mental health difficulty will have their needs met at this level.²⁷⁸ It clearly recommends the need to prioritise the full range of mental health services from primary to specialist mental health services for both adults and children.

Mental Health Reform recommends that Government uphold the existing recommendations in *A Vision for Change* on mental health and primary care, including the Expert Group’s recommendations on the following:

- implementation of the consultation/liaison model to ensure effective communication between
- primary care and specialist mental health services²⁷⁹
- provision of a comprehensive range of interventions in primary care for mental health difficulties²⁸⁰
- delivery of appropriate mental health training among GPs across the country.²⁸¹ MHR is of the view that such training should be extended to other primary care professionals, including, for example, public health and practice nurses
- research and information on the prevalence of mental health difficulties and the interventions provided to effectively plan primary care services and the interface between primary care and specialist mental health services²⁸²

More recently, a commitment has been made within the Programme for Partnership, 2016 to ensure greater access to mental health services in primary care. However, despite a recognition at both national and international level of the importance of mental health in primary care for both adults and children, eleven years on from *A Vision for Change* such supports are not routinely available across the country.

A key recommendation of the Children’s Mental Health Coalition (CMHC) in its report on meeting the mental health support needs of children and adolescents in Ireland is to:

²⁷⁶ Mental health is central to the values and principles of the Alma Ata Declaration - holistic care will never be achieved until mental health is integrated into primary care.

²⁷⁷ WHO & WONCA (2008) *Integrating mental health into primary care A global perspective*, p. 11.

²⁷⁸ AVFC (2006) p. 60.

²⁷⁹ *Ibid.*, p. 68.

²⁸⁰ *Ibid.*

²⁸¹ *Ibid.*

²⁸² *Ibid.*

“build the capacity of the primary care sector to provide comprehensive mental health services...., including early intervention, detection, appropriate interventions and referral where necessary”.²⁸³

This recommendation was developed based on a review of the national and international literature on good practice in the delivery of mental health services in primary care settings.²⁸⁴ The literature identified fundamental gaps in mental health in primary care, which led to the identification of specific measures to address such shortfalls, including:

- the development and implementation of a clear framework for collaboration and referral between mental health services – voluntary, community, primary care and specialist mental health services
- the provision of effective consultation and advice by specialist mental health services to the primary care sector and other specialist services
- the adequate resourcing of the primary care sector to provide mental health services, including the appointment of primary care mental health workers and the reimbursement of GPs for their time on mental health
- the delivery and evaluation of appropriate training, supervision and support in mental health for GPs and other primary care professionals across the country

There are serious concerns that a number of individuals, particularly children and adolescents, referred to specialist mental health services could be supported within the primary care setting, given the appropriate supports. However, due to a lack of investment in mental health in primary care to date, some people who could have their needs met at this level end up on waiting lists for secondary services which are already overstretched and under-resourced. Moreover, during this waiting period, mental health difficulties experienced by individuals may worsen and/or be exacerbated. At the end of March 2017, over 2,800 children and adolescents were waiting for a first appointment with CAMHS, of which almost 280 (i.e.10%) were waiting over one year.²⁸⁵

In addition to the existing recommendations set out in *A Vision for Change*, the updated policy should reflect the following recommendations. Consideration should also be given to international evidence-informed good practice guidelines on the assessment, diagnosis and treatment of mental health difficulties at primary care level, available from the World Health Organisation, the American Academy of Pediatrics Task Force on Mental Health, and the National Institute for Clinical Excellence (NICE) in the UK.

Recommendation 1: Increase the number of mental health workers in primary care services across the country to a minimum of one dedicated mental health post per primary care team in order to build capacity at primary care level to meet the mental health needs of adults and children.

Action: The HSE Mental Health Division, in collaboration with the HSE Primary Care Division, should appoint mental health workers in each primary care team across the country. Existing mental health workers, in addition to any new workers, should be appropriately trained and such training should be monitored and evaluated on an ongoing basis.

²⁸³ CMHC (2015).

²⁸⁴ Kerin, L. (2015).

²⁸⁵ HSE (2017) *Performance Assurance Report January - March 2017*, Dublin: HSE.

Rationale

Mental Health Reform, in June 2017, 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 higher. This will ensure that individuals accessing services are receiving mental health support from fully qualified professionals.

The CMHC 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 is 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.²⁸⁶ 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”.²⁸⁷ 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, which 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.”²⁸⁸

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

²⁸⁶ Eapen, V. & Jairam, R. (2009). “Integration of child mental health services to primary care: challenges and opportunities”. *Ment Health Fam Med*. Mar 2009; 6(1): 43–48.

²⁸⁷ WHO (2008).

²⁸⁸ 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.

adherence, trauma reduction, referral to specialist mental health services and/or community agencies”.²⁸⁹

The UK has significantly invested in creating and expanding this role of PCMHs in the workforce to bridge the gap between primary health care and secondary mental health services. A comprehensive discussion, evaluation findings and core competencies for primary mental health workers were published in the UK national CAMHS review, 2008.²⁹⁰

In addition, 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.

Recommendation 2: The development of talking therapies (including primary care psychology) within the primary care sector to ensure that the mental health needs of the population are addressed at the lowest possible level of the mental health system.

Action: The HSE should develop a national action plan (including a recruitment plan) for the development of talking therapies throughout all parts of the country.

Action: The HSE should carry out an assessment of the number of psychologists/psychotherapists/other counsellors required at primary care level.

Action: The Department of Health should introduce a regulatory framework under the remit of CORU, Ireland’s multi-profession health regulator, for talking therapies in Ireland with a statutory regime governing the registration of psychologists, psychotherapists and counsellors.²⁹¹

Rationale

One of the strongest messages to come out of the consultation that fed into *A Vision for Change* was that people with mental health difficulties want alternatives to medication, including access to talking therapies. *A Vision for Change* states that “...the consensus among users and service providers was that psychological therapies should be regarded as a fundamental component of basic mental health services, rather than viewed as additional options that are not consistently available.”²⁹² This view was reiterated in the Independent Monitoring Group’s consultation

²⁸⁹ WHO (2008).

²⁹⁰ Department of Health (2008) *Children and Young People in Mind: The final report of the national CAMHS review*. NHS, UK.

²⁹¹ For over a decade, numerous bodies involved in ‘talking therapies’ as well as the wider mental health sector have been articulating their concern over the lack of statutory regulation for psychologists, counsellors and psychotherapists in Ireland and have called for these professions to be included under the Health and Social Care Professionals Act 2005. Mental Health Reform has previously called for the progression of the regulation of these professions in its 2013 paper, *Mental Health in Primary Care in Ireland*.

²⁹² AVFC (2006), p. 13.

meetings held in 2012 by the HSE²⁹³ and in Mental Health Reform's consultation meetings carried out in recent years.

The 2001 primary care strategy sought to promote a team-based, multidisciplinary approach to primary care that included "psychological expertise". It was acknowledged that providing mental health support through primary care, including the provision of psychological supports, would make mental health support accessible to more people.²⁹⁴

There is also sufficient evidence demonstrating that psychotherapy is an effective treatment. An Irish review of the evidence has found that psychotherapy either alone or in combination with other treatments/supports is effective for a wide range of mental health diagnoses in adults, young people and children.²⁹⁵ The average success rate for participants in psychotherapy is 65-72%, and a majority of clients would require 20-45 sessions in order to recover.²⁹⁶

The WHO argues that there can be successful treatment of depression in primary care using a combination of medication and psychotherapy/counselling,²⁹⁷ while a 2007 study in the UK provides evidence that counselling in primary care brings slight improvements compared with normal GP care and that service users are very happy with such counselling.²⁹⁸

There is also evidence that providing counselling through primary care is cost-effective. The HSE Working Group on Mental Health in Primary Care cited a 2001 UK study, which found that counselling led to savings in the UK. There were fewer referrals to National Health Service (NHS) Out-Patient Services and fewer GP consultations in the year after counselling.²⁹⁹ In the UK, the National Institute for Health and Clinical Excellence (NICE) advocates that the NHS should provide "psychological therapies".³⁰⁰

Despite a recognition at national and international level of the importance and effectiveness of different talking therapies, there appears to be a continued over-reliance on medication and a dearth of talking therapies at primary care level, with no such supports available in certain areas. In 2012, the HSE acknowledged that there were "significant gaps in provision and access to psychological therapies in Ireland with an over reliance on medication."³⁰¹ As recently as 2015, people with experience of mental health difficulties reported that this form of "holistic" treatment [talking therapies] was "delivered in a positive way and in an effective manner"....but that there were significantly long waiting lists and a lack of supports in local areas.³⁰²

²⁹³ HSE National Vision for Change Working Group (2012).

²⁹⁴ HSE (2005) *Primary care strategy: making it happen: a framework action plan for local implementation in the Eastern Region*, Dublin: HSE.

²⁹⁵ Carr, A. (2007) *The Effectiveness of Psychotherapy: A Review of Research prepared for the Irish Council of Psychotherapy*, Dublin: Irish Council of Psychotherapy.

²⁹⁶ Ibid.

²⁹⁷ WHO (2003). *Mental Health Policy and Service Guidance Package: The Mental Health Context*. Geneva: WHO.

²⁹⁸ Taylor, et al. (2007) *Public health interventions to promote positive mental health and prevent mental health disorders among adults: Evidence Briefing*, National Institute for Health and Clinical Excellence, available at http://www.nice.org.uk/about/nice/whoweare/aboutthehda/hdapublications/public_health_interventions_to_promote_positive_mental_health_and_prevent_mental_health_disorders_among_adults.jsp

²⁹⁹ Mellor-Clarke (2001) *Counselling in Primary Care in the Context of the NHS Quality Agenda: The Facts*. British Association for Counselling and Psychotherapy, cited in Guidance Document on the Provision of Counselling in a Primary Care Setting by the HSE Working Group on Mental Health in Primary Care, p. 3.

³⁰⁰ Mental Health Foundation, Mind, rethink, The Sainsbury Centre for Mental Health & YoungMinds. (undated) *We need to talk: The case for psychological therapy in the NHS* available at <http://www.mind.org.uk/assets/0000/1929/weneedtotalkreport.pdf>

³⁰¹ HSE (2012).

³⁰² Mental Health Reform's public consultation meetings 2015.

Primary care services are often the first point of referral for many children and adults with mental health needs. However, the current system of talking therapies, including primary care psychology, requires additional resources to address the increasingly high demand on the existing service. Enhancing such supports would ensure the development of an integrated service that meets the mental health needs of the population at all levels of care.³⁰³

Recommendation 3: The expansion of the Counselling in Primary Care service (CIPC) beyond medical card holders in order to meet the counselling needs of low to middle income individuals with mild to moderate mental health difficulties. The limit on the number of counselling sessions to be made available to each individual should be increased to 20.

Action: The HSE should enhance public awareness of the CIPC service, particularly among low income families and individuals who may be in need of such counselling supports.

Rationale

The Counselling in Primary Care service, although a positive initiative, 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.

In 2014, CIPC was allocated a development budget of €3.8 million, which represents just one half of one percent of the mental health service budget.³⁰⁴ This compares to investment of £300 million for the Increasing Access to Psychological Therapies (IAPT) service in the UK, representing 5% of the UK mental health spend.³⁰⁵

The demand for CIPC is steadily growing and the number of referrals to the service has increased by almost 30% between 2014 and 2016.³⁰⁶ 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 months.³⁰⁷ Under the UK's IAPT service, the target is that 75% of referrals would be seen within six weeks and 95% within 18 weeks.³⁰⁸

Mental Health Reform welcomes the commitment in the Programme for Government to “extend counselling services in primary care to people on low income”.³⁰⁹ It is imperative 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.³¹⁰

³⁰³ In May 2017, 114 assistant psychologist posts were sanctioned by the Department of Public Expenditure and Reform for recruitment to HSE primary care services.

³⁰⁴ See HSE Mental Health Division Operational Plan 2014, p. 21.

³⁰⁵ Department of Health (2012) IAPT Three Year Report: The First Million Patients. Department of Health: UK.

³⁰⁶ Information provided by CIPC.

³⁰⁷ Ibid.

³⁰⁸ 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/>

³⁰⁹ Department of the Taoiseach (2016)

³¹⁰ Information provided by CIPC.

The existing limitations of the Counselling in Primary Care service, in addition to the increasing demand on 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 increase the number of individuals returning to work who may be absent 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.³¹¹ 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

Recommendation 4: The development of a national action plan in order to implement the ‘shared care’ approach between primary and specialist mental health services.

Action: The HSE’s Clinical Care Programme Lead on Mental Health, in collaboration with the Clinical Care Programme Lead on Primary Care, should develop an implementation plan for its guidance paper *Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services*. The development of this plan should be informed by consultation with all relevant groups, particularly the Irish College of General Practitioners (ICGP) and the College of Psychiatrists of Ireland (CPI) and should address any existing gaps in the HSE’s guidance paper.³¹²

Action: The HSE should extend referral pathways beyond GPs and psychiatrists to other members of the primary care team, in order to improve access to specialist mental health services.³¹³

Action: The HSE should implement its Clinical Care Programme on early intervention in psychosis in full.

Rationale

The need for a shared care approach between primary care and specialist mental health services is already recognised in national policy. *A Vision for Change* recommends that clear links be “developed between mental health services and primary care/community resources, to coordinate

³¹¹ Department of Health (2012).

³¹² HSE (2012).

³¹³ HSE Primary Care and Mental Health Working Group, op. cit., p. 20.

appropriate service provision for [individuals] at risk of mental health problems”.³¹⁴ The principles of shared care are further endorsed by the Mental Health Commission³¹⁵ and the World Health Organisation.³¹⁶

In the UK, a report by the Department of Health on improving the mental health outcomes of children and young people recognised the importance of the shared care approach. Specifically, it recommends that “there is a dedicated named contact point in targeted or specialist mental health services for every primary care provider, including GP practices. Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers”.³¹⁷

The Children’s Mental Health Coalition has previously recommended that primary care providers be supported through access to specialist mental health staff. Structures to enable this include facilitating primary care access to specialised mental health consultation, co-location of mental health staff in primary care settings and the delivery of appropriate training programmes for primary care providers in child and adolescent mental health.

The benefits to ‘shared care’ are widely evidenced and include the following:

- enabling GPs to learn about mental health from specialists
- creating a clear pathway between primary and secondary care
- reducing referrals to secondary care for mild mental health difficulties

Despite this common understanding, and the fact that in a study of Irish psychiatrists, 35% ranked shared care as the area in most need of improvement in delivering mental health services in primary care,³¹⁸ there continues to be a fundamental gap in collaborative working between the two tiers. The CMHC has previously reported concerns regarding the dearth of national primary care mental health supports and barriers between Tier 1 and Tier 2 services. This is profoundly illustrated by the results of the Coalition’s small-scale survey which shows the bewildering number of agencies involved in children’s mental health care.³¹⁹ It documents these agencies mutual frustration at the lack of communication and coordination between the various stakeholders involved, including between primary and secondary services.

While the HSE’s Guidance Paper on a ‘shared care approach’ to primary care and mental health services falls short of being a national, binding policy, it provides valuable support for the development of a shared care approach for mental health service delivery. In order to ensure the effective implementation of a shared care approach in all areas of the country, direction at national level is imperative. This could be supported through collaboration between the HSE’s respective Clinical Care Programme Leads on Mental Health and Primary Care on the development of a

³¹⁴ AVFC (2006), p. 6.

³¹⁵ Byrne, M. & Onyett, S. (2010), *Teamwork within Mental Health Services in Ireland: Resource paper*, Dublin: Mental Health Commission, p. 15.

³¹⁶ WHO (2005) *Mental Health Policy, Plans and Programmes (updated version 2)*, Geneva: WHO.

³¹⁷ Department of Health (2016) *Future in Mind: Promoting, protecting and improving our children and young people’s mental health and well-being*. DoH: UK.

³¹⁸ Coptly, M. (2004) *Mental Health in Primary Care*, Dublin: Health Service Executive/Irish College of General Practitioners, p. 22.

³¹⁹ Work Research Centre (2015) Mapping exercise to ascertain the range and configuration of children’s and young people’s primary, secondary and tertiary mental health services and supports: survey results. Available at <http://www.childrensmentalhealth.ie/wp-content/uploads/2015/03/Childrens-Mental-Health-Coalition-mapping-survey.pdf>.

dedicated action plan. There is also the potential to utilise the mental health area leads and primary care area leads under the new CHO structure to drive, support and monitor the implementation of any action plan that is developed.

In addition, the Mental Health Commission has recommended that a 'stepped care' model be adopted, which can further specify the 'shared care' approach, minimise inappropriate referrals and make best use of resources.³²⁰ In accordance with this model, individuals are matched to different therapies that vary in length and intensity based on their individual needs, with the aim being to allocate each person to the least intensive treatment likely to meet their needs. The stepped care model is flexible and operates on certain fundamental principles that keep it in line with recommendations from research.³²¹ Individuals experiencing mental health difficulties should be provided with supports that encompass a stepped care approach to ensure that their needs are being met at the most appropriate level.

Recommendation 5: Primary care services should facilitate integrated care for individuals with a dual diagnosis of mental health difficulties and alcohol/substance misuse where the individual does not require specialist mental health services.

Action: The HSE should fully implement the commitment in the primary care strategy *Primary Care: A New Direction* that primary care services will “cover the general aspects of both mental health and ‘drug misuse’”.³²²

Rationale

Primary care professionals play an important role in supporting individuals with dual diagnosis, “starting from initial detection, diagnosis and referral through to ongoing support where an individual has been discharged from specialist services”. “Primary care may also have a role to play in meeting the physical health needs of individuals with a dual diagnosis who are at higher risk of physical health problems than the general population”.³²³

There is growing recognition that individuals with mild or moderate mental health difficulties and problematic substance or alcohol use are likely to present to primary care services. In the UK, this recognition has given rise to guidance for the primary care psychological therapies services on how to address dual diagnosis.³²⁴

In addition, the American Academy of Pediatrics Task Force on Mental Health has developed strategies for preparing primary care services in the provision of enhanced mental health care

³²⁰ Byrne, M. & Onyett, S. (2010), p. 15.

³²¹ First, treatment is delivered on the basis that it should always have the best chance of delivering positive outcomes, while burdening the individual as little as possible. Treatment is provided according to the individual's particular needs, a variety of empirically validated therapies are provided by practitioners who are either trained to deal with high-intensity or mild-moderate difficulties, and the individual has a say in which treatment programme they are allocated to. In addition, a system of review is put in place so that any individuals who are not improving or deteriorating can be “stepped up” to more intensive treatments if necessary, while others can be “stepped down” to a less intensive treatment or “stepped out” of therapy altogether when appropriate.

³²² Department of Health (2001) *Primary Care: A New Direction*, Dublin: Department of Health p. 26.

³²³ Drug Scope/UK Drug Policy Commission/Centre for Mental Health (2009) *Dual Diagnosis: A Challenge for the Reformed NHS and for Public Health England* available at <http://www.ukdpc.org.uk/publication/dualdiagnosis-challenge-reformed-nhs/>

³²⁴ *Ibid.*

services.³²⁵ Such guidance provides recommendations on caring for children with mental health and substance abuse difficulties.

The prevalence of co-morbid mental health difficulties and substance misuse is considerably high, and is set out in further detail in chapter 9. However, Mental Health Reform continues to hear reports of both statutory and voluntary service providers outside the mental health system having difficulty getting mental health support for their service users (adults and children) who have a dual diagnosis. It is clear that there are structural gaps that militate against good quality, integrated support for individuals with a dual diagnosis in primary care, which must be addressed through revised mental health policy.

Recommendation 6: Free access to primary care should be provided to individuals who require long-term mental health care.

Action: The HSE should provide medical cards to all individuals who require long term mental health treatment.

Action: The Departments of Social Protection and Health should work collaboratively to implement the recommendations of the *Make Work Pay report for People with Disabilities*, relating specifically to the medical card. This should be achieved within the agreed timeframes.

Rationale

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.³²⁶ 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.

A recent report on homelessness and mental health documents that some of the service user participants expressed that without a medical card, they experienced difficulties in accessing [mental health] support.³²⁷

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 people with mental health disabilities.

³²⁵ American Academy of Pediatrics, Task Force on Mental Health (2010) *Enhancing pediatric mental health care: strategies for preparing a community*. Pediatrics.125(3 suppl): S75–S86.

³²⁶ Nolan, A. & Nolan B. (2004) *Ireland's Healthcare System: Some issues and challenges*, Dublin: ESRI.

³²⁷ Mental Health Reform (2017) *Homelessness and Mental Health: Voices of Experience*, Dublin: MHR.

The recent publication of the *Make Work Pay for People with Disabilities* report documents that “the potential loss of the Medical Card [has been reported] as the single most important disincentive to taking up employment”.³²⁸

The report further identifies that “Ireland (along with the US) appears to be unusual amongst OECD countries in that people must forfeit entitlements to free medical care on taking up work, which occurs at relatively low levels of income”.³²⁹ The OECD’s Report (2015) *Breaking the Barriers: A Synthesis of Findings Across OECD Countries* argued that health and other entitlements related to a person’s disability should not be affected by benefit or labour market status.

While people who have been on a disability payment for at least a year can retain a medical card for a further three years on return to work, “people with lifelong conditions generally do not see this temporary retention as sufficient, in that it does not offer the security of continued access to the Medical Card, and the supports it brings”.³³⁰ In addition, people with disabilities, particularly those with intermittently-occurring symptoms, have real concerns about how difficult and how quickly they could get their different benefits (including the medical card) restored in a situation where employment does not work out.

Overall, the medical card, including retention of this benefit, is of crucial importance for people with (mental health) disabilities. Participants of the *Make Work Pay* report expressed that eligibility for the medical card should be based on factors other than purely means, such as disability or health status. 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.

Recommendation 7: A national evaluation of mental health care delivery in primary care settings, among GPs and other primary care professionals, should be delivered. This evaluation should assess whether existing training delivered to GPs and other disciplines in mental health is being implemented effectively and meeting the needs of both adults and children.

Action: The HSE Mental Health Division, in collaboration with the ICGP and other professional associations, should roll out an evaluation of mental health care delivery in primary care settings across the country. Any gaps identified in the evaluation should be addressed through the development of a dedicated action plan.

Action: For the purposes of continuous professional development, the relevant professional associations³³¹ should develop national training programmes for qualified trainees in the area of mental health in primary care. This should build on previous training courses, such as that provided by DCU, in partnership with the ICGP and the HSE. The potential for online training should also be considered in this context.

³²⁸ Make Work Pay Interdepartmental Group (2017) *Make Work Pay for People with Disabilities Report to Government* 2017. Dublin: Department of Social Protection.

³²⁹ Ibid.

³³⁰ Ibid.

³³¹ Such training should be delivered across the various disciplines operating at primary care level, including GPs, psychologists, OTs, social workers and nurses (public health and practice nurses).

Action: A specific component on child and adolescent mental health should be included in the core curriculum for trainee GPs and other primary care professionals. Where adult mental health in primary care is not included in trainee curricula across the disciplines, this should be addressed as a matter of priority.

Action: The HSE should promote awareness among GPs and other primary care professionals across the country of opportunities for training in mental health. Incentives should be provided for such professionals to engage in such training.

Rationale

There is significant international evidence that suggests that primary care professionals, including GPs, should be appropriately trained in mental health. In a paper summarising findings for the European Region of the WPA Task Force on ‘Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care’, Semrau et al. (2011)³³² note insufficient training for primary care staff frequently results either in mental health problems not being recognised or in treatment methods being unknown.

The recent UK report *Future in Mind* recognises that universal services, including general practice, play a key role in preventing mental health difficulties. “General Practice and the primary care team have an important part to play in supporting families, children and young people to develop resilience and in identifying and referring [mental health difficulties] early. There is significant potential in that the GP practice is a less stigmatising environment than a mental health clinic and many GPs have improved accessibility to....people”.³³³

In Ireland, the draft iCAMHS guidelines reports that it is the role of GPs “to recognise risk factors for mental health disorders, to provide treatment or advice where appropriate, and to refer to more appropriate community care personnel or specialist services when this is indicated”.³³⁴

The guidance document issued by the *Vision for Change* Working Group on Mental Health in Primary Care made a key recommendation that professionals are facilitated to attend a module run by DCU called ‘Team Based Approaches to Mental Health in Primary Care’.³³⁵ Unfortunately, to date, only 100 primary care professionals (approximately) have taken part in the mental health training provided through DCU.

Despite the development of a range of materials and training programmes to support GPs in mental health care, including mental health as a module in the core curriculum of trainee GPs, there is a lack of evidence as to how such training is implemented in practice. There is a real concern that individuals are often not getting appropriate support, whether it be assessment, treatment and/or referral from their GPs, where they present with a mental health difficulty.

As part of MHR’s 2011 consultation with service users it was noted that there was a lack of knowledge among GPs about mental health issues and that many GPs were not aware of mental health support services available in the community. In a number of Mental Health Reform’s public

³³² Semrau, M. et al. (2011). “Lessons learned in developing community mental health care in Europe”. Institute of Psychiatry, King’s College London, UK. *World Psychiatry* 2011;10: 217-225.

³³³ Department of Health (2015).

³³⁴ CAMHS Specialist Child and Adolescent Mental Health Service Advisory Group, (2013), Irish Child & Adolescent Mental Health Service (iCAMHS) National Quality Guidelines Document. Unpublished draft pending HSE approval since October 2013.

³³⁵ *Ibid.*

meetings in 2013 and 2014, people raised the issue of GP knowledge of mental health, with one individual saying that “some GPs admit they’ve never dealt with certain problems before and they don’t know what to do.” Mental Health Reform’s Grassroots Forum has expressed concerns about the lack of information provided by GPs on medications and have identified a need for enhanced information provision on the potential risks and benefits to prescription drugs within the primary care setting.

In relation to children and young people, Irish guidelines for GPs on the diagnosis and referral of child and adolescent mental health in primary care settings have been issued by the Irish College of General Practitioners (ICGP).³³⁶ However, there appears to be a gap in the provision of training, at national level, for primary care professionals, including GPs, in child and adolescent mental health. In addition, where GPs and other professionals do possess training in this area, there is no evidence as to how this translates in practice.

Furthermore, the lack of reimbursement of GPs for their participation in the current Irish shared care system is identified in the literature as a fundamental barrier, among others, to the efficacy of an accessible, collaborative model that could improve mental health services in primary care.³³⁷ Adequate financial and human resource investment is one of the key ‘non-negotiable’ conditions critical to ensure successful integration of first line mental health services into primary care. Primary care clinicians must be reimbursed for the investment of their time on restructuring services to encompass child and adult mental health, training on mental health, as well as their time spent in the development of collaborative clinical relationships with mental health specialists.

Recommendation 8: The SCAN (Suicide Crisis Assessment Nurse) programme should be expanded so that it is provided in all primary care centres across the country. The extension of the programme beyond existing hours of service should also be considered.

Action: The HSE should extend SCAN to liaise with homeless services. Guidance should be developed by the HSE on effective inter-agency working between SCAN and homeless services.

Action: The HSE should implement the recommendations of the research report on the evaluation of the SCAN service.³³⁸

Action: The HSE should extend the SCAN programme/model to under 18’s.

Rationale

The Suicide Crisis Assessment Nurse (SCAN) service 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 individuals than traditional mental health services.³³⁹ The evaluation also found that SCAN may result in lower costs or at least better health outcomes at relatively low cost.³⁴⁰

³³⁶ O’Keefe et al. (2013) Child and Adolescent Mental Health Diagnosis and Management, CAMHS Quality in Practice Committee. Dublin: ICGP.

³³⁷ American Academy of Pediatrics Task Force on Mental Health. (2009). Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration. *Pediatrics*. 2009;123(6):1611].

³³⁸ HSE (2012) *Research Evaluation of the Suicide Crisis Assessment Nurse (SCAN) Service* available at <http://www.nosp.ie/scan-report-2012.pdf>.

The expansion of SCAN services to under 18s should also be considered. Given the high prevalence of self-harm and suicide among children and young people in Ireland, a range of response measures should be developed as a matter of priority. Further information on self-harm and suicide rates is provided in chapter 5.

Recommendation 9: Mental health in primary care services for children and young people should be delivered in a youth-friendly manner.

Rationale

The CMHC’s literature review on meeting the mental health support needs of children and young people identified that “although General Practice is acknowledged as the place [where most mental health difficulties first present],³⁴¹ the international evidence is that young people experience a range of barriers to accessing mental health support in primary care.³⁴² These barriers range from organisational obstacles such as service design or service delivery in ways that young people don’t want to engage with, or attitudinal barriers, such as the fear of being stigmatised for having a mental health difficulty”.

One of the key recommendations from the PERL study is to “ensure that, when young people do seek help, quality, youth-friendly mental health services and supports will be available and accessible to them.”³⁴³

A useful good practice guide has recently been developed in the UK to help GPs and other primary care professionals to develop youth-friendly practice, and to better identify and address the mental health needs of the young people who come to see them.^{344,345} No doubt, considerable learning can be gained from the practices of Jigsaw, which has delivered youth friendly mental health supports across Ireland in recent years.

Recommendation 10: The Department of Health should develop a national e-mental health strategy.

Action: The Department of Health should consult with stakeholders in Ireland and with its peers in Europe to develop a national e-mental health strategy.

Action: The Department of Health should 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.

³³⁹ Ibid.

³⁴⁰ Ibid.

³⁴¹ World Health Organisation (2012) *Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors*. WHO, Geneva.

³⁴² Gulliver, A., Griffiths, K.M. & Christensen, H. (2010) “Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review”, *BMC Psychiatry* 2010, 10:113.

³⁴³ Cannon et. al. (2013).

³⁴⁴ Woodhouse, A. (2014) *How to Promote Young People’s Well-being within Primary Care*. Paul Hamlyn Foundation and The Mental Health Foundation. London.

³⁴⁵ The guide was developed as a result of research with over 170 young people on the topic of their experiences of using primary care service.

Rationale

Almost 10% of the population in Ireland over the age of 15 years has a 'probable mental health problem' and 15.4% of children aged 11-13 and 19.5% of young adults aged 19-24 have had a mental health disorder.³⁴⁶ As prevalence of mental health difficulties throughout the population reach significantly high rates, demand for care has also increased in recent years.³⁴⁷ This may be due to the economic crisis, pressure in the labour market and reduced stigma, as well as promotion of mental health and well-being.

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 would address health inequalities and social exclusion, particularly in times of increased demand and overstretched 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). 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.³⁴⁸ 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%).³⁴⁹ Mobile apps and online programmes related to mental health and well-being were likely to be used by a relatively high proportion of students (30% and 40% respectively).³⁵⁰

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.³⁵¹

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.³⁵² All parts of the UK either have or are about to produce an eHealth strategy within which mental health is dealt with and in Belgium e-mental health has received growing support with at least 20% of treatment centres occasionally offering eHealth.

³⁴⁶ 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, p. 25,29.

³⁴⁷ For example, demand for CAMHS increased from 8,663 referrals in 2011 to 13,062 in 2014, i.e. by more than 50%.

³⁴⁸ Dooley, B., Fitzgerald, A. (2012) p. 35.

³⁴⁹ Karwig, G., Chambers, D. & Murphy, F. (2015) *Reaching Out in College: Help-Seeking at Third Level in Ireland*, Dublin: ReachOut Ireland, p. 24.

³⁵⁰ Ibid.

³⁵¹ Department of Health (2015).

³⁵² 10-15% of all mental health care providers use these applications during treatment.

In Ireland, the Life Skills Online programme (based on Cognitive Behavioural Therapy (CBT)) facilitated by Aware was recently 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.³⁵³

The Department of Health has stated that eHealth will be “a critical enabler to deliver the change and transformation required to introduce new models of care”,³⁵⁴ including in the area of mental health. However, e-mental health has not featured yet as a distinct area of work in Ireland’s eHealth strategy. There is an opportunity to develop such a strategy in order 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. HSE Mental Health and the Department of Health should draw on international research³⁵⁵ and policy³⁵⁶ to develop and implement an e-mental health strategy.

This strategy should address the identified challenges to e-mental health including:

- lack of product effectiveness/quality
- lack of awareness of and confidence in e-solutions
- lack of end-user involvement
- privacy issues
- a fragmented legal framework and
- underdeveloped clinical governance systems

³⁵³ Aware (2015) 2014 Annual Report and Accounts, Dublin: Aware, p. 8.

³⁵⁴ HSE & Department of Health (2015) eHealth Strategy for Ireland, Dublin: HSE, p. 6.

³⁵⁵ VU University Amsterdam established the Triple-E network in 2013, an eHealth research network for promoting the cost effectiveness of mental health care delivery through innovative digital technologies. Interapy is a 100% online mental health treatment provider for the most common mental health difficulties. Mobilab at the Thomas More University is a multidisciplinary centre of expertise, conducting applied research into well-being and technology (connecting research, education and practice). Mobilab has specific expertise on eHealth, mHealth, security and privacy of medical data. ISW Limits N.V. is a spin-off from the University of Louvain and specialises in well-being at work. It has developed a broad range of online tools for both the public at large and for the business context in particular, with an extensive ehealth SME network. ISW Limits is a leader in using online applications in the areas of well-being, care and mental health (e-mental health).

³⁵⁶ Several EU eHealth policies and initiatives should be considered such as the eHealth Network, GAMIAN-Europe, Green Paper on Mental Health, European Pact on Mental Health and Well-being, EU Compass for Actions on Mental Health and Well-being, the European Network for Mental Health Promotion, the Joint Action on Mental health and well-being and the EU eHealth task force.

Chapter 5: Adult mental health services

Mental Health Reform recommends that Government uphold the existing recommendations in *A Vision for Change* on adult mental health services (AMHS) including the Expert Group's recommendations on:³⁵⁷

- a person-centred, community-based, recovery-orientated model for adult mental health care
- development of community mental health teams (CMHTs)
- multidisciplinary, home-based and assertive outreach care
- 24/7 crisis intervention arrangements
- a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families and
- specialist community mental health support for the social inclusion and recovery of people with severe and enduring mental health difficulties

In addition to the existing recommendations set out in *A Vision for Change*, the revised policy should reflect the following recommendations:

Recommendation 1: The full implementation of the National Clinical Care Programme for the assessment and management of individuals presenting to emergency departments following self-harm. This programme should also be extended to ensure that it adequately meets the needs of individuals who have deliberately self-harmed, including through increased operational hours.

Action: The HSE should allocate funding for the full implementation of the National Clinical Care Programme on Self-Harm, including for the appointment of additional 'self-harm liaison nurses' where necessary.

Action: The HSE should closely monitor mental health service compliance and performance under the standard operating procedures on the National Clinical Care Programme on Self-Harm.

Action: The HSE should review the Clinical Care Programme following a period of one year and ensure any necessary improvements to the programme are made.

Action: The HSE, in consultation with homeless services, should develop guidance for self-harm liaison nurses on developing good working relationships with homeless services to ensure effective liaison and follow-up for people who are homeless and are self-harming.

Rationale

In 2015, the National Registry recorded 11,189 presentations to hospital due to self-harm nationally, involving 8,791 individuals.³⁵⁸ The latest report of the National Registry documents that "between 2011 and 2013 there has been successive decreases in the rates of self-harm". "An

³⁵⁷ AVFC (2006) p. 92-103.

³⁵⁸ Griffin, E., Arensman, E., Dillon, C.B., Corcoran, P., Williamson, E. and Perry, I.J. (2016) National Self-Harm Registry Ireland Annual Report 2015. Cork: National Suicide Research Foundation.

essentially unchanged rate in 2015 indicates a further stabilisation of the rate of self-harm in Ireland since 2013". However, the report also recognises that the rate in 2015 was still 9% higher than in 2007, the year before the economic recession.^{359,360}

The National Suicide Research Foundation has identified that there is an association between self-harm and suicide; individuals who self-harm are over 42 times more likely to die by suicide than persons in the general population.³⁶¹ This finding is further supported by recent UK-based research showing a significant relationship between self-harm and suicide among both adults and young people.³⁶²

Among individuals who engage in highly lethal acts of self-harm, subsequent risk of suicide is highest,³⁶³ with fatality rates of over 70%. Worryingly, between 2007 and 2015, the proportion of self-harm presentations involving hanging increased by 78%.³⁶⁴ The NSRF has previously highlighted that increases in highly lethal methods of self-harm (among both men and women) demonstrate the importance of suicide risk assessment combined with psychiatric and psychosocial assessment, considering the high risk of subsequent suicide.

Repetition of self-harm is also a strong indicator of future suicide. The proportion of acts of repeated self-harm in 2015 accounted for 21.4%.³⁶⁵ Of all the people who presented to hospital with self-harm in 2015, almost 15% made at least one repeat presentation to hospital during that calendar year.³⁶⁶ Therefore, repetition continues to pose a major challenge in responding to the mental health care needs of individuals across the population. It must be recognised that self-harm very often forms a repeat behaviour pattern. The strongest risk factor for the occurrence of an incident of self-harm is a history of multiple previous acts of self-harm.³⁶⁷ The NSRF has recommended the national implementation of evidence-based treatments, shown to reduce risk of repetition.

In line with previous years, in 2015, there was considerable variation in 'next care' recommended to self-harm patients, in addition to the proportion of patients who left hospital before a recommendation was made. Significant variations in the referral pathways provided to 'patients' has also been evidenced. In 2015:³⁶⁸

- only 73% of [self-harm] patients were assessed by a member of the mental health team in the hospital
- only 80% of individuals not admitted to the presenting hospital received a psychiatric assessment prior to discharge and only 14% of patients who left before recommendation (against medical advice) received an assessment. The WHO Intervention Guide

³⁵⁹ Ibid., p. 7.

³⁶⁰ In 2015, the national male rate of self-harm was 1% higher than in 2014. The female rate of self-harm in 2015 was 3% higher than 2014. Since 2007, the male rate has increased by 15%, whereas the female rate is 3% higher than in 2007.

³⁶¹ Griffin, E., Arensman, E., Dillon, C.B., Corcoran, P., Williamson, E. and Perry, I.J. (2014) National Self-Harm Registry Ireland Annual Report 2014. Cork: National Suicide Research Foundation, p. 9.

³⁶² Bergen et al. (2012) "Premature death after self-harm: a multicentre cohort study." *The Lancet*. 380: 1568 - 74.

³⁶³ Ibid.

³⁶⁴ Griffin, E., Arensman, E., Dillon, C.B., Corcoran, P., Williamson, E. and Perry, I.J. (2016).

³⁶⁵ Ibid.

³⁶⁶ Ibid.

³⁶⁷ Perry (2012) discusses the 'dose-response relationship' between the number of self-harm presentations and risk of repetition.

³⁶⁸ Griffin, E., Arensman, E., Dillon, C.B., Corcoran, P., Williamson, E. and Perry, I.J. (2016).

recommends assessing comprehensively everyone presenting with thoughts, plans or acts of self-harm/suicide³⁶⁹

- in 13% of cases, the individual left the ED before a next care recommendation could be made
- next care varied significantly by HSE hospital group. The observed variation in recommended next care is likely to be due to variation in the availability of resources and services but it also suggests that assessment and management procedures with respect to self-harm patients are likely to be variable and inconsistent across the country

A subgroup of the National Mental Health Clinical Programme Steering Group produced National Guidelines for the Assessment and Management of Patients presenting to Irish Emergency Departments following self-harm. The latest report of the National Registry has recommended that these guidelines be implemented nationally as a matter of priority.

Connecting for Life includes a standard to ensure best practice among health and social care practitioners through (a) the implementation of clinical guidelines on self-harm and (b) the delivery of accredited education programmes on suicide prevention.³⁷⁰ A key outcome of the Strategy is to reduce the rate of presentations of self-harm in the whole population and amongst specified priority groups.³⁷¹ It recognises that the foundations of a sustained approach to preventing and reducing suicide and (especially repeated) self-harm are consistently available services and integrated care pathways, across both statutory and non-statutory services.³⁷²

Recommendation 2: Targeted suicide prevention initiatives should be provided at a capacity that effectively reaches groups at risk of self-harm and suicide, such as individuals from ethnic minority communities, including Travellers, individuals from the LGBTI community, homeless people and those in the deaf community.

Action: NOSP should ensure that the above-mentioned programmes are developed and made available across the country, enabling outreach to all individuals from the aforementioned groups.

Action: NOSP should allocate funding for the appointment of mental health workers for at-risk groups.

Action: NOSP should ensure that ASIST training is delivered to community leaders in at-risk communities, including professionals working with individuals who are homeless, people who are deaf, LGBTI people and individuals from ethnic minority groups, including Travellers.

Action: The National Suicide Research Foundation should develop an evidence base on the risk behaviours and effective service responses for social groups at higher risk of suicide and self-harm. This should be achieved by including homeless status, ethnicity and sexual orientation (beyond gender binary) as identifiers in data collected for analysis of suicide and self-harm.

Action: The Department of Justice should include a specification in their Service Level Agreements with direct provision service providers to provide mental health literacy and suicide

³⁶⁹ Machale et al., 2013; Knesper, 2011; NICE, 2011 strongly recommended that all self-harm patients presenting to the ED should receive a comprehensive risk and psychosocial-psychiatric assessment.

³⁷⁰ NOSP (2015), p. 33.

³⁷¹ Ibid., p. 28.

³⁷² Ibid., p. 32.

awareness training for their staff. This should form part of any revised reception conditions for asylum seekers.

Action: The See Change anti-stigma/discrimination campaign should develop a strand of action targeted at reducing the stigma around accessing mental health/crisis supports among at-risk groups.

Action: The HSE should ensure that all homeless services have access to on-site mental health consultation and suicide prevention services.

Action: The HSE should continue to work with the Irish College of General Practitioners and other professional associations to improve GPs' and other discipline's (such as public health and practice nurses') knowledge about how to respond to people with mental health difficulties and individuals at risk of suicide/self-harm.

Rationale

Some social groups are at higher risk of suicide and self-harm. These high risk groups include people with a diagnosis of depression or schizophrenia (as noted in *A Vision for Change*),³⁷³ people who are homeless,³⁷⁴ people who are deaf, LGBTI individuals and people from ethnic minority communities.

Research has found that there are differences in the rates of suicide between some ethnic minority communities and majority populations.³⁷⁵ For example, the All-Ireland Traveller Health Study Our Geels 2010 found that instances of suicide are seven times higher among Traveller men than in the general population.³⁷⁶

With regard to people who are homeless, in 2011, the Simon Community found that of 603 people using Simon services, 19% had engaged in self-harm behaviour while 17% reported having attempted suicide in the previous six months.³⁷⁷ Further research carried out with homeless adults in Limerick and Dublin shows that 13.4% of participants had self-harmed in the past 6 months while 24.7% had self-harmed prior to the past six months. 29% of participants had attempted suicide in the past six months while 28% had attempted suicide prior to the past six months.³⁷⁸

The NSRF has reported that "while presentations of self-harm by [homeless people] account for a minority of attendances (5%), the incidence of self-harm within this population is large". "Since 2007 the number of presentations by [homeless people] has increased significantly by 67%, and such presentations are often associated with substance misuse. The NSRF recommends that "more evidence around appropriate interventions for [homeless people] is necessary, as well as connecting mental health services with relevant community and voluntary agencies".³⁷⁹

³⁷³ AVFC (2006), p. 60.

³⁷⁴ O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) *Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities*. Dublin: The Partnership for Health Equity.

³⁷⁵ McKenzie, K., Serfty, M. and Crawford, M. (2003) "Suicide in BME communities", *The British Journal of Psychiatry* 183:100-101.

³⁷⁶ Quirke, B. (2010) *Selected Findings and Recommendations from the All-Ireland Traveller Health Study - Our Geels*, Dublin: Pavee Point.

³⁷⁷ Dublin Simon (2014) *Homelessness Makes You Sick*, available at <http://www.dubsimon.ie/NewsReports/TabId/292/ArtMID/1182/ArticleID/69/Simon-Health-Snapshot.aspx>.

³⁷⁸ O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015).

³⁷⁹ Griffin, E., Arensman, E., Dillon, C.B., Corcoran, P., Williamson, E. and Perry, I.J. (2016).

Deaf people have a higher likelihood (40-50%)³⁸⁰ of developing mental health difficulties than the general population and have additional risk factors, including difficulties and delays in accessing assessment and treatment.³⁸¹ Such factors may put members of the deaf community at higher risk of suicide and self-harm.

Among the LGBTI community, a recent study documents that 34% of participants had engaged in self-harm, with 60% of people reporting that their self-harm was related to their LGBTI identity. Self-harm rates were highest among 14-18 years olds (56%) and were twice as high among 19-25-year-old LGBTI people in comparison to a similar age group (17-25) in the My World national youth mental health study. Furthermore, 21% of LGBTI people had attempted suicide, with suicidal behaviour highest among the younger individuals.³⁸² Similar to self-harm, attempted suicide was three times higher among 19-25 year old LGBTI people in comparison to 17-25 year olds in the My World study.³⁸³

While *Connecting for Life* recognises the need for targeted initiatives for higher risk groups, the policy does not go far enough in specifying agencies' commitments to implement such initiatives.

Recommendation 3: An evaluation of the role of the community and voluntary (C&V) sector in providing mental health services, including out of hours crisis supports, and related social supports, should be completed. In addition, the delivery of mental health services by the C&V sector should be carefully regulated on an ongoing basis by an approved body.

Action: A dedicated action plan should be developed to adequately resource the community and voluntary sector to meet its potential role. The HSE Mental Health Division and NOSP should allocate ring-fenced funding for the development of new and existing community and voluntary mental health/crisis supports.

Action: The HSE Mental Health Division and NOSP should provide standard guidelines to community and voluntary groups on providing mental health/crisis supports that are in accordance with evidence-based practice.

Action: The HSE Mental Health Division and NOSP should monitor the practices of community and voluntary groups in the delivery of mental health/crisis supports and assess such performance against standard guidelines.

Action: The HSE Mental Health Division and NOSP, in collaboration with the relevant agencies, should develop clear guidance for collaborative working between community and voluntary, primary care and specialist mental health services.

Rationale

Connecting for Life recognises the role of the community and voluntary sector in supporting people with mental health difficulties and includes a commitment to support local communities' capacity to prevent and respond to suicidal behaviour.³⁸⁴ Goal 2 states that "well-structured and coordinated

³⁸⁰ Information provided by DeafHear.

³⁸¹ Du Feu, M. & Chovaz, C. "Mental Health and Deafness", *American Journal of Psychiatry* 171: 11 (2014): 1226.

³⁸² 1 in 3 14-18 year olds had attempted suicide with 50% doing so in the past year. 1 in 5 19-25 year olds had attempted suicide with 25% doing so in the past year.

³⁸³ Dooley, B., Fitzgerald, A. (2012).

³⁸⁴ NOSP (2015), p. 31.

community-based initiatives can translate into protective benefits for families and individuals, which contribute to reduced risk of suicidal behaviour. An empowered community can respond to the [mental health] needs of its members and protect them in difficult times and can sustain these positive effects over time”.³⁸⁵ Specifically, the Strategy commits to:³⁸⁶

- improving the continuation of community level responses to suicide through planned, multi-agency approaches
- ensuring that accurate information and guidance on effective suicide prevention are provided for community-based organisations
- delivering training and education programmes on suicide prevention to community-based organisations

Community and voluntary organisations provide wide ranging support for individuals experiencing mental health difficulties, including crisis supports such as helplines and out of hours services. 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.

In a study of the Life Skills Group programme, facilitated by Aware, it was found that there were statistically significant reductions in terms of scores of depression and anxiety seen in participants on completion of the programme and these differences were maintained at 12-month follow-up.³⁸⁷ The programme had an uptake of 2,174 individuals across the country in 2014.³⁸⁸ Many of Mental Health Reform member organisations deliver mental health and/or crisis supports, a full description of which can be found in its *Nine Years On* report.

“Evidence and experience from around the world clearly shows that to create measurable improvements in positive mental health outcomes it takes the involvement of the whole community, the whole-of-government, and all of society working in unison”.³⁸⁹ The valuable role community and voluntary organisations have to play in supporting the mental health of individuals and communities has been set out in earlier chapters. It is clear that adequate resourcing of the sector should be ensured to support new and existing mental health initiatives across the country. An evaluation of existing programmes, in addition to ongoing regulation of the sector, is crucial to ensure the best possible outcomes for individuals accessing such services and supports.

Member groups of Mental Health Reform have also cited the importance of integrated working between community and voluntary groups and specialist mental health services. Currently, there is no formal process of collaboration between the two sectors and where good practice does exist, it is in certain geographical areas and is often based on established rapport between particular staff. In order to support the integration and recovery of individuals with mental health difficulties in their own communities, it is important that enhanced working between the C&V sector and primary and secondary mental health services is achieved. This may include regular meetings between staff of different services, a shared understanding and learning of the respective roles and skills of the different services, and shared care planning.

³⁸⁵ Ibid.

³⁸⁶ Ibid.

³⁸⁷ Aware (2015), p. 8.

³⁸⁸ Ibid.

³⁸⁹ NOSP (2015), p. 60.

Recommendation 4: Creative arts therapies should be made available to all individuals engaged in mental health services through the integration of arts therapists on mental health multi-disciplinary teams throughout the country.

Action: The HSE Mental Health Division should appoint creative arts therapists to community mental health teams across the country through the provision of development funding.

Action: Statutory recognition of creative arts therapists should be afforded to ensure that existing services are delivered by qualified, regulated therapists. This will also provide validation of current professional standards amongst therapists in Ireland.

Action: Research should be commissioned to contribute to the evidence base on creative arts therapies in improving the mental health and well-being outcomes of individuals with pre-existing difficulties.

Rationale

The Arts Council of Ireland has defined creative arts therapies as “integrating the experience of a given art form with the theories and practice of psychology, psychotherapy and psychiatry as a unique form of therapeutic intervention.”³⁹⁰ The American Art Therapy Association builds on this concept by stating that “the creative process of art making is healing and life enhancing”.³⁹¹

Bill Ahessy discusses the use of art as a “vehicle for emotional self-expression, interaction and change”. The author continues to explain how creative arts therapies are “particularly effective for people who find it difficult to communicate verbally...for example people who have mental health difficulties who [may] find it difficult to talk about their experiences and feelings in words”.³⁹² It can be argued that this form of therapy may be particularly helpful in working with individuals from ethnic minority communities and people from the deaf community.

The UK’s National Institute for Health and Clinical Excellence (NICE) promotes the use of creative arts therapies in the delivery of care of people with mental health difficulties. In particular, it advises mental health professionals to consider offering such therapies to all individuals with a diagnosis of schizophrenia.

A review of research for the NICE guidelines for treatment of schizophrenia indicated that creative arts therapies are effective in reducing negative symptoms (e.g. lack of energy, loss of motivation, loss of interest in activities, people and personal appearance, memory problems and concentration difficulties) across a range of treatment modalities, in inpatient and outpatient populations. It was also found that creative arts therapies can boost self-confidence, self-esteem and concentration, help people gain self-awareness and communicate better with others, and reduce feelings of isolation and exclusion.³⁹³

³⁹⁰ Arts Council of Ireland, 2003, p. 111.

³⁹¹ Eustace, A. (2015) Centre for Creative Therapies: Homeless Mental Health Pilot. Available at https://issuu.com/davidkeegan9/docs/final_centre_for_creative_therapies.

³⁹² Ahessy, B. (2013) “Creative Arts Therapies: What Psychologists Need to Know”. *The Irish Psychologist*, 39 (11), 274-281.

³⁹³ National Collaborating Centre for Mental Health, 2010.

Two Irish studies on the effects of music therapy with individuals experiencing mental health difficulties illustrated significant benefits based on service user feedback.^{394,395} The following was reported from some of the participants:

“It opened some blocked emotions and I could finally cry”

“I find it so hard to express myself, somehow the music and singing helps”

“I needed less medication and it has no unwanted side effects”

In her evaluation of an art psychotherapy project for individuals with mental health difficulties who are homeless, Ann Eustace refers to the MATISSE study, which has assessed the effectiveness of arts therapies and has effectively contributed to the development of an evidence base. Eustace states that through “this and other work, an evidence base is slowly emerging that is providing useful and growing intelligence around the value, benefits and utility of art therapy. The indications are that when appropriately used and in harmony with good practice, art psychotherapy may result in improved mental health and reduction of negative symptoms”.³⁹⁶

Findings from the aforementioned project affirm that “delivering art psychotherapy adds a new dimension to supports to enable individuals with mental health difficulties to move out of their current situation and to enhance their capacity to cultivate positive change in their lives”. The early indicators from the project show that art psychotherapy is “well-received and has had a positive impact on the mental health and well-being” of many of those who participated. The impact varies along a continuum of outcomes from engagement and attendance to some clients manifesting more pronounced positive outcomes”. Client feedback also shows that clients have been supported to “restore, strengthen, and sustain relationships and their capacity to stabilise and in some cases secure and/or sustain tenancy” has been demonstrated.³⁹⁷

Overall, it is important that art therapy is located within a structure and suite of other services. This should be achieved through the appointment of creative arts therapists on multidisciplinary mental health teams to promote integrated working, in addition to collaboration with external service providers such as housing providers, educational and employment supports.

Recommendation 5: Intensive, long-term support services for individuals with severe and/or enduring mental health difficulties should be reconfigured to improve the outcomes for this group of individuals, with an emphasis on a ‘housing first’ approach.

Action: The HSE Mental Health Division should develop a strategy for the development and delivery of specialist long-term recovery and social inclusion supports that take a ‘housing first’ approach. This strategy should be developed in consultation with key stakeholders.

Action: The HSE Mental Health Division should allocate funding for the development of recovery services for individuals with severe and enduring mental health difficulties.

³⁹⁴ Adult male outpatients with chronic and enduring mental illness in an independent focus group conducted as part of a music therapy research study in Ballyfermot Mental Health Association, Dublin.

³⁹⁵ Service user feedback in relation to music therapy comes from collaboration between the Irish Advocacy Network (IAN) and a music therapist at Mayo Mental Health Services (McCaffrey, 2011). As part of a service evaluation review IAN held an independent focus group in which music therapy participation was discussed.

³⁹⁶ Eustace, A. (2015).

³⁹⁷ Ibid.

Rationale

A small group of individuals with severe and enduring mental health difficulties will require long-term recovery supports. This may be due to difficulties in sustaining improvements in functioning and stability and/or continued social and personal difficulties.

The Royal College of Psychiatrists in the UK recognises the need for the specialist skills of community rehabilitation teams. These teams have the capacity “to work with individuals with very complex and longer-term mental health needs in an incremental and holistic way, holding hope for and working collaboratively towards their ongoing recovery and independence”. “As well as key clinical skills, this process involves good liaison and partnership working within a complex system of providers of mental healthcare, and with commissioners of services in primary care”. Community rehabilitation teams established in the UK have been noted to be an integral component of a whole-system care pathway for this vulnerable group of individuals.³⁹⁸

In the UK, community rehabilitation teams play a key role in supporting individuals to transition through the care pathway, from hospital to community settings and from high to low supported accommodation.³⁹⁹ In essence, they provide specialist expertise⁴⁰⁰ to support individuals with complex needs to achieve the highest level of independence in the community. Team members also provide visiting supports (with the aim of assisting both the individual and supported accommodation staff) in order to promote individual care and recovery plans and provide more intensive supports during periods of instability, working with the individual to avoid placement breakdown or hospital admission wherever possible. This may involve the amendment of care plans and facilitating access to additional mental health support (e.g. the local crisis resolution team).

Community rehabilitation teams and other community psychosis services⁴⁰¹ also liaise and collaborate with a wide range of other providers in the statutory and voluntary sectors, to enable individuals to access services that support their recovery and promote their social inclusion. These include social services, housing, vocational rehabilitation, education and employment services, advocacy and peer support services, and primary care.

A particular role for community rehabilitation teams is the review and support for ‘repatriation’ of those individuals placed out of area. Out-of-area placements remove people from their communities and criticisms have been made of the quality of care and lack of recovery ethos in

³⁹⁸ Kalidindi, S., Killaspy, H. and Edwards, T. (2012) *Community psychosis services: the role of community mental health rehabilitation teams*, London: Royal College of Psychiatrists UK.

³⁹⁹ To be effective, this process usually requires incremental steps, such as graduated self-medication programmes, assistance to improve in daily living skills, and detailed planning and support for a graduated move into less supported accommodation. It also requires sensitive insight-related work, such as the identification and agreement of relapse indicators, and agreement about the interventions and supports that can help during periods of crisis.

⁴⁰⁰ Community rehabilitation teams provide expertise in the following areas: prescription of complex medication regimes; supporting service users to develop skills to self-manage their medication through graduated self-medication programmes; routine physical health screening in keeping with guidance for patients on different medication regimes; referral and support to access dental care, primary care and secondary medical services as required; NICE-recommended ‘high-intensity’ psychological interventions for psychoses, in addition to low intensity intervention; promotion of recovery orientated services, including the use of WRAP and other recovery tools; managing activities of daily living (e.g. personal care, laundry, shopping, cooking, cleaning, budgeting, paying bills); accessing community activities and vocational rehabilitation services to improve social and occupational functioning (leisure, education, work); accessing appropriate social security benefits (welfare benefits advice) and supporting the client’s wider support network, including families and friends and staff in supported accommodation.

⁴⁰¹ The development in the UK of specialist community mental health services over the past decade (assertive outreach, early intervention, crisis intervention and home treatment teams and, in some areas, specialist personality disorder services) has concentrated the focus of CMHTs on people with severe and enduring psychoses.

some.^{402,403} Specialists in long-term care are involved in assessing the appropriateness of making individual out-of-area placements and reviewing the needs of people placed in them in order to clarify whether local services could provide a better alternative. In the UK, ‘out-of-area reviewing officers’, supported by rehabilitation psychiatrists and rehabilitation services, carry out this role. Without them, many individuals become stuck in placements unnecessarily, with no clear care pathway back to their local area.⁴⁰⁴

A national survey of ‘mental health rehabilitation services’ in Ireland found that individuals who were in receipt of ‘rehabilitation services’ were eight times more likely to successfully progress than those in receipt of standard care, in terms of transitioning into and/or sustaining community living.^{405,406} At 18 months, 21% of individuals receiving a rehabilitation service and 73% of those on the waiting list had had at least one admission to hospital.⁴⁰⁷ Those who received rehabilitation services were also more likely to show improvement in their social functioning.⁴⁰⁸ Improvement in outcomes were greater among those participants already living in the community, demonstrating that long stay inpatient units often lack the necessary staff and therapeutic interventions to support the recovery of the individual.^{409,410}

The findings from this study have illustrated that long-term recovery services can positively impact on outcomes for individuals with enduring and complex mental health difficulties. However, a reconfiguring of existing rehabilitation services in Ireland is required. Although *A Vision for Change* recommended the development of rehabilitation teams across the country, there has been a lack of implementation, a lack of clarity on pathways of care, and there remains inadequate resources and infrastructure to achieve the aims of social inclusion and recovery for those with longer term and complex mental health difficulties, as outlined in the policy.⁴¹¹

In fact, it appears that there is a continued pattern of individuals receiving higher levels of support than they require, perpetuating the process of institutionalisation in the community. For example, in the review of the Galway/Roscommon community mental health services published by the HSE in 2014 (cited in Chapter 2), the review group found that some people in community residences were being over provided with care and that some could have lived independently.⁴¹²

Specialist rehabilitation services should be reconfigured and expanded to support the recovery of individuals with severe and enduring mental health difficulties. These services should be

⁴⁰² Ryan, T., Pearsall, A., Hatfield, B., et al. (2004) “Long-term care for serious mental illness outside the NHS: a study of out of area placements”. *Journal of Mental Health*, 13, 425–429.

⁴⁰³ Out-of-area care is expensive, costing on average around 65% more than similar local services (Killaspy & Meier, 2010).

⁴⁰⁴ Kalidindi, S., Killaspy, H. & Edwards, T. (2012).

⁴⁰⁵ Lavelle, E. (2012) *Mental Health Rehabilitation and Recovery Services in Ireland: A multicentre study of current service provision, characteristics of service users and outcomes for those with and without access to these services*, Dublin: Mental Health Commission, p.45.

⁴⁰⁶ For those recruited into the study as inpatients, this outcome was defined as achieving and sustaining community discharge and for those recruited as community patients it was defined as sustaining the community placement or progressing on to a less supported placement

⁴⁰⁷ Lavelle, E. (2012), p. 31.

⁴⁰⁸ *Ibid*, p. 2-3.

⁴⁰⁹ Ryan, T., Pearsall, A., Hatfield, B. & Poole, R. (2004).

⁴¹⁰ Trieman, N., Leff, J. “The TAPS Project 36: The most difficult to place long- stay psychiatric inpatients-outcome one year after relocation”. *Br. J. Psychiatry* 1996: 169: 289-292.

⁴¹¹ The national survey of mental health rehabilitation services carried out in 2008 found that only 16 (AVFC recommended 39) specialist services existed across Ireland. It identified that all of the mental health rehabilitation services were under-resourced in terms of multidisciplinary input, lacked low level rehabilitation supports, and were not found to be operating with the recommended “assertive outreach” model, either because of lack of local consensus about the role and function of the community rehabilitation component of the service or because of lack of resources.

⁴¹² HSE (2014) *Final Report of the Expert Review Group on Community Mental Health Services in Galway/Roscommon*, Appendix P.

adequately resourced with multidisciplinary staff with the necessary expertise to provide tailored evidence-based treatments and interventions for individuals with complex needs in the community. Specialist teams should collaborate with primary care services and secondary mental health services and work in partnership with social services, including in the areas of employment, housing and education, to facilitate the individual's recovery and social inclusion. In essence, such teams should support the highest level of independence for the individual. Aside from promoting positive outcomes for the individual, 'rehabilitation teams' also have the potential to reduce the costs to society associated with lengthy hospital admissions and the "lack of productivity/dependence" of people with long-term and complex mental health difficulties.

Recommendation 6: 24/7 crisis intervention mental health services should be made available in every community across Ireland in order to improve access to out of hours supports for people with mental health difficulties. This should be complimented with the establishment of crisis houses in all areas throughout the country.

Action: The HSE Mental Health Division should develop an implementation plan for the national roll-out of community based 24/7 crisis mental health services, in addition to the establishment of crisis houses.

Rationale

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 coordinated, 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 provide 7 day service responses for known mental health service users in crisis, including provision of a weekend service in nine locations nationally".⁴¹³ 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".⁴¹⁴

The urgent requirement for crisis services can be demonstrated by the prevalence of individuals presenting to emergency departments (EDs) with mental health difficulties. In a study on the profile of frequent attenders to a Dublin inner city emergency department, it was identified that the presence of "a mental illness" was associated with a significantly higher attendance rate in the ED. The authors concluded that it is likely that "insufficient community-based mental health services....contribute to the reasons why people re-present to EDs".⁴¹⁵

Furthermore, Ireland continues to have one of the highest rates of suicide among young people in Europe. 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.⁴¹⁶ It further documents that Ireland had an above

⁴¹³ See HSE Mental Health Division Operational Plan 2017.

⁴¹⁴ Ibid.

⁴¹⁵ Ramasubbu, B., Donnelly, A. & Moughty, A. (2016) "Profile of Frequent Attenders to a Dublin Inner City Emergency Department", *Irish Medical Journal*, 109(4):389.

⁴¹⁶ UNICEF Office of Research (2017) *Building the Future: Children and the Sustainable Development Goals in Rich Countries*, Innocenti Report Card 14, UNICEF Office of Research – Innocenti, Florence.

average international suicide rate in the 15-19 age group between 2008 and 2013. It has also been evidenced that people with severe mental health difficulties are a high risk group for suicide.⁴¹⁷

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 study by Jigsaw that identifies the lack of out of hours supports for children and young people.⁴¹⁸

The lack of crisis supports across the country is consistently reported to Mental Health Reform by people with self-experience, family supporters and carers, as well as by 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.

It should be noted that a small number of mental health teams across Ireland have been offering a more appropriate, responsive way in to urgent support, including the provision of 7-day-week day hospitals alongside home treatment and assertive outreach teams and 24/7 telephone support from specialist mental health staff. However, this type of service provision is patchy, with hundreds of thousands of adults and children in communities across Ireland having no access to out of hours supports.

Despite the investment required to develop crisis services, there is no doubt that there are significant cost savings associated with its implementation. The result of delivering extended community services in Celbridge, Co. Kildare was 27% lower costs [per capita] and half the rate of overall admissions and length of stay [to the service].⁴¹⁹ While it requires enough community mental health team staff to be available across 7 days, it may result in less staff being needed in acute units and a reduction in costs for overtime and agency staff.

In the UK, the Government has taken significant steps to improve access to crisis mental health supports for both adults and children. This is largely reflected in the publication of the Crisis Care Concordat,⁴²⁰ which commits to ensuring that every local area develop its services so that people experiencing a mental health crisis can avail of supports 24 hours a day, seven days a week. The Care Quality Commission has endorsed the Concordat and has made specific recommendations to improve crisis supports across the UK in line with the principles of the agreement.⁴²¹ In its review of crisis services, the Commission has identified that there are some local areas in the UK which are effectively meeting the needs of people in mental health crisis.⁴²²

⁴¹⁷ National Office for Suicide Prevention (2015) *Connecting for life: report of the research advisory group for the national framework for suicide prevention strategy*, Dublin: HSE.

⁴¹⁸ Headstrong, *The National Centre for Youth Mental Health (2013) Economic Burden and Cost to Government of Youth Mental Ill-Health*. Dublin: Headstrong, p. 5.

⁴¹⁹ Gibbons, P., Lee, A., Parkes, J. and Meaney, E. (2012) *Value for money: a comparison of cost and quality in two models of adult mental health service provision*. Dublin: HSE.

⁴²⁰ The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. In February 2014, 22 national bodies involved in health, policing, social care, local government and the third sector came together and signed the Crisis Care Concordat.

⁴²¹ Care Quality Commission (2015) *Right Here, Right Now*. Available at http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf.

⁴²² *Ibid.*

Furthermore, 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, ongoing care and discharge support".⁴²³ Furthermore, the NHS produced a report on transforming urgent and emergency care services in England.⁴²⁴ This report set out guidance for the development of mental health crisis supports, including that effective local crisis care pathways should be developed.

Future in Mind, a report in the UK on improving mental health services for young people, identifies that "the litmus test of any local mental health system is how it responds in a crisis".⁴²⁵ It specifically recommends that the support and intervention as outlined in the Crisis Care Concordat is implemented, including the provision of an out of hours mental health service. The report also refers to the provision of home treatment teams and appropriate and timely psychiatric liaison from specialist mental health services.

It is noteworthy that the rate of hospital re-admissions among people with mental health difficulties is significantly higher in Ireland than in the UK. According to OECD data on "unplanned hospital readmissions for mental disorders" the rate of re-admissions [to the same hospital] for schizophrenia was 21.6 per 100 in Ireland and 8.1 per 100 in the UK. The rate of re-admissions [to the same hospital] for bipolar disorder was 21.3 per 100 in Ireland and 10.3 per 100 in the UK.⁴²⁶

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 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. It is imperative that such services are developed as a matter of priority.

Recommendation 7: Mental health services should ensure that long-term service users have the opportunity to develop a consistent relationship with a named psychiatrist on the team and not be subject to frequent changes of psychiatrist.

Action: The HSE Mental Health Division should direct community mental health teams to ensure that long-term service users are assigned to and meet with a named psychiatrist for the duration of their treatment. Such individuals should also have consistency with respect to all mental health staff assigned to them (OTs, SWs, nurses, etc.) to the greatest extent possible.

⁴²³ NHS (2014) NHS Services, Seven Days a Week Forum Evidence base and clinical standards for the care and onward transfer of acute inpatients, available at <https://www.england.nhs.uk/wp-content/uploads/2013/12/evidence-base.pdf>.

⁴²⁴ UEC Review Team and ECIST (2015) Safer, Faster, Better: good practice in delivering urgent and emergency care. A Guide for local health and social care communities, available at <http://www.nhs.uk/NHSEngland/keogh-review/Documents/safer-faster-better-v28.pdf>

⁴²⁵ Department of Health (2016) Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. DoH: UK.

⁴²⁶ This information was published in 2011 and is based on 2009 data.

Rationale

Mental Health Reform has previously advocated that people with mental health difficulties should be provided with opportunities to build positive and sustained relationships with mental health professionals providing their care. There is no doubt that this would contribute to the provision of more person-centred care.

MHR's Grassroots Forum has reported that there is a lack of consistency with respect to staff working with individuals with mental health difficulties. Many individuals feel that they see numerous professionals over very short timeframes. This has an adverse impact on the individual in that they have to continually repeat sensitive information to a number of different professionals, many of whom they have no relationship with, or have not seen before. This is a problem particularly in relation to psychiatrists, wherein under the current system a long-term mental health service user is usually required to see a different psychiatrist every six months, constantly disrupting the continuity of their care relationship. It is also fundamentally disrespectful to long-term mental health service users to have a system that operates on the basis that they must see a different psychiatric clinician every six months.

In Mental Health Reform's public consultation meetings, individuals with self-experience reported the following:

"I rarely see my consultant, more often it's a member of her team, and as the team rotates every 6 months there's no opportunity to build up a relationship. I've often found myself meeting someone who has no clue of my history and so cannot understand the difficulties I'm facing at the time."

"[It's] soul destroying. It takes a lot of courage to ask for help and having to explain to a new person ever few weeks does not work".

Chapter 6: Children and young people

This chapter should be read in line with the national children's framework *Better Outcomes, Brighter Futures*, the National Youth Strategy and the National Strategy on Children and Young People's Participation in Decision Making.

Mental Health Reform recommends that Government uphold the existing recommendations in *A Vision for Change* on child and adolescent mental health services and supports, including the Expert Group's recommendations on the:

- need to prioritise the full range of mental health services from primary to specialist mental health services
- need to provide mental health services to children and adolescents aged 0-18 years
- need for evidence-based mental health promotion programmes to be implemented in primary and post primary schools
- need for clear links to be developed between CAMHS and primary care services
- development of specialist mental health services for children and adolescents, including in the areas of eating disorders, substance misuse, mental health and intellectual disability and forensic services⁴²⁷

In addition to the existing recommendations set out in *A Vision for Change*, the revised policy should reflect the following recommendations:

Recommendation 1: The HSE should improve access to mental health services for children and adolescents with a disability, by developing a protocol for improved coordination between mental health and disability services.

Recommendation 2: The HSE Mental Health Division should provide clear and easily accessible service information for children, young people and their parents, including information on where to go for support and what to do to respond appropriately while waiting to access CAMHS.

In addition, education programmes on child and youth mental health should be provided to parents and families, in order to equip them to support children and young people with respect to their mental health.

Recommendation 3: The HSE Mental Health Division should extend referral pathways to CAMHS by enabling a range of local services, including schools and primary care professionals other than GPs, to make referrals.⁴²⁸ The extension of referral pathways as

⁴²⁷ AVFC (2006), p. 90.

⁴²⁸ The Quality Network for Community CAMHS Standards (2011, UK) recommend as good practice that there are "documented, up-to-date referral pathways into CAMHS via a range of local services". Their guidance is that these local services could include GPs, emergency departments, schools, social services, paediatric services, youth offending teams, substance misuse services, etc. So too, the Government of Victoria, Australia has prioritised earlier access to CAMHS expertise through facilitating referral relationships between CAMHS and other services involved in caring for children. The policy in Victoria has been that professionals working in other agencies can refer to CAMHS, including school professionals, general practitioners, government agencies such as Child Protection and Juvenile Justice, nurses, other private practitioners and specialists.

set out in the CAMHS Standard Operating Procedures, published in 2015, (albeit limited) should be adhered to by all services, immediately.

Recommendation 4: The HSE Mental Health Division should ensure that all CAMHS provide a specialist out of hours and crisis service that is well publicised, fully staffed and resourced to provide a rapid response.

Recommendation 5: The HSE Mental Health Division should develop and implement a standardised and transparent approach to managing referrals and waiting lists in child and adolescent mental health services.

Rationale

Better Outcomes, Brighter Futures includes a clear commitment (1.8) to implement *A Vision for Change* as it relates to children and young people, in particular to improve access to early intervention youth mental health services and coordination of service supports, with a focus on improving mental health literacy and reducing incidents of self-harm and suicide.

However, Irish evidence suggests that families in Ireland experience significant difficulties in accessing CAMHS due to a number of different factors, including restrictive referral criteria, a lack of specialist services, lengthy waiting periods and a lack of information about what to do during the waiting period.⁴²⁹ There are also concerns regarding the lack of capacity in primary care (as outlined in detail in chapter 4), the lack of crisis/out of hours supports and difficulties in navigating the child and adolescent mental health system.

The Children's Mental Health Coalition has also identified that a key challenge to providing high quality, accessible mental health services and supports is inadequate inter-agency communication and collaboration. This challenge exists within mental health services, between mental health and primary care services, and between mental health, disability and child and family services.⁴³⁰

A small survey conducted by the Coalition in two areas in Ireland identified different agencies involved in supporting the mental health of children. Findings from the survey illustrate the frustration experienced by mental health professionals in trying to work in collaboration with a bewildering array of services in order to effectively support children and adolescents with mental health difficulties.⁴³¹

The low level of staff in child and adolescent mental health services is also a key factor impeding timely access to supports. As set out in Chapter 10, the number of staff in post in CAMHS was just 51% of the staffing level recommended in *A Vision for Change* as of December 2015.

As of March 2017, 2,818 children and adolescents were waiting to be seen by CAMHS, of which 279 (10%) had been waiting more than 12 months. Despite, an increase in the number of referrals to CAMHS, it must be acknowledged that the numbers of children waiting longer than 12 months to get a first appointment continues to grow (i.e almost 10% between March 2016 and March 2017).⁴³²

⁴²⁹ Coyne, I. et al. (2014). *Adolescents and parents' experiences of attending child and adolescent mental health services (CAMHS) in Ireland: The report*. TCD, Dublin.

⁴³⁰ Children's Mental Health Coalition (2015).

⁴³¹ Ibid.

⁴³² HSE (2017).

Recommendation 6: Mental health services should fully comply with the Mental Health Commission’s Code of Practice Relating to the Admission of Children under the Mental Health Act, 2001, including that no child under the age of 18 years should be inappropriately placed in adult inpatient units.⁴³³

Action: The HSE Mental Health Division should continue to monitor the placement of children in both CAMHS and adult inpatient units and report on such data on a monthly basis.

Action: The HSE Mental Health Division should ensure that all mental health services adhere to the CAMHS inpatient standard operating procedures,⁴³⁴ including protocols to be complied with where child and adolescent inpatient beds are not available.⁴³⁵

Action: The HSE Mental Health Division should introduce a performance target for all mental health services to ensure that all children and adolescents admitted to adult wards in an emergency/crisis with ongoing needs be transferred to a CAMHS unit within 48 hours.⁴³⁶

Action: The HSE Mental Health Division should develop guidelines for mental health services to comply with when a child/adolescent is placed on an adult inpatient ward. At national level, protocols should be agreed for CAMHS and AMHS that defines the required environment (age-appropriate), safeguarding arrangements, level of ongoing involvement of CAMHS in the care, the frequency of clinical/observation reviews, family visits, access to advocacy and discharge planning.⁴³⁷

Action: The HSE should allocate funding for the development of crisis services for children and adolescents with mental health difficulties. Much of the data on child admissions to adult inpatient units indicates that children are often placed on adult wards in order to meet crisis/emergency mental health needs when there is no CAMHS inpatient bed available.⁴³⁸ It is clear that there is a lack of dedicated mental health crisis supports for children and young people.

Action: The HSE should commit to the development of accessible, developmentally appropriate, and evidence informed inpatient services for children and adolescents.

Rationale

Despite the Mental Health Commission’s Code of Practice relating to the admission of children under the Mental Health Act, 2001, the practice of placing children and adolescents in adult inpatient units continues. Between January and December 2016, 82.1% of child admissions to acute services were to CAMHS inpatient units, while 17.9% were to adult units.⁴³⁹ This is in comparison to approximately 73% and 27% respectively in the previous year.⁴⁴⁰ While this represents a reduction in the admission of children to adult inpatient services (approx. 9%)

⁴³³ Mental Health Commission (2006) Code of Practice Relating to Admission of Children under the Mental Health Act 2001, Dublin: MHC.

⁴³⁴ Health Service Executive, 2015. Child and Adolescent Mental Health Services standard operating procedure. Dublin: Health Service Executive.

⁴³⁵ This action is reflected in the Quality Improvement Network for Multi-Agency CAMHS (QINMAC) guidelines.

⁴³⁶ This action is reflected in the QINMAC_QNIC guidelines as a means of reducing the risks associated with a child/adolescent being placed on an adult ward.

⁴³⁷ The QINMAC-QNIC guidelines note that where the young person is placed in an adult mental health unit such protocols should be implemented.

⁴³⁸ Ombudsman for Children (2015) Annual Report 2014, Dublin: OCO, p. 31.

⁴³⁹ HSE (2017).

⁴⁴⁰ Ibid.

between 2015 and 2016, year to date data shows that as of December 2016, almost 20% of children/adolescents were still being admitted to acute adult services.

The Ombudsman for Children recently reported that a number of complaints submitted to his Office were about children being inappropriately placed in adult inpatient facilities, particularly children at risk of suicide or self-harm, and that these situations appeared to be due to a lack of suitable emergency placements. The Ombudsman has reported concerns about the length of delay in transferring children and adolescents to appropriate age-friendly facilities following their initial admission to adult services, which took considerable time in some cases. The report states that the “complaints received highlight a pattern of concern about timely access to the required services. Although steps are being taken to look at increasing the number of inpatient facilities, it is vital to look at the services and supports available to children in the interim. It is especially important to ensure that children are not inappropriately placed, and specifically, to consider the suitability of Accident & Emergency services when children are presenting with a mental health crisis”.⁴⁴¹

It is well-evidenced that adult inpatient units are not appropriate, safe environments for children and adolescents and that care in such settings may be ineffective.^{442,443} Evidenced risks to children when placed in adult inpatient units include:⁴⁴⁴

- rights of children and young people not being respected
- physical, psychological or sexual harm from other patients, staff or visitors
- compromises in quality of care for children/adolescents if care is provided by staff without education and training in the care and treatment of children and young people or if the available equipment is inappropriate in size or design
- inadequate or inappropriate parent/carer and family support and involvement in care
- interruptions to normal development if opportunities for play, leisure and education are not provided
- unnecessary trauma from witnessing distressing sights and sounds
- compromises in the care of children/adolescents when staff and resources are diverted to provide care for adult patients

Recommendation 7: Implementation of the national protocol on inter-agency collaboration between the HSE and TUSLA should be evaluated in order to adequately meet the mental needs of children and adolescents.

Action: The protocol should be developed following an independent evaluation of current practices and any existing deficits should be addressed. Implementation of the revised protocol should be monitored on an ongoing basis.

⁴⁴¹ OCO (2015) p. 31-32.

⁴⁴² Office of the Children’s Commissioner (2007) *Pushed into the Shadows - Young People’s Experience of Adult Mental Health Facilities*. The Children’s Commissioner for England.

⁴⁴³ Royal College of Psychiatrists (2006) *Building & Sustaining Specialist CAMHS*. Council Report CR137, Royal College of Psychiatrists, London. www.rcpsych.ac.uk/publications/collegereports/cr/cr137.aspx.

⁴⁴⁴ Royal Australasian College of Physicians (2008). Standards for the care of children and adolescents in health services. Pediatrics & Child Health Division, Royal Australasian College of Physicians, New South Wales. www.racp.edu.au.

Action: Staff working in CAMHS and TUSLA should be made aware of this protocol, and be provided with the necessary training, supervision and support to ensure its implementation.

Rationale

The need for effective inter-agency collaboration between child and adolescent mental health and child and family services is widely recognised. TUSLA has stated that given that [it] and the HSE are now “separate entities it is essential that there is good inter-agency cooperation with key services that have remained in the HSE, including primary care, child and adolescent mental health and disability services”.⁴⁴⁵

Better Outcomes, Brighter Futures captures this sentiment in national policy as it includes a commitment to achieve effective inter-agency working in mental health service provision, including between TUSLA and the HSE.⁴⁴⁶

Despite such commitments, practice of effective collaboration between the two agencies has not been implemented at a systemic level. Where good practices occur they are often based on good relationships between particular staff members across services. The National Review Panel, in its 2014 annual report, made recommendations to address inter-agency difficulties on protocols about agreed thresholds, mutual expectations and sharing of information, a matter the Panel described as becoming more significant since the separation of child protection services from the HSE.⁴⁴⁷ Such recommendations related to a range of services, including TUSLA and HSE mental health services.

The Children’s Mental Health Coalition has identified a number of barriers to effective inter-agency working and equitable access to services for a number of children including:⁴⁴⁸

- a lack of shared understanding of mental health that goes beyond diagnostic labels and addresses the psychological well-being of children and young people
- ineffective key performance indicators that do not allow for/promote collaboration between agencies
- a lack of information sharing
- the absence of clear referral pathways

The impact of a lack of standard policy and practices for collaboration across agencies has been documented by Sloper (2004), with particular reference to children in care with mental health difficulties. The author suggests that shortfalls in this area result in children and families.⁴⁴⁹

- having to deal with a number of different professionals and agencies
- being provided with conflicting advice
- falling between gaps in services
- experiencing service inefficiencies and poor supports

⁴⁴⁵ TUSLA (2015) Annual Report, Dublin: TUSLA, p. 6.

⁴⁴⁶ Department of Children and Youth Affairs (2014).

⁴⁴⁷ The National Review Panel (2015) Annual Report 2014, Dublin: HSE p. 13.

⁴⁴⁸ Children’s Mental Health Coalition (2013) *Someone to Care*, Dublin: Mental Health Reform.

⁴⁴⁹ Sloper, P. (2004). *Facilitators and barriers for coordinated multi-agency services*. Child: Care, Health & Development, 30, 571-580.

- experiencing worsening of existing difficulties

Additional outcomes include a failure to engage families, lost prevention opportunities, failure to recognise the impact of trauma on behaviour, failure to refer children for assessments or services, high thresholds for access to services, lack of engagement with legal, education, health and mental health services, ineffective service delivery, poor attention to permanency, poor transition planning for 16- and 17-year-olds and poor transitioning into adulthood.^{450,451}

The Mental Health Commission, while recommending that CAMHS should remain independent from child and family services, concluded that “close relationships” should be developed between the two agencies.⁴⁵² It promotes integrated working and inter-agency collaboration and communication to address the mental health needs of children in care and in contact with child and family services. This position is reflected in the recommendations of the Taskforce on the development of a new Child & Family Support Agency.⁴⁵³

While acknowledging that the achievement of effective inter-agency working at a systems level is challenging, a number of recommendations have been identified in the literature to support this process, including:^{454,455}

- strategic commitment to integrated practice at Government level
- a focus on child-centred outcomes
- identifying the benefits and goals of joint working that relate to each agency’s remit
- a commitment to joint working in the relevant agencies
- agency staff being supported by senior management in this way of working and this being complemented by the provision of adequate resources
- incorporating collaborative processes in written policies and procedures
- conducting applications for joint funding, inter-agency service planning and facilitated strategic planning
- guidelines for embedding inter-agency working within participating agencies
- mechanisms to respond to agency under-performance
- clarity on where responsibility lies for the monitoring of compliance with protocols
- the co-location of staff
- clear understanding of roles and expertise among agencies and agency staff

⁴⁵⁰ Herz, D., Lee, P., Lutz, L., Stewart, M., Tuell, J., & Wiig, J. (2012). *Addressing the needs of Multi- System Youth: Strengthening the connection between Child Welfare and Juvenile Justice*. Washington: Center for Juvenile Justice Reform.

⁴⁵¹ Newman, L., Wagner, M., Cameto, R., Knokey, A. M., & Shaver, D. (2010) *Comparisons across time of the outcomes of youth with disabilities up to 4 years after High School. A report of findings from the National Longitudinal Transition Study (NLTS) and the National Longitudinal Transition Study-2 (NLTS2)* (NCSE 2010-3008). Menlo Park, CA: SRI International.

⁴⁵² Mental Health Commission. (2012). *Response to Task Force report on the Child and Family Agency*. Dublin: MHC.

⁴⁵³ Report of the Taskforce on the Child and Family Support Agency (2012) Dublin: Department of Children and Youth Affairs.

⁴⁵⁴ Shufelt, J.L. & Cocozza, J.J. (2006) *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study*. National Center for Mental Health and Juvenile Justice Research and Program Brief. Accessed 6 June 2013, from <http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf>

⁴⁵⁵ Health and Social Care Advisory Service (2008). *Youth Offending Teams mental health mapping*. London: London Children and Families Project.

- joint training in order to address differences in language and communication. It can also counteract staff resistance if goals, processes and procedures are addressed, along with sharing of positive results, and it can facilitate the development of programme manuals and other written materials

Specific recommendations for enhanced inter-agency communication and collaboration are also set in the CMHC's *Someone to Care* report, in response to existing gaps, as outlined above.

There are a number of good practice examples that can be considered in the development of standardised inter-agency working between TUSLA and CAMHS. The Choice and Partnership Approach in the UK and Australia is a CAMH service model that enables early access for children and young people through referral relationships between CAMHS and other child and family service agencies.⁴⁵⁶

Overall, systemic issues are preventing good inter-agency and multidisciplinary planning and service provision, as has been repeatedly identified in the literature in Ireland and worldwide. It is important to note that piecemeal changes are unlikely to achieve the goal of supporting the mental health needs of children and young people for whom the State is responsible; systemic change is required.

Recommendation 8: The HSE Mental Health Division should review its CAMHS Standard Operating Procedures biennially in order to keep abreast of good practice.

Action: The HSE Mental Health Division should adhere to its commitment to review, update and fully implement the Standard Operating Procedures in CAMHS services as a matter of priority.⁴⁵⁷

Action: The HSE Mental Health Division should review the CAMHS SOPs on a biennially basis and modify them as required in order to reflect ongoing developments in the area of child and adolescent mental health care.

Rationale

The effective implementation of the CAMHS Standard Operating Procedures is necessary for standardising service provision in all CAMH services across the country. The SOPs have the potential to go some way towards addressing the current shortfalls in child and adolescent mental health service provision, including lengthy waiting lists, restrictive referrals pathways, gaps in inter-agency collaboration and deficits in information provision for children and families.

It is important that all aspects of CAMHS are delivered in a consistent and timely fashion, regardless of where the service is accessed throughout the country. This will require full compliance with CAMHS SOPs by all child and adolescent mental health services across the country.

⁴⁵⁶ Mental Health Foundation (2009) Evaluation of the Choice and Partnership Approach. UK: National CAMHS Support Service.

⁴⁵⁷ This commitment is set out in the HSE's Mental Health Division Operational Plan 2017.

Recommendation 9: Development of CAMHS-specific quality standards and guidelines. This should be supported with the implementation of a quality and outcome monitoring system for CAMHS.

Action: The HSE Mental Health Division should review the draft CAMHS Quality Guidelines, developed by the CAMHS advisory group, and progress the guidelines to publication.

Action: The HSE Mental Health Division should take account of the WHO's guidance on developing a quality improvement process,⁴⁵⁸ in addition to the Quality Network for Community CAMHS Service Standards in the UK.

Action: The HSE should develop an information system for CAMHS that can report on outputs and outcomes, and contribute to CAMHS improvement.⁴⁵⁹

Rationale

The World Health Organisation (WHO) identified that a quality improvement process is essential good practice for CAMHS to measure whether “services increase desired mental health outcomes and whether they are consistent with current evidence-based practice”.⁴⁶⁰

There is promising international evidence that “outcome monitoring systems” demonstrate a positive impact on treatment effectiveness and efficiency for child/family mental health services.⁴⁶¹ However, it appears that the effectiveness of CAMHS treatment or intervention is not being routinely measured in Ireland. Although the specialist, multidisciplinary CAMHS advisory group developed operational guidelines based on the Mental Health Commission's Quality Framework, these draft guidelines were sent to the HSE for approval and progression in October 2013 and have not yet been finalised. CAMHS Quality Guidelines have the potential to provide a basis for audit and evaluation of services. This lack of documented quality guidelines for CAMHS in Ireland is not aligned with good practice in the provision of CAMHS, as advised by the World Health Organisation.

Recommendation 10: The development and implementation of a national framework to support children and adolescents to effectively transition from CAMHS to adult mental health services.

Action: The HSE Mental Health Division should ensure that all mental health services comply with the CAMHS Standard Operating Procedures, including protocols on supporting children and adolescents to transition from child to adult mental health services.

Action: The HSE Mental Health Division should develop further guidance on the effective transition of children/adolescents from CAMHS to adult services, based on the CAMHS SOPS. CAMHS compliance with such guidance should be monitored and measured on an ongoing basis.

⁴⁵⁸ World Health Organisation (2005). Mental Health Policy and Service Guidance Package: CAMH policies and plans. WHO, Geneva.

⁴⁵⁹ Ibid.

⁴⁶⁰ World Health Organisation (2005).

⁴⁶¹ Garland et al. (2013). “Improving Community-Based Mental Health Care for Children: Translating Knowledge into Action”. Administration and Policy in Mental Health. 40(1): 6–22.

Action: The development of youth specialist mental health services should be explored by the HSE Mental Health Division.

Rationale

The transition from child to adult mental health services can be a stressful process for the young people involved, as the adult system is significantly different to CAMHS, involving new care teams and care planning, new peers, and a new physical environment, regulated by new policies and procedures.

Research shows that this transition occurs at a time (between 16-18 years) of heightened mental health vulnerability among the younger population,⁴⁶² in the presence of diminished supports. Patrick McGorry, founder of Headspace in Australia, has noted that “public specialist mental health services have followed a paediatric-adult split in service delivery...however, the pattern of peak onset and the burden of mental disorders in young people means that the maximum weakness and discontinuity in the system occurs just when it should be at its strongest”.⁴⁶³ McGorry further notes that continuity of care, or at least an effectively managed transition, is paramount at this time.⁴⁶⁴

The Social Care Institute for Excellence in the UK has synthesised the evidence on good practice on the transition from child and adolescent to adult mental health care. Several key messages on good practice include:⁴⁶⁵

- service transition is a process and good practice needs to take account of the wider context of young people’s lives, including education, employment, housing and overall health needs
- young people, their families and carers should have their views taken seriously and be facilitated to participate actively in the process of transition
- the provision of good information, consistent support from a key worker and flexible, non-stigmatising community-based services appropriate for the age group
- collaborative flexible working between agencies, clear protocols and transparent planning meetings

The Standard Operating Procedures (SOPs) for community and inpatient CAMHS include guidance on the transition to adult mental health services. Specifically, the document states that⁴⁶⁶

- every young person of 17 years and above requires a transition plan within their ICP if it is intended that their care will move on to general adult mental health services⁴⁶⁷
- joint working between CAMHS and adult mental health services, including review/handover meetings, is required

⁴⁶² Cannon, M., Coughlan, H., Clarke, M., Harley, M. & Kelleher, I. (2013).

⁴⁶³ McGorry, P.D. (2007) “The specialist youth mental health model: strengthening the weakest link in the public mental health system”. *Med J Aust.* 1;187(7 Suppl):S53.

⁴⁶⁴ While, A. et al. (2004) *Good practices that address continuity during transition from child to adult care: synthesis of the evidence.* *Child Care, Health & Development*, 30,5,439-452.

⁴⁶⁵ Sainsbury, M. & Goldman, R. (2011) *Mental Health Service Transitions for Young People: Children’s and Families’ Guide.* Social Care Institute for Excellence, London.

⁴⁶⁶ HSE (2015).

⁴⁶⁷ The SOPs clearly state that not all young people will require a transition plan, but it is essential that all are assessed for it and the outcome of the assessment of future need is recorded clearly.

- where in-patient treatment is nearing completion, but might need to be continued beyond the 18th birthday, consideration may be given by the CAMHS in-patient team to completing the intervention as an in-patient within the CAMHS unit⁴⁶⁸
- the young person's key worker will be responsible for managing a smooth transition

One of the four key recommendations that Cannon, et al. (2014) make in light of the mental health vulnerability that young people in Ireland aged 19 to 24 experience, along with a recommendation for increased access to mental health services, is that Ireland develop “comprehensive, specialist youth mental health services that provide continuous care through the adolescent and emerging adult years.”⁴⁶⁹ This has been echoed by the Children’s Mental Health Coalition in its key findings for supporting the mental health needs of children and adolescents.

Consultation with young people shows that there is wide consensus among this group on the need for a specific adolescent/young adult service that enables this group to be among their peers and that provides a service that does not terminate at the age of 18 years. Instead, such a service provides a continuum of support from mid-teenage years to the mid-twenties, followed by post-discharge access to services and therapeutic support.”⁴⁷⁰

The Orygen Youth Health (OYH) project in Melbourne Australia is a good practice example of youth specialist mental health care, whereby early intervention is delivered to young people presenting with various types of mental health difficulties.⁴⁷¹ Among the supports provided by OYH are extended hours, mobile multidisciplinary teams providing intensive community based crisis response and home treatment, psychosocial and therapeutic individual and family services, peer support groups and a specialist youth inpatient unit.

468 In all such cases, the Mental Health Division must be informed through the appropriate Community Health Organisation management structure that is responsible for the CAMHS in-patient unit. The Mental Health Commission should also be informed. In such cases, best interest principles must apply. Such principles must take into account the needs of the individual young person who has just turned 18 as well as the other children/young people who are in the unit. The maximum period of time that a young person who has just turned 18 should remain as an in-patient within a CAMHS unit is no longer than two weeks.

⁴⁶⁹ Cannon, M., Coughlan, H., Clarke, M., Harley, M. & Kelleher, I. (2013).

⁴⁷⁰ Buckley, S. et al. (2012).

⁴⁷¹ Purcell, R. et al. (2011) “Toward a Twenty-First Century Approach to Youth Mental Health Care: Some Australian Initiatives”. *International Journal of Mental Health*, vol. 40, no. 2, Summer 2011, p. 72-87.

Chapter 7: Older people

There are a number of national and international instruments⁴⁷² that recognise that “later life can and should be a time for active citizenship.... and for engaging in the kinds of activities that enhance physical and mental health”.⁴⁷³

The 2002 Madrid International Plan of Action on Ageing calls on governments to empower older people and ensure their full participation in society.⁴⁷⁴ This is reflected in the UN Principles for Older People, which include a principle on promoting the participation of older people. More specifically the Principles state that older persons should also have “access to healthcare to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness”.⁴⁷⁵

Ireland’s National Positive Ageing Strategy, 2013, states that it will “enable and support all ages and older people to enjoy physical and mental health and well-being to their full potential”.⁴⁷⁶ This will be achieved through promoting and respecting “older people’s engagement in economic, social, cultural, community and family life” and by “fostering a shared understanding across Government and all sectors of society about the meaning of positive ageing^{477,478} and to direct and guide policy and service delivery towards that purpose”.

The Strategy also recognises that particular attention should be paid to the needs of more marginalised, vulnerable, hard-to-reach and minority groups of older people such as those living in rural areas, persons with impaired [decision making] capacity or dementia and those who care for them, older migrants and people from different ethnic backgrounds, older people with specific physical and intellectual disabilities, Travellers and lesbian, gay, bisexual and transgender older people.

The Healthy Ireland framework makes a commitment to improving “partnerships, strategies and initiatives that aim to support older people to maintain, improve or manage their physical and mental well-being”.⁴⁷⁹ This entails addressing risk factors and promoting protective factors at every stage of life, including old age, to support lifelong health and well-being.

While *A Vision for Change* included a dedicated chapter on mental health care for older people, its recommendations were not specific enough on developing capacity within primary care to treat mental health difficulties, or on addressing stigma among this age group. Mental Health Reform

⁴⁷² UN First World Assembly on Ageing 1982; UN Principles for Older Persons 1991; International Year of Older Persons 1999; UN Second World Assembly on Ageing, the Madrid International Plan of Action on Ageing (MIPAA) 2002 and the MIPAA+5 and MIPAA+10 Reviews; Europe 2020 - Innovation Union (2010) and the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA); European Year for Active Ageing and Solidarity between Generations 2012.

⁴⁷³ Department of Health (2013) *Positive ageing - starts now! The national positive ageing strategy*, Dublin: Department of Health, p. 5.

⁴⁷⁴ United Nations (2002) *Report of the Second World Assembly on Ageing: Madrid International Plan of Action on Ageing*. Available at www.un.org/ageing/madrid_intlplanaction.html

⁴⁷⁵ United Nations, 1991. United Nations Principles for Older Persons. Available at www.un.org/ageing/un_principles.html (Accessed 16 September 2010).

⁴⁷⁶ Department of Health (2013), p. 18.

⁴⁷⁷ Ibid.

⁴⁷⁸ Positive ageing is an approach that aims to maintain and improve the physical, emotional and mental well-being of older people. It extends beyond the health and community service sectors, as the well-being of older people is affected by many different factors including socioeconomic status, family and broader social interactions, employment, housing and transport. Social attitudes and perceptions of ageing can also strongly influence the well-being of older people, whether through direct discrimination or through negative attitudes and images. Office for an Ageing Australia website: www.ageing.health.gov.au/fofa

⁴⁷⁹ Department of Health (2013) p. 25.

recommends that Government uphold the existing recommendations in *A Vision for Change* on mental health care for older persons, including the Expert Group's recommendations on the:⁴⁸⁰

- need for such care to extend over a continuum of services from health promotion, primary care and home supports to acute general hospital care, specialist day care, acute psychiatric inpatient care, specialised mental health service continuing care, and non-specialist continuing care in hospital settings and nursing home care
- need to consider the interdependence of physical and mental health care in older persons
- need for an extensive and integrated range of care options available to older people

In addition to the existing recommendations set out in *A Vision for Change* the revised policy should reflect the following recommendations:

Recommendation 1: A national action plan on identifying and meeting the mental health needs of older people living in Ireland, including through assessment, diagnosis and treatment/care, should be developed.

Action: The Department of Health, in collaboration with the HSE and other relevant agencies, should develop a national action plan on meeting the mental health needs of the older population based on the findings of the Irish Longitudinal Study on Ageing (TILDA).

Action: The HSE should provide training for staff across health and social services on recognising the particular mental health needs and risks of older adults and on referring to appropriate supports. Such training should also be extended to other agencies such as nursing home staff, as well as primary care professionals.

Rationale

The first wave of TILDA found evidence that a large proportion of older people with depressive symptoms were not receiving any treatment for depression and had not been diagnosed as having depression by their doctor. 78% of people with objective evidence of depression did not report a doctor's diagnosis and 85% of older adults with objective evidence of anxiety did not report a doctor's diagnosis.⁴⁸¹ This large unmet need for diagnosis and treatment may reflect the nature of depressive disorders in older adults, as they are less likely to report sadness, depressed mood or feelings of worthlessness, which are often considered hallmarks of depression. TILDA has also reported the stigma attached to mental health difficulties among the older population.

Recommendation 2: The capacity within primary care to appropriately respond to mental health difficulties among the older population and to recognise the mental health impact of chronic physical health conditions among older people should be enhanced. This should be supported with the necessary resourcing.

Recommendation 3: The physical health of (older) people with ongoing mental health difficulties should be regularly assessed and cared for appropriately.

⁴⁸⁰ AVFC (2006) p. 114-123.

⁴⁸¹ The Irish National Longitudinal Study on Ageing. *Fifty Plus in Ireland 2011: First results from the Irish longitudinal study on ageing*, Chapter 6: 'Mental health and cognitive function', available at <http://tilda.tcd.ie/publications/reports/>

Action: The ICGP and other professional associations should ensure that GPs and other relevant disciplines are appropriately trained, including through continuous professional development, to recognise and respond to mental health difficulties among older people.

Action: Government, in collaboration with the Department of Health and the HSE, should ensure that in the commissioning of all primary level mental health services and supports, the provision of comprehensive physical health assessments is a key component of service delivery.

Rationale

This recommendation should be read in line with MHR's recommendations in chapter 4 on enhancing mental health in primary care, including through the delivery of training to all GPs and other relevant disciplines and the monitoring of such training to ensure its effective implementation. The principles of shared care as outlined in Chapter 4 also apply in this context.

The Expert Group on *A Vision for Change* recognised the strong correlation between physical and mental health and that people with severe mental health difficulties have poorer physical health than the general population.⁴⁸² Similarly, people with poor physical health are at higher risk of experiencing mental health difficulties. The Expert Group identified that GPs are the key providers of general health care to this group of individuals.

There is evidence that people with severe mental health difficulties have a reduced life expectancy and die an estimated 15-20 years before the general population. Furthermore, the bulk of increased mortality in people diagnosed with severe mental health difficulties is largely attributed to preventable physical health problems such as cardiovascular disease, obesity and diabetes.

A published report by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the US found that adults aged 18 or older with any mental disorder or major depressive episode in the past year were more likely than adults without these conditions to have high blood pressure, asthma, diabetes, heart disease and stroke. The same study found that adults with 'serious mental illness' in the past year were more likely than adults without 'serious mental illness' to have high blood pressure, asthma and stroke. In terms of health service utilisation, adults with any mental disorder used both emergency departments and hospitalisation more than those without a mental disorder. Similar results were found for those with severe mental disorders and those with major depression.⁴⁸³

Furthermore, in a study of individuals with severe mental health difficulties, accessing a North Dublin general practice, it was identified that improvements need to be made in the monitoring of the physical health of individuals accessing the service. The study highlighted the need for more consistency in checking weight, smoking status, blood pressure and the cardiovascular risk score of this group of individuals. It also recommended that the low number of female "patients" participating in active breast cancer surveillance and cervical screening should be addressed.⁴⁸⁴

⁴⁸² AVFC (2006) p. 63.

⁴⁸³ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (April 5, 2012) *The NSDUH Report: Physical Health Conditions among Adults with Mental Illnesses.*, Rockville, MD: SAMHSA.

⁴⁸⁴ Pringle, E. and Bates, M. (2011) "Physical illness in patients with severe mental disorders". *World Psychiatry* 2011;10:138-151.

NICE sets out clear guidelines on the need for ongoing⁴⁸⁵ physical assessments of people with mental health difficulties, in particular those individuals with psychosis or schizophrenia.^{486,487} Specifically, the guidelines state that GPs should ensure that protocols are in place to carry out comprehensive physical assessments and to share the results, under shared care arrangements, when the individual is in the care of primary and secondary services.

The WHO has developed a toolkit that assists primary health care workers in addressing health issues which are prevalent among the older population, including depression. The toolkit's purpose is to:⁴⁸⁸

- improve the primary health care response for older persons
- sensitise and educate primary health care workers about the specific needs of older people
- provide primary health care workers with a set of tools/instruments to assess older people's health
- raise awareness among primary health care workers of the range of minor/major disabilities experienced by older people
- provide guidance on how to make primary health care management procedures more responsive to the needs of older people
- offer direction on how to do environmental audits to test primary health care centres for their age-friendliness

There are significant costs associated with treating mental health difficulties separately to other areas of care and there is no doubt that there is a strong link between physical and mental health difficulties, as evidenced above. Furthermore, mental health difficulties often increase physical health problems and can make existing physical health problems worse. Altogether, the extra physical healthcare needs caused by mental health difficulties was estimated in 2012 to cost the NHS at least £10 billion.⁴⁸⁹ Further education and training should be provided for primary care staff, in particular GPs, to ensure such professionals have an understanding of the important relationship between physical and mental health, particularly among the older population.⁴⁹⁰ This should be replicated across mental health services and other health and social sectors that regularly come into contact with older people.

More broadly, actions to address the relationship between physical and mental health difficulties across the life span must be developed.

⁴⁸⁵ Individuals with psychosis or schizophrenia should receive a comprehensive physical health assessment within 12 weeks of having treatment of a first episode of psychosis; one year after starting treatment and thereafter annual comprehensive physical health assessments.

⁴⁸⁶ NICE (2015) Psychosis and schizophrenia in adults - Quality Statement 6 Assessing Physical Health. NICE quality standard [QS80]. Available at <https://www.nice.org.uk/guidance/qs80/chapter/Quality-statement-6-Assessing-physical-health>

⁴⁸⁷ The NICE guidelines recommend that comprehensive physical health assessments should focus on physical health problems common in people with psychosis and schizophrenia by monitoring weight (plotted on a chart) – weekly for the first 6 weeks, then at 12 weeks, at 1 year and then annually; waist circumference annually (plotted on a chart); pulse and blood pressure at 12 weeks, at 1 year and then annually; fasting blood glucose, HbA1c and blood lipid levels at 12 weeks, at 1 year and then annually and overall physical health. Interventions should be offered in line with NICE guidelines on lipid modification, preventing type 2 diabetes, obesity, hypertension, prevention of cardiovascular disease and physical activity.

⁴⁸⁸ WHO (2008) Age-friendly Primary Health Care Centres Toolkit, Geneva: WHO.

⁴⁸⁹ Centre for Economic Performance (2012) *How Mental Illness Loses Out in the NHS*, p. 1.

⁴⁹⁰ The UK's Royal College of Psychiatry supports additional training in general practice to encourage more learning about the development and relationship between physical and mental health.

Recommendation 4: Access to talking therapies through primary care for older people with mild to moderate mental health difficulties should be enhanced.

Rationale

In a recent study in the UK that evaluated the outcomes of the IAPT (Improving Access to Psychological Therapies) service among older people,^{491,492} findings demonstrated that psychological supports are beneficial to older people. This reflects the results of systematic reviews that have shown that psychological therapies are effective in addressing depression and anxiety in older adults.^{493,494,495,496,497} In the study, recovery rates were generally better among older people than the younger population, particularly in relation to depression and anxiety.⁴⁹⁸ Attendance at a higher number of sessions was also associated with higher levels of recovery and older adults were shown to be less likely to drop out of the service. This may be a contributor to higher recovery rates among the older population.

However, access to IAPT services was lower than expected among older adults, accounting for only 4% of all referrals over a period of 20 months.^{499,500} The study identified that people aged over 65 were less likely to be referred to IAPT by their GP and they were more likely to self-refer. This pattern of low referrals by GPs was attributed to a lack of knowledge and understanding among such professionals in identifying mental health needs among older people. The authors of the study have recommended that enhanced awareness among GPs is required in order to improve their capacity to address mental health in later life. The Association of Occupational Therapists of Ireland has also described the need to improve access for older people to primary care mental health services.

The option of self-referral through the IAPT service provides another route into services and targets individuals or groups who would not otherwise access such supports. A paper by Brown, Boardman, Whittinger and Ashworth (2010) concluded that the self-referral system in IAPT is mostly advantageous, improving access to harder-to-reach communities, and to those individuals

⁴⁹¹ Prina et al. (2014) "Improving access to psychological therapies and older people: Findings from the Eastern Region". *Behaviour Research and Therapy*, 56 (2014) 75-81.

⁴⁹² This study included representation from six Public Care Trusts (PCT) in the east of England, which altogether comprises 10% of the population. The study had a large sample size that included over 16,000 individuals and data from almost 100,000 sessions over a 20-month period.

⁴⁹³ Cuijpers, P., van Straten, A., Smit, F., & Andersson, G. (2009) "Is psychotherapy for depression equally effective in younger and older adults? A meta-regression analysis". *International Psychogeriatrics*, 21(1), 16-24.
<http://dx.doi.org/10.1017/S1041610208008089>

⁴⁹⁴ Goncalves, D.C., & Byrne, G.J. (2012). "Interventions for generalized anxiety disorder in older adults: systematic review and meta-analysis". *Journal of Anxiety Disorders*, 26(1), 1e11. <http://dx.doi.org/10.1016/j.janxdis.2011.08.010>

⁴⁹⁵ Hendriks, G.J., Oude Voshaar, R.C., Keijsers, G.P., Hoogduin, C.A., & van Balkom, A.J. (2008) "Cognitive-behavioural therapy for late-life anxiety disorders: a systematic review and meta-analysis". *Acta Psychiatrica Scandinavica*, 117(6), 403e411. <http://dx.doi.org/10.1111/j.1600-0447.2008.01190.x>

⁴⁹⁶ Krishna, M., Jauhari, A., Lepping, P., Turner, J., Crossley, D., & Krishnamoorthy, A. (2011) "Is group psychotherapy effective in older adults with depression? A systematic review". *International Journal of Geriatric Psychiatry*, 26(4), 331e340. <http://dx.doi.org/10.1002/Gps.2546>

⁴⁹⁷ Pinquart, M., Duberstein, P.R., & Lyness, J.M. (2007). "Effects of psychotherapy and other behavioral interventions on clinically depressed older adults: a metaanalysis". *Aging & Mental Health*, 11(6), 645e657.
<http://dx.doi.org/10.1080/13607860701529635>

⁴⁹⁸ The differences were not statistically significant in many cases, with the exception of a reliable recovery on the anxiety scale, but this is probably due to the small sample sizes in some of the sites.

⁴⁹⁹ Prina et al. (2014).

⁵⁰⁰ The study expected this proportion to be closer to 13% based on the age structure in the east of England and the prevalence of mental health difficulties found that in the Adult Psychiatric Morbidity Survey.

who do not seek the support of a GP due to “stigma, pre-conceived attitudes towards doctors, or health beliefs”.⁵⁰¹

The Counselling in Primary Care service in Ireland does not provide for self-referrals. In light of the low rate of referrals made by GPs (of older people) to the IAPT service in the UK, access to talking therapies for older people (including through self-referral) should be explored in the Irish context. Attention must be given to particularly vulnerable older people who reside in residential centres or other facilities in terms of access.

Recommendation 5: Unnecessary prescribing of medication for mental health difficulties among the older population should be reduced. This should be complemented by enhanced management of medication among older adults.

Action: The HSE should provide guidance for older people and professionals working with older people on medication management. This should include information on psychotropic medication, advice on the effects of taking a number of different medications simultaneously, and advice on minimising the risk of adverse effects.

Action: The HSE should develop a protocol for integrated communication about individual clients’ medication regimens between agencies working with older people.

Action: The HSE should develop a programme to enhance the capacity of pharmacists to assist older people with their medication management, particularly where mental health difficulties are present. There is also the potential for pharmacists to provide outreach support to older people in the community for the purpose of assisting individuals with taking their medication.

Rationale

There is evidence that there may be an over reliance on the prescribing of medication for older people, including in the treatment of mental health difficulties. According to recent Irish research, 12% of those aged between 50 and 64 are taking five or more medications (polypharmacy) with this percentage rising to 41% among those aged 75 years and over.⁵⁰² While a number of medications may be necessary to manage certain diseases, it can indicate the use of inappropriate prescribing.

The potential adverse effects of medication on older people is also of concern. Research has found an association between polypharmacy,⁵⁰³ functional impairment, falls and fractures, hospital admissions and mortality. Donoghue, et al. (2015) found that antidepressants are associated with gait impairments in older people, increasing the risk of adverse outcomes, including falls.^{504,505}

⁵⁰¹ Brown, J.S., Boardman, J., Whittinger, N., & Ashworth, M. (2010) “Can a self-referral system help improve access to psychological treatments?” *British Journal of General Practice*, 60(574), 365e371. <http://dx.doi.org/10.3399/bjgp10X501877>.

⁵⁰² Department of Health (2013) p. 32.

⁵⁰³ Poly-pharmacy is defined as the concurrent use of five or more medications; excessive poly-pharmacy is defined as the concurrent use of 10 or more medications.

⁵⁰⁴ Donoghue, O.A., O’Hare, C., King-Kallimanis, B., & Kenny, R.A. (2015). “Antidepressants are independently associated with gait deficits in single and dual task conditions”. *Am.J.Geriatr.Psychiatry.*, 23(2), 189-199.

⁵⁰⁵ The cost to the economy of falls and fractures in older people is approximately €500 million annually, which includes costs associated with emergency department visits, hospital stays, GP and out-patient visits and long stay residential care. The most predictive risk factors for falling are muscle weakness, history of falls and gait/balance deficits and poly-pharmacy.

The authors have recommended interventions aimed at improving physical function, which is a known safeguard against falls and functional disability.

Furthermore, TILDA identified that antidepressant use was associated with decreased heart rate variability in older people. This is particularly relevant due to the high prevalence of cardiovascular disease (CVD) and increased prescribing of antidepressants in this age group.⁵⁰⁶ TILDA has recommended that longitudinal evidence be gathered to determine whether observed effects of antidepressants on heart rate variability translate into cardiovascular disease morbidity and mortality in depressed older adults.

Overall, there is a requirement to respond to the over-prescribing of medication among older people at national level and to provide a range of alternative therapies, including talking therapies as outlined above. Often older adults will be engaged with a number of services and the respective services are not aware of the range of treatments/medication the individual is in receipt of. There is a need for a more integrated approach among services and agencies to address this gap.

Recommendation 6: A national social care model to reduce isolation, disablement and inactivity among older people should be developed in order to prevent mental health difficulties arising and promote recovery of older people experiencing/at risk of mental or emotional distress.

Action: The Department of Health, in collaboration with other relevant Government departments and agencies, should develop a national social care model in order to meet the social care needs of the older population.

Action: The HSE should enhance outreach supports and home help, based on evidenced need, in order to meet the social care needs of older people living in the community, including those with existing mental health difficulties. A restructuring of the current home care model should be explored, in order to adequately meet the needs of the older population. This may be supported by the establishment of a national statutory scheme for home care.

Action: The HSE should consider relevant NICE guidelines in the development of any social care model, including NICE guidance on *Older People: Independence and Well-being* and *Mental Well-Being in over 65s: Occupational Therapy and Physical Activity Interventions*.

Action: The HSE should commit to the further development of housing supports with integrated care for older people, including those with mental health difficulties. For example, Fold Ireland provides housing with care services for older people, including for those who have been diagnosed with dementia.

Action: The HSE should ensure that visiting/tenancy sustainment supports are provided for older people who wish to live independently in the community, including older people with mental health difficulties.

⁵⁰⁶ O'Regan, C., Kenny, R.A., Cronin, H., Finucane, C., & Kearney, P.M. (2015). "Antidepressants strongly influence the relationship between depression and heart rate variability: findings from The Irish Longitudinal Study on Ageing (TILDA)". *Psychol.Med.*, 45(3), 623-636.

Rationale

The additional funding allocated to home help services (home help and home care packages) by Government in June 2016 must be acknowledged. However, according to Age Action, “thousands of older people are simply not getting the support that they need.”⁵⁰⁷ Age Action has stated that “home help services are in crisis with growing waiting lists right across Ireland - even with these additional resources, community care is still grossly underfunded”.⁵⁰⁸ In April 2017, a waiting list of more than 2,400 (mostly elderly) people for home care packages was reported.⁵⁰⁹

Findings from a recent study⁵¹⁰ highlight significant difficulties in accessing home supports for older people (from home and acute settings); supports which are fundamental to improving mental health outcomes. Such difficulties include:

- long waiting times
- red tape and lack of flexibility
- task-focused care provision (particularly in the case of home help where 1 hour only per week may be allocated to an older person)
- a move away from domestic support
- lack of recognition of psycho-social needs
- variability between support services based on geographical location

The study highlights that the allocation of home care package (HCP) hours were not based on demographics but on set budgets. Therefore, in areas with a high proportion of older people, hours are ‘spread more thinly’. According to the authors, “demand for HCP hours frequently outstrips supply, with over half of the participants of the study reporting a difference between the HCP hours the older person was assessed as needing, the amount applied for and the hours granted.”⁵¹¹

Despite a 25% increase in the population of those aged 65 years and over and a near 30% increase in the population of those 85 years and over between 2008 and 2015, there has been nearly a 2% decrease in the number of people receiving home help and home care packages.⁵¹²

In the same period, the funding for long-term care has increased, in addition to the number of individuals being supported under the Nursing Home Support Scheme. With some 4.5% of older people living in long-term residential care in Ireland, this is 40% above the EU average.⁵¹³ Previous research has shown that Ireland has the second highest proportion of people aged 65 and over

⁵⁰⁷ Age Action (16th June, 2016) “Age Action welcomes additional home help funding”, press release available at <https://www.ageaction.ie/news/2016/06/16/age-action-welcomes-additional-home-help-funding>

⁵⁰⁸ Ibid.

⁵⁰⁹ O'Regan, E. (12 April 2017). “Just 300 extra home-care packages for 2,400 people”. Irish Independent. Available at <http://www.independent.ie/irish-news/health/just-300-extra-homecare-packages-for-2400-people-35615936.html>

⁵¹⁰ Donnelly, S., O'Brien, M., Begley, E. and Brennan, J. (2016) *“I'd prefer to stay at home but I don't have a choice” Meeting Older People's Preference for Care: Policy, but what about practice?* Dublin: University College Dublin.

⁵¹¹ Ibid.

⁵¹² Donnelly, S., O'Brien, M., Begley, E., and Brennan, J. (2016) *“I'd prefer to stay at home but I don't have a choice” Meeting Older People's Preference for Care: Policy, but what about practice?*, University College Dublin. Retrieved from https://www.ageaction.ie/sites/default/files/aa2c_asi2c_iasw_final_research_report-a4-report_lr_for_web_2.pdf

⁵¹³ Colgan, L. (3 June 2016) “Home care spend falls as the elderly population rises: More old people now in residential homes”. The Irish Daily Mail. Available at [https://www.alzheimer.ie/getattachment/About-Us/News-and-Media/Media-coverage/Daily-Mail-\(1\).PDF.aspx](https://www.alzheimer.ie/getattachment/About-Us/News-and-Media/Media-coverage/Daily-Mail-(1).PDF.aspx).

resident in nursing homes and hospitals in the EU.⁵¹⁴ Between 2004 and 2013 there was a 44.6% increase in the number of residents in nursing homes categorised as low dependency and a 17.6% increase in the number of residents with medium dependency⁵¹⁵, suggesting that higher numbers of older people in Ireland with low-medium support needs are now entering long-term residential care.

Age Action has advocated for the roll out of a National Re-ablement Programme to improve and maintain older people's physical strength and mental health, enabling greater independence, and reducing the need for ongoing home support and long term care.⁵¹⁶ The cost effectiveness of such a programme has been shown in a pilot in North Dublin, which found a reduction in the need for home help hours following the provision of intensive supports. Findings from the pilot project showed improvements in self-care, day to day activities, mobility, social participation and emotional well-being (among other outcomes). Following participation in the programme, 21% of individuals required no on-ongoing home support and 59% required decreased home supports.⁵¹⁷ There is some evidence to suggest that those individuals who have reached the 6 month period after re-ablement have maintained low intensity or no requirement for home care.

In the UK, there has been considerable investment in re-ablement programmes by Government in recent years. Overall, re-ablement has been associated with significantly greater improvements in health-related quality of life, in addition to social care outcomes, compared with people using conventional home care services.⁵¹⁸ People who had used home care re-ablement had significantly better outcomes, when measured between nine and twelve months later, in comparison to those using conventional home care services.

Moreover, there is a significant evidence base for health-promoting occupational therapy (OT) interventions for independent community living among older adults.⁵¹⁹ 'Lifestyle Redesign' is an OT wellness programme based on healthy ageing, helping older people to improve their quality of life. It utilises OT principles of client-centred engagement to empower individuals to set goals and facilitate achievement of such goals.⁵²⁰ Client goals may include the ability to prepare simple meals, to email friends and family or expand leisure interests, to enhance social networks or attend religious services. It encourages older people to foster healthy habits and participate in varied activities that promote physical and mental health and well-being.

The first Lifestyle Redesign study, known as the 'Well Elderly Study', was a randomised control trial of the efficacy and cost-effectiveness of a 9-month lifestyle intervention designed to slow age-

⁵¹⁴ Drennan, J., Lafferty, A., Treacy, M.P., Fealy, G., Phelan, A., Lyons, I. and Hall, P. (2012) *Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts*. Dublin: NCPOP & University College Dublin.

⁵¹⁵ DoH (2013).

⁵¹⁶ Age Action (2015) Pre-Budget Submission 2016 available at https://www.ageaction.ie/sites/default/files/attachments/age_action_priorities_for_budget_2016.pdf

⁵¹⁷ Information provided by Age Action.

⁵¹⁸ Glendinning, C., Jones, K., Baxter, K., Rabiee, P., Curtis, L.A., Wilde, A., Forder, J.E. and Arksey, H. (2010) *Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study)*. York: Social Policy Research Unit, University of York.

⁵¹⁹ The notion that remaining active and productive improves life satisfaction underpins many occupational therapy theoretical viewpoints. Kielhofner's Model of Human Occupation and the Canadian Model of Occupational Performance suggest that active engagement in a variety of occupations promotes and maintains physical, cognitive and emotional health, while disengagement or inactivity leads to deterioration and dysfunction. These theories state that occupational performance is as a result of the dynamic relationship between persons, occupations (meaningful activities, tasks and roles) and the environment (Baum and Christiansen, 2005). Occupation, defined as activity that is meaningful for individuals, is essential for the maintenance of quality of life at all stages of the life course (Clark et al., 1991; Law et al., 1998, Yerxa, 1998).

⁵²⁰ Mandel et al., 1999; Horowitz et al., 2004.

related declines among independent community living older adults.^{521,522} The focus was to educate older people about the impact of everyday occupations, enable them to organise a healthy and meaningful pattern of activity, and to acquire and practise behaviours for managing daily life that promote healthy ageing.⁵²³ The interventions were found to have a positive effect on a wide range of outcomes, such as life satisfaction, role functioning and self-rated physical and emotional health (relating to pain, physical functioning, role limitations, vitality, social functioning and general mental health).⁵²⁴ Significantly, 90% of the therapeutic gain was retained 6-months post-intervention.⁵²⁵

Following the Well Elderly study, a number of smaller scale studies were conducted across Europe, to examine the transferability of occupation-based health-promoting interventions for older populations across different cultures and countries. Craig and Mountain (2007) conducted one such study in the UK, designing the Lifestyle Matters intervention in conjunction with older people. Based on this occupational approach to healthy ageing, it assisted participants to improve quality of life and avoid the negative spiral of decline associated with social isolation and poor mental health.⁵²⁶ Despite the small scale of the study, the results are significant, and along with the US Well Elderly study of Lifestyle Redesign, it is cited in the UK national guidelines on the promotion of mental health and well-being of older people, which are currently implemented across the UK.

Recommendation 7: Local initiatives that aim to enhance the social inclusion of older people within their communities should be developed, in order to improve the mental health outcomes of this group.

Action: Government should allocate funding for the development of community initiatives which promote the mental well-being of older people through social inclusion.

Action: Mental health services should provide information to older people accessing care about the community and social supports available in their local areas.

Rationale

The first set of results from TILDA reported that quality of life increases with greater social integration and there is a strong positive association between social engagement and physical and mental health outcomes.⁵²⁷

While the majority of the older adult population of Ireland are deemed to be socially integrated⁵²⁸ as measured by the Social Network Index, approximately 6% of women and 7% of men are socially isolated.⁵²⁹ Older people with poorer (self-rated) health are more likely to report being

⁵²¹ Clark et al., 1997.

⁵²² The study included 361 older people from two large subsidised housing complexes. Participants met in a weekly group over 9 months and had monthly individual sessions with occupational therapists. The emphasis was on participants identifying their own goals and empowering them. The programme included discussion of the power of occupation, ageing, health and occupation, transport, safety, social relationships, cultural awareness and finances.

⁵²³ Yamanda et al., 2010.

⁵²⁴ (Clark et al., 1997; Clark et al., 2001; Hay et al., 2002).

⁵²⁵ Clark et al., 2001.

⁵²⁶ Mountain et al., 2008, Mountain and Craig, 2011.

⁵²⁷ Timonen, V., Kamiya, Y. & Maty (2011) *Social engagement of older people* available at <http://tilda.tcd.ie/assets/pdf/glossy/Chapter4.pdf>.

⁵²⁸ TILDA reveals high levels of engagement with family and friends among the older population as a whole; involvement in civic and religious activities, with more than 80 per cent of this population group having voted in the last general election; and one in five older adults aged 65-74 engaged in voluntary work daily or weekly.

⁵²⁹ Timonen, V., Kamiya, Y. & Maty (2011), p. 58.

isolated than their healthier counterparts and large differences have also been identified in some aspects of social engagement by levels of education,⁵³⁰ i.e. the most integrated group is the most educated and the most isolated group is the least educated.

While not all socially isolated older adults experience loneliness, better interventions must be developed for those who are isolated and lonely. The Institute of Public Health (IPH) reports that chronic loneliness affects approximately 10% of older people⁵³¹ and loneliness has been shown to predict a wide variety of mental and physical health outcomes such as depression. The IPH has produced a report on loneliness and ageing, which includes key recommendations, including the need to 1) develop and foster a better understanding of the concept of loneliness, 2) identify chronic loneliness as a social health priority, 3) ensure that loneliness interventions are based on evidence, 4) establish services and initiatives (including social participation) to tackle chronic loneliness and 5) support the development of a strong evaluation culture of interventions on loneliness.⁵³²

The National Council on Ageing and Older People (NCAOP) recommended that social intervention measures, including contact with a range of community services, can play an important role in lessening a sense of isolation, and may be the link needed to prevent the development of mental health difficulties and/or may lessen the impact of existing difficulties.^{533,534} Interestingly, TILDA, in its report on the economic status of people over 50, identifies that utilisation of community health and social care services across the older population remains low.⁵³⁵

In another TILDA report⁵³⁶ it was identified that many individuals, especially those in rural areas, must travel to access key services. This can cause significant difficulties in access to social and health care services and supports, particularly where older people are relying on public transport or lifts from others. Transport services that are available, particularly in rural areas, are often limited in terms of routes and schedules and therefore do not always meet the needs of older adults. This is supported by the fact that 58% of adults living in rural areas rate the public transport services in their area as poor or very poor.

The report recommends that there is an increasing need for improved transport networks and facilities that meet the specific needs of older adults, especially in rural areas. This is fundamental to ensuring that people maintain levels of social participation and access the range of services required for an active and independent life, thus leading to improved health and well-being.

⁵³⁰ Participation in formal, organised activities, such as volunteering, is highest among those with higher levels of education.

⁵³¹ Harvey, B. & Walsh, K. (2016) *Loneliness and Ageing: Ireland, North and South*, Dublin: Institute of Public Health in Ireland.

⁵³² Ibid.

⁵³³ Keogh, F. & Roche, A. (1996) *Mental Disorders in Older Irish People: incidence, prevalence and treatment*, Dublin: National Council for the Elderly.

⁵³⁴ One of the key documents that emphasises the contribution of education to the health and well-being of older people in Ireland is *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998). Among the recommendations in this report include: encouraging and facilitating retired people to be involved in physical, educational, creative and social activities; encouraging and supporting older people to participate in extra-mural adult education programmes at universities and colleges as part of a lifelong learning process; enabling older people to become confident users of technology so that they can participate more fully in society (page 46 - NCAP social inclusion paper - CDBs).

⁵³⁵ TILDA (2014) *The Over 50s in a Changing Ireland: Economic Circumstances, Health and Well-being* available at <https://www.ucd.ie/t4cms/Wave2-Key-Findings-Report%20The%20Over%2050s%20in%20a%20Changing%20Ireland.pdf>

⁵³⁶ *Transport patterns in community-dwelling adults aged 50 years and over in Ireland.*

Furthermore, inadequate income and resources may result in older people being excluded and marginalised from participating in activities which are considered the norm for other people in society'.^{537,538}

The National Action Plan for Social Inclusion 2007-2016 commits to the goal of sufficient income for older people to enable them to enjoy an acceptable standard of living. This goal is further reflected in the National Strategy for Positive Ageing. The impact of poverty and deprivation on an individual's willingness and ability to participate in social activities should be considered in the promotion of social inclusion among older people.

The National Positive Ageing Strategy also highlights difficulties for older people in accessing information about available services and supports, which can have a negative impact on the social inclusion and quality of life of this group.

The NCAOP recognised that local development structures are key mechanisms for promoting the social inclusion of older people at local level.⁵³⁹ These structures also offer a space for older people and older people's groups to voice the concerns of this group of individuals through direct engagement. Training should be provided to ensure that participating individuals and organisations have the capacity to articulate their views (based on their own knowledge and experience) and to effectively participate in local level planning and decision making. It is necessary that inter-agency coordination is developed, at local and national level, in order to provide joined up services and supports for older people that promote their inclusion within society.

In summary, social engagement and inclusion is key for promoting older people's mental health and preventing mental health difficulties. Older people engaging in active social participation and having strong social networks has been associated with improved quality of life and reduced depression.⁵⁴⁰ It is clear that there is a need for the development of community supports, e.g. resource centres and community development initiatives, that support this. Previously, the NCAOP identified gaps in service provision for older people and recommended the need to expand choice, mainstream existing services and improve linkages between services.⁵⁴¹ "Government should maximise the benefits of network integration, thereby improving the mental health and overall emotional well-being of the older population".⁵⁴²

⁵³⁷ Government of Ireland, 1997. *Sharing in Progress: National Anti-Poverty Strategy*. Dublin: Stationery Office

⁵³⁸ The NCAOP stated its concern regarding the low numbers of older people in paid employment, the need to alleviate housing deprivation among those older people who experience poor physical housing conditions and who are unable to remedy defects from their own resources; the Council argued that rural older people face a greater risk of housing and secondary deprivation, while those aged 75 and over are at greater risk of basic deprivation. In addition, it asserted that recipients of certain pensions (Old Age Non-Contributory Pension, Contributory Widow's Pension and Non Contributory Widow's Pension) are at particular risk of poverty and at high risk of experiencing deprivation.

⁵³⁹ Delaney, S., Cullen, K. and Duff, P. (2005) *The Social Inclusion of Older People at Local Level: The Role and Contribution of CDBs*, Dublin: NCAOP.

⁵⁴⁰ McCrory, C., Leahy, S., & McGarrigle, C.A. (2014) *What factors are associated with change in older people's quality of life*. In Nolan, A., O'Regan, C., Dooley, C., Wallace, D., Hever, A., Hudson, E. and Kenny, R.A. (Eds.), *The over 50s in a changing Ireland: economic circumstances, health and well-being*. Dublin: The Irish Longitudinal Study on Ageing.

⁵⁴¹ Delaney, S., Cullen, K. and Duff, P. (2005).

⁵⁴² Santini, Z.I., Koyanagi, A., Tyrovolas, S., & Haro, J.M. (2015). "The association of relationship quality and social networks with depression, anxiety, and suicidal ideation among older married adults: Findings from a cross-sectional analysis of the Irish Longitudinal Study on Ageing (TILDA)". *J.Affect.Disord.*, 179:134-41. doi: 10.1016/j.jad.2015.03.015. Epub;2015 Mar 26. 134-141.

Recommendation 8: The Department of Health, in collaboration with the Department of Social Protection and the relevant agencies, should develop a national strategy on addressing the support needs of individuals supporting/caring for their elderly parents, in order to prevent them from developing mental health difficulties. This strategy should be accompanied by an implementation plan to ensure it translates into action, in addition to adequate resources.

Rationale

TILDA has identified that a 'sandwich generation' of women exist who care both for elderly parents and dependent children and are at increased risk of developing mental health difficulties. "A key challenge facing public health in Ireland is the rapid increase in the ageing population and the increasing demands on the middle generation for both financial and informal care which may lead to an increasing negative impact on their mental health".

"Provision of advice and support for women on how to plan, financially and otherwise, for dual caring in the future may offset some of these negative effects on health. Stress management programmes have been found to be effective in preventing adverse mental health outcomes. Overall, there is a need for integrated public health policies for targeting people at risk, and the development of effective interventions to prevent mental health difficulties among this group of people".⁵⁴³

Care Alliance Ireland has recognised that while providing care can be an "enriching and rewarding" experience, where expectations placed on family carers are reasonable and adequate supports are provided", caring can also be "a source of burden and stress".⁵⁴⁴ It has been shown in Ireland that caring for a relative/friend at home can take a toll on the family/carer's mental, emotional and physical health.⁵⁴⁵ There is further evidence to support the idea that older 'carers' may be more vulnerable to the negative consequences associated with caring.⁵⁴⁶

Additional research carried out by Care Alliance Ireland, examining the health status of 1,411 family 'carers', found that respondents reported comparatively high levels of depression and anxiety, when compared to the general population. Negative aspects associated with 'caring' included restricted leisure hours and a high risk of being exposed to stress, emotional strain and social isolation. The extent of the limitation imposed by 'caring' on leisure and recreation appeared to be a key factor both in the likelihood of health [including mental health] suffering due to 'caring' and of low quality of life for family 'carers'.⁵⁴⁷

A 2009 Irish study of family 'carers' found that over 50% of respondents experienced being mentally and physically 'drained' by their 'caring' role and over 50% reported a significant mental health difficulty, the most frequent being anxiety disorder.⁵⁴⁸ The types of 'caring' tasks most reported to cause ill-health were dealing with verbal/emotional abuse, coping with

⁵⁴³ McGarrigle, C.A., Cronin, H., & Kenny, R.A. (2014). "The impact of being the intermediate caring generation and intergenerational transfers on self-reported health of women in Ireland". *Int.J.Public Health.*, 59(2), 301-308.

⁵⁴⁴ Care Alliance Ireland (2015) *Family Caring in Ireland*, Dublin: Care Alliance Ireland, p. 17.

⁵⁴⁵ McGee, H. et al. (2008) *Older People = Recipients but also Providers of Care: An analysis among community samples in the Republic of Ireland and Northern Ireland*. *Health and Social Care in the Community* 16 (5), p. 548-553.

⁵⁴⁶ Care Alliance Ireland (2015).

⁵⁴⁷ Care Alliance Ireland (2008) *Health and Well-being of Family Carers in Ireland: Results of a survey of recipients of the Carer's Allowance*. Dublin: Care Alliance Ireland. www.carealliance.ie/userfiles/file/CareAllianceIrelandHealthandWell-beingofFamilyCarersNo v2008.pdf.

⁵⁴⁸ Carers Association of Ireland and the Irish College of Psychiatrists (2009) *The Health of the Carer in Ireland Survey*. [www.carersireland.com/userfiles/CPsychI%20Carers%20Survey%20full%20report%2026%20Nov%2009\(1\).pdf](http://www.carersireland.com/userfiles/CPsychI%20Carers%20Survey%20full%20report%2026%20Nov%2009(1).pdf).

bizarre/inconsistent behaviour, and getting up in the night. Many 'carers' also expressed worry about how the person they 'cared for' would cope if they were not in a position to continue to provide 'care', due to illness or death.

The mental health impact on 'carers' has also been evidenced internationally. Research in the UK identified that four out of every ten respondents ['carers'] reported that their mental health had deteriorated in the last year.⁵⁴⁹ Cross country comparison by the OECD found that the prevalence of mental health difficulties amongst 'carers' was 20% higher than amongst none carers.⁵⁵⁰

Furthermore, a Scottish study found that unpaid 'carers' had twice the prevalence of long term illness and disability as the rest of the population and 86% of respondents in the study reported stress, anxiety and depression.⁵⁵¹ Almost half of 'carers' involved in this study reported that their conditions had started after they began 'caring' and of those whose condition predated their 'caring' role, a quarter said it had worsened since they started 'caring'.

On the other hand, the same study found that people 'caring' for ten years or more were less likely to be in poor health than those 'caring' for a shorter period of time. This suggests that 'carers' may adapt to their responsibilities so as not to adversely affect their health. It is of crucial importance that 'carers' receive the appropriate supports from the State so as to protect their own mental health. **No doubt, such supports should apply to all family supporters/carers, not simply those who are caring for elderly parents. This recommendation should be read in line with Chapter 1 on Service User, Family Member and Carer Engagement.**

⁵⁴⁹ Princess Royal Trust for Carers (2011) *Always on Call, Always Concerned: A survey of the experiences of older carers*. www.carers.org/sites/default/files/always_on_call_always_concerned.pdf.

⁵⁵⁰ OECD (2011) *Help Wanted? Providing and paying for long term care*. www.oecd.org/els/health-systems/47836116.pdf.

⁵⁵¹ Carers Scotland (2011). *Sick, Tired and Caring: The impact of unpaid caring on health and long term conditions*, Scotland: Carers Scotland.

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

There is a vast literature on the relationship between mental health and the criminal justice system.^{552,553} In general, the prison environment is a risk factor for emotional distress⁵⁵⁴ and is also considered to be a grossly inappropriate setting for prisoners with existing mental health difficulties.^{555,556} Knight and Stephens (2009) contend that the prison ethos conflicts with the principles of healthcare provision, which emphasise self-determination, underpinned by a philosophy of recovery.⁵⁵⁷

The prevalence of mental health difficulties is significantly high among the prison population. Kelly (2007) showed a strong correlation between the closure of large psychiatric hospitals and the growth in the number of people with mental health difficulties within the Irish prison system,⁵⁵⁸ though there could be different factors influencing such change. In a study undertaken on the mental health of Irish prisoners, results showed that severe mental health difficulties existed in all parts of the prison population, with mental health difficulties among men on remand exceeding the international average.^{559,560} Statistics from another study highlighted that the prevalence of mental health difficulties ranged from 16% (male) and 41% (female) among committals to 27% for sentenced men and 60% for sentenced women.^{561,562} The Irish Prison Service (IPS) Psychology Service's own data suggest that the majority of referrals it receives concern the issue of 'mental health' (37% of all referrals).⁵⁶³ Furthermore, Professor Harry Kennedy, Medical Director of the Central Mental Hospital, reported that severe, enduring and disabling mental illness such as schizophrenia has increased within the prison population from 3% in 2005 to 7-8% in 2015.⁵⁶⁴

While there has been some discussion of human rights in the context of individuals accessing community mental health services, this has been less so for those individuals engaged in the forensic system. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) continues to reiterate its serious concern about how

⁵⁵² Peay, J. (2003) *Decisions and Dilemmas: Working with Mental Health Law*, Oxford: Hart.

⁵⁵³ Laing, J. (1999) *Care or Custody? Mentally Disordered Offenders in the Criminal Justice System*, Oxford: Oxford University Press.

⁵⁵⁴ Durcan, G. (2008) *From the Inside: Experiences of Prison Mental Health Care*, London: Sainsbury Centre for Mental Health.

⁵⁵⁵ Ibid.

⁵⁵⁶ WHO (2007) WHO Health in Prisons Project in Collaboration with its Collaborating Centre, UK Department of Health and the Sainsbury Centre for Mental Health, Geneva: WHO.

⁵⁵⁷ Knight, L. & Stephens, M. (2009) "Mentally Disordered Offenders in Prison: A Tale of Neglect?" *International Journal of Criminology* 1-16.

⁵⁵⁸ Kelly, B.D. (2007) "Penrose's Law in Ireland: An Ecological Analysis of Psychiatric Inpatients and Prisoners". *Irish Medical Journal* 100 (2) 373-4.

⁵⁵⁹ Linehan, S., Duffy, D., Wright, B., Curtin, K., Monks, S. and Kennedy, H.G. (2005) "Psychiatric Morbidity in a Cross Sectional Sample of Male Remanded Prisoners". *Irish Journal of Psychological Medicine* 22 (4) 128-132.

⁵⁶⁰ The rate of psychosis among remand prisoners stands at 7.6%, more than double the rate found in comparable samples in other jurisdictions.

⁵⁶¹ Kennedy, H.G., Monks, S., Curtin, K., Wright, B., Linehan, S.A., Duffy, D.M., Teljeur, C and Kelly, A. (2005).

⁵⁶² A Forbes article identified that a large majority of youth in the juvenile justice system (70%) has one or more diagnosable mental health or substance use disorders, not to mention the prevalent comorbidities such as poverty, victimization, post-traumatic stress disorders (PTSD) and poor education opportunities that contribute to untreated mental health issues. Current literature suggests that the prevalence of mental health disorders in the juvenile justice system is more than three times higher than in the general youth population (Forbes). Furthermore, more than 75% of youth in the system have experienced traumatic victimization such as physical abuse, domestic violence, and traumatic neglect, leaving them vulnerable for mental health disorders and PTSD.

⁵⁶³ Porporino, J.F. (2015) *"New Connections" Embedding Psychology Services and Practice in the Irish Prison Service*, Dublin: Irish Prison Service, p. 33.

⁵⁶⁴ Thompson, S. (7 April 2017) "It's an ethical challenge, choosing which prisoners we can take". *The Irish Times*. Available at <http://www.irishtimes.com/life-and-style/health-family/it-s-an-ethical-challenge-choosing-which-prisoners-we-can-take-1.2158924>.

Ireland's criminal justice system provides for the needs of prisoners with mental health difficulties.⁵⁶⁵

Despite international guidance that individuals with severe mental health difficulties should be diverted from the criminal justice system,^{566,567} for many individuals this is not achieved. Following admission to prison, many individuals with mental health difficulties experience "ill-treatment" within the system, in addition to a lack of care that is commensurate to that provided in the community. Individuals with severe mental health difficulties continue to be subjected to detention in prison observation cells, to the over-prescribing of medication and to an environment which ultimately undermines the ethos of recovery.⁵⁶⁸

Overall, Mental Health Reform recommends that Government uphold the existing recommendations in *A Vision for Change* on mental health in the criminal justice system.

In addition to the existing recommendations set out in *A Vision for Change* the revised policy should reflect the following recommendations

Court diversion

Recommendation 1: Individuals with mental health difficulties should be diverted from the criminal justice system at the earliest possible stage, and have their needs met within community and/or non-forensic mental health services.

Action: The Departments of Health and Justice, in collaboration with the relevant agencies, should explore the potential for pre-court diversion programmes in order to minimise the risk that individuals with severe mental health difficulties will fall into the criminal justice system.

Action: The HSE Mental Health Division should build the capacity of community based mental health services to identify and address the particular needs of individuals with mental health difficulties at risk of entering or re-engaging with the criminal justice system.

Action: The Department of Justice, in collaboration with the Department of Health and the HSE Mental Health Division, should ensure that members of the judiciary, the Gardaí and other relevant legal professionals are provided with the necessary training in diversion, in order to appropriately divert people with severe mental health difficulties from the criminal justice system. Through this process, the particular care needs of the individual should be identified and addressed through a care plan.

Action: The aforementioned bodies should develop a national protocol on inter-agency collaboration/working to ensure effective liaison and engagement between the courts, the Gardaí, mental health services and other relevant agencies.

⁵⁶⁵ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2011) *Report to the Government of Ireland on the Visit to Ireland carried out from 25th January to 5th February 2010*. Strasbourg: Council of Europe.

⁵⁶⁶ Rule 109 of the UN Standard Minimum Rules of the Treatment of Prisoners states that persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons and arrangements shall be made to transfer them to mental health facilities as soon as possible.

⁵⁶⁷ The European Prison Rules 2006 state that 'persons who are suffering from mental illness and whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for the purpose.'

⁵⁶⁸ Irish Penal Reform Trust (2012) *IPRT Submission to the Cross Sectoral Group on Mental Health and Criminal Justice*. Available at <http://www.iprt.ie/contents/2407>.

Action: The HSE should ensure continued funding for the provision of court diversion screening in all remand prisons across the country.

Rationale

It is widely recognised that people with a disability, particularly those with a mental health or intellectual disability, may end up coming to the attention of the criminal justice system when their support needs are not adequately met. Specific measures should be put in place to reduce the extent to which adults and children with mental health difficulties end up in the forensic system, by ensuring the widespread availability of a diversion system that operates at the earliest stage possible.

For example, Wraparound Milwaukee in the United States is a system of coordinated, community based care for children [and their families] with serious emotional, behavioural, and mental health needs. The programme provides care in a holistic manner by identifying and addressing a range of support needs, including mental health, substance abuse, social service, and other supportive needs. Elements of the programme include an appointed care coordinator⁵⁶⁹ and child and family team, access to a 24/7 crisis intervention service, and a network of established supports.⁵⁷⁰ The programme targets children who have a diagnosed mental health difficulty, children who are involved in two or more service systems, including mental health and juvenile justice, and children who have been identified for out-of-home placements in a residential treatment centre. Children and young people can be referred to the programme by probation officers and child welfare workers and, if deemed appropriate for the programme, will be court ordered to participate in it.⁵⁷¹

Wraparound Milwaukee has been cited as one of the most successful wraparound programmes, and repeated evaluations have found that its participants show marked improvement in their behaviour and socialisation, and that they are significantly less likely to re-offend than participants of more traditional programmes.⁵⁷² There also appear to be cost benefits to the types of supports provided in Wraparound Milwaukee, with the average monthly cost of service delivery amounting to less than half the cost of traditional residential programming.^{573,574} Both the National Mental Health Association (NMHA) and SAMHSA's Center for Mental Health Services (CMHS) have enthusiastically endorsed the wraparound approach, and CMHS has been actively promoting wraparound as part of its "systems of care" initiative.⁵⁷⁵

⁵⁶⁹ The care coordinator provides strength-based assessments, coordinates the child and family team, conducts care planning meetings, helps determine needs and resources with the child and family, assists the team in identifying services to meet those needs, arranges for community agencies to provide specific services, and monitors the implementation of the care plan.

⁵⁷⁰ The CFT is a system of support that includes the family's natural supports (such as relatives and friends) and professionals (including probation or child welfare workers). The mobile crisis support is a 24-hour crisis intervention service that is available to meet the needs of youths and families when a care coordinator is unavailable. The team consists of psychologists and social workers trained in intervening in family crisis situations that might otherwise result in the removal of youths from their homes, schools, or communities.

⁵⁷¹ Headstrong (undated) *Service Coordination, Support Facilitation & Wraparound: The Evidence Base for Individualised Support in Youth Mental Health* available at https://www.headstrong.ie/wp-content/uploads/2014/01/Service_Coordination__Case_Management__and_Wraparound_v3__updated_12-3-13_1.pdf.

⁵⁷² Jigsaw (undated) *Service Coordination, Support Facilitation & Wraparound: The Evidence Base for Individualised Support in Youth Mental Health*. Available at http://archive.headstrong.ie/wp-content/uploads/2014/01/Service_Coordination__Case_Management__and_Wraparound_v3__updated_12-3-13_1.pdf

⁵⁷³ Kamradt, B. (2000) "Wraparound Milwaukee: Aiding Youth with Mental Health Needs." *Juvenile Justice Journal*, 7(1):14–23.

⁵⁷⁴ Milwaukee County Behavioral Health Division (2003) *Wraparound Milwaukee: 2002 Annual Report*. Milwaukee, Wis.: Milwaukee County Behavioral Health Division, Department of Health and Human Services.

⁵⁷⁵ NMHA (2004) *Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices*. Alexandria, Va.: National Mental Health Association.

There is further opportunity to redirect individuals with mental health difficulties from the criminal justice system at the point of arrest. In 2016, members of the Gardaí accounted for 25% of all applicants for civil detentions by invoking section 12(1) of the Mental Health Act, 2001.⁵⁷⁶ While this is a significant reduction on the previous year, it is clear that members of An Garda Síochána play a significant role in civil detention; therefore, Gardaí should be adequately trained and supported to address situations where mental health difficulties present. The Expert Group on AVFC strongly pushed for mental health training for Gardaí⁵⁷⁷ which was followed by a report of a Working Group⁵⁷⁸ and a Memorandum of Understanding between the HSE and An Garda Síochána⁵⁷⁹ to clarify roles and responsibilities. While training is provided for new recruits it is not clear the extent to which training has been provided to the existing Garda workforce and how such training is implemented in practice.^{580, 581}

It is of fundamental importance that all members of An Garda Síochána are skilled in diverting people with severe mental health difficulties from the criminal justice system, where possible. The First Interim Report of the Interdepartmental Group to examine issues relating to people with 'mental illness' who come in contact with the criminal justice system made a clear recommendation that An Garda Síochána "implement a diversion policy for use in suitable cases when they come in contact with adults with mental illness who may have committed a minor offence".⁵⁸² The Group has also recommended that "An Garda Síochána, the DPP and the HSE consider whether it will be necessary to develop protocols and/or guidelines for the operation of a Garda diversion policy".⁵⁸³

The Care Not Custody initiative in the UK is planned to roll out in 2017, with provision for the employment of mental health nurses in courts and police stations to ensure that people with mental health difficulties get the treatment they need as soon as possible.⁵⁸⁴

At the next level of diversion, the Mental Health Prison In-reach and Court Liaison Service has proven positive, with improved identification of mental health difficulties, increased number of diversions, and a reduction in the waiting time for the provision of treatment after identification of need.⁵⁸⁵ In total, 750 diversions from prison were made from 2006 to 2013, with diversions increasing in later years.⁵⁸⁶ While a referral system exists from remand centres across the country, there is a need to ensure that this service continues to cover remands nationally through adequate resourcing. This will enable the widest possible use of diversion to the community and/or non-forensic mental health services from within the prison system.

⁵⁷⁶ Mental Health Commission (2017) *Annual Report 2016*, Dublin: Mental Health Commission, p. 61.

⁵⁷⁷ AVFC (2006), p. 142.

⁵⁷⁸ Mental Health Commission and An Garda Síochána (2009) Report of Joint Working Group on Mental Health Services and the Police, Dublin: MHC.

⁵⁷⁹ An Garda Síochána and HSE (2010) Memorandum of Understanding on Removal to or Return of a Person to an Approved Centre in accordance with Section 13 & Section 27, and the Removal of a Person to an Approved Centre in Accordance with Section 12 of the Mental Health Act.

⁵⁸⁰ (See Whelan, B & M. Brennan (2014) "The interface between mental health and the criminal justice system: legal and policy perspectives", in *Mental Health in Ireland: Policy, practice and law* edited by Higgins, A. and McDaid, S.).

⁵⁸¹ <http://www.irishexaminer.com/ireland/gardai-want-training-for-mental-illness-cases-413839.html>.

⁵⁸² Interdepartmental Group (2016) First Interim Report of the Interdepartmental Group to examine issues relating to people with mental illness who come in contact with the criminal justice system. Available at <http://www.justice.ie/en/JELR/Pages/First-Interim-Report-of-the-Interdepartmental-Group-to-examine-issues-relating-to-people-with-mental-illness-who-come-in-contact-with-the-criminal-justice-system>.

⁵⁸³ Ibid.

⁵⁸⁴ "Mental health nurses to be posted in police stations", Available at: <https://www.theguardian.com/society/2014/jan/04/mental-health-nurses-police-stations-pilot-scheme>.

⁵⁸⁵ *Prison In-Reach and Court Liaison Services in Ireland*, available at [http://www.nda.ie/cntmgmtnew.nsf/0/8B71583417C5138080257444003F95FC/\\$File/paper03_conor_oneill.htm](http://www.nda.ie/cntmgmtnew.nsf/0/8B71583417C5138080257444003F95FC/$File/paper03_conor_oneill.htm).

⁵⁸⁶ See Response by the Director General of the Irish Prison Service to the Report of the Commission of Investigation into the Death of Gary Douch, available at [.http://www.justice.ie/en/JELR/DouchGary%20-%20Response%20by%20IPS%20re%20Death%20of%20Gary%20Douch%20\(PDF%20-%2082KB\).pdf/Files/DouchGary%20-%20Response%20by%20IPS%20re%20Death%20of%20Gary%20Douch%20\(PDF%20-%2082KB\).pdf](http://www.justice.ie/en/JELR/DouchGary%20-%20Response%20by%20IPS%20re%20Death%20of%20Gary%20Douch%20(PDF%20-%2082KB).pdf/Files/DouchGary%20-%20Response%20by%20IPS%20re%20Death%20of%20Gary%20Douch%20(PDF%20-%2082KB).pdf).

This recommendation is reflected in the work of the Irish Penal Reform Trust (IPRT), who also advocate that children who come into contact with the law should be diverted to mental health community based settings, where appropriate.⁵⁸⁷ The Prison In-reach and Court Liaison Service has been extended to Oberstown Children Detention Campus and such services should continue to be adequately resourced in order to provide a child-appropriate diversion system.

In addition, the current Programme for Partnership commits to increasing therapeutic supports for children in Oberstown:

“We will also support the increased use of therapeutic intervention services for children in detention within Oberstown, including psychology, speech and language therapy and, where appropriate, referrals to addiction services to children.”⁵⁸⁸

This commitment should be implemented as a matter of priority.

For those individuals who require treatment in the Central Mental Hospital, transfers should be provided in a timely manner. Judge Michael Reilly has highlighted that during his inspections between 2008 and 2012, there were “a number of prisoners who were mentally-ill and not transferred to the Central Mental Hospital as there were no bed spaces available”.⁵⁸⁹ As outlined by Judge Reilly:

“The provision of sufficient beds in the CMH or other secure facility must be undertaken as a matter of urgency.”⁵⁹⁰

As recent as February 2017, Michael Donnellan, Director General of the Irish Prison Service, stated that “we have, at any one time, up to 30 people in prison who are psychotic or are waiting for a place in an acute mental facility. Mental health is a huge issue in prisons”.⁵⁹¹

The European Committee for the Prevention of Torture (CPT) has previously expressed concerns about the capacity of the Central Mental Hospital and has suggested that even with the increase in number of beds with the development of the new forensic facility, it will still not be in a position to meet the demands on it from the criminal justice system.⁵⁹²

It is important to consider, however, that individuals with severe mental health difficulties should be imprisoned as a last resort. In order to reduce [re]offending, the mental health care needs of such individuals should be addressed in the community, as opposed to in the forensic system. This sentiment has been reflected in recommendations produced by the CPT, which call on the Irish Government to “enhance the possibilities for regular psychiatric hospitals to receive mentally-ill prisoners”.⁵⁹³ This is in addition to the Central Mental Hospital providing beds for the “most acute

⁵⁸⁷ IPRT (2012), p. 15.

⁵⁸⁸ Department of An Taoiseach (2016).

⁵⁸⁹ Inspector of Prisons (2011) Guidance on Physical Healthcare in a Prison Context, p. 31 available at <http://www.inspectorofprisons.gov.ie/en/JELR/Guidance%20on%20physical%20healthcare%20in%20a%20prison%20context.pdf/Files/Guidance%20on%20physical%20healthcare%20in%20a%20prison%20context.pdf>.

⁵⁹⁰ Ibid.

⁵⁹¹ “Mental health is ‘massive problem in prisons’, says Prison Service DG” (2 February 2017). RTE. Available at <https://www.rte.ie/news/2017/0202/849543-prisons-asylums-committee/>.

⁵⁹² European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2015) Report to the Government of Ireland on the Visit to Ireland carried out from 16 to 26 September 2014. Strasbourg: Council of Europe. p. 41.

⁵⁹³ Ibid.

mentally-ill prisoners”.⁵⁹⁴ It is worth noting that a significant proportion of crimes committed by individuals with severe mental health difficulties are minor offences.

In his Guidance on Physical Healthcare in a Prison Context, the Inspector of Prisons, Judge Michael Reilly states:

“There are many prisoners who suffer from mental illness, many of which are vulnerable and should not be accommodated in our prisons”.⁵⁹⁵

Successful diversion of this group of individuals will require the provision of adequately resourced community mental health services that take account of the specific needs of those at risk of coming to the attention of or re-entering the criminal justice system.⁵⁹⁶

The remit of the UK Bradley Report⁵⁹⁷ was the treatment of people with mental health difficulties and people with intellectual disabilities in the criminal justice system in England and Wales.⁵⁹⁸ In summary, the report set out a vision for better supports for such individuals at all stages of the criminal justice system, from early intervention and prevention to police custody, the courts, prisons and resettlement.^{599,600}

Overall, in the absence of appropriate mental health services, many individuals with severe mental health difficulties, who could have their needs met within the mental health system, will continue to fall through the gaps and end up in the criminal justice system. Community mental health services must be appropriately equipped to respond to such needs.

⁵⁹⁴ Ibid.

⁵⁹⁵ Inspector of Prisons (2011) p. 8.

⁵⁹⁶ IPRT (2012) p. 4.

⁵⁹⁷ Department of Health (2009a) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.
http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf.

⁵⁹⁸ A UK review of community mental health services concluded that in that jurisdiction at least, there was evidence of a lack of skills and knowledge in specialist community intellectual disability teams regarding “offending behaviour.”

⁵⁹⁹ While not specifically about people with intellectual disability who also have mental health difficulties and have involvement with the criminal justice system, the recommendations are of relevance to this group.

⁶⁰⁰ A summary of the original Bradley Report recommendations and report/update on these recommendations by the Bradley Commission is provided below:

1. Prevention and early detection – interventions are targeted to firstly prevent individuals entering the criminal justice system, and secondly, to provide help to those within the criminal justice system as early as possible. There is clear evidence of benefits to this approach.
2. Police – liaison and diversion services within all police custody suites/stations, including screening for vulnerable people and assessment of needs, providing information to police to enable diversion, signposting to local health and social care services. NHS England has provided a single Operating Model for liaison and diversion.
3. Courts – immediate consideration to extending to vulnerable defendants the provisions currently available to vulnerable witnesses. Avoidance of unnecessary custody by having a maximum wait of 14 days for court reports on mental health. Liaison and diversion services support in court can be beneficial, including the provision of court reports. Some progress has been made in making greater use of the Mental Health Treatment Requirement in the UK; however, there is further potential to improve sentencing and to offer training in mental health and learning disability awareness to sentencers.
4. Prison – adequate community alternatives to prison for vulnerable offenders where appropriate. Mental health screening on arrival at prison and urgent consideration to including intellectual disability in this process. Avoidance of unnecessary delays in transferring prisoners with acute, severe “mental illness” to an appropriate care setting.
5. Resettlement – greater continuity of care as people leave prison and the provision of support people who have carried out petty offences who have mental health difficulties or intellectual disabilities to not reoffend.

Recommendation 2: Local acute and low secure units (sometimes called ‘psychiatric intensive care unit’ or PICU) for individuals with severe mental health difficulties who have been charged with a serious criminal offence should be introduced. Care options (including with respect to court diversion) for this group of individuals must be extended beyond admission to the Central Mental Hospital.

Action: The HSE Mental Health Division, in consultation with key stakeholders, and based on existing evidence, should develop a national action plan on establishing local acute and low secure units. This should be supported with the allocation of dedicated funding.

Rationale

Most court diversions concern people with severe mental health difficulties who have committed very minor offences and can be diverted to community based services. However, there is a service gap between the local level and the Central Mental Hospital for individuals with severe mental health difficulties who have been charged with more serious offences and cannot safely be treated in a community mental health team or local approved centre. Ideally, this group of individuals would be accommodated in local acute, low secure units, however such supports do not exist in Ireland. At present, where possible, such individuals are admitted to the Central Mental Hospital under section 15 of the Criminal Law (Insanity) Act 2006 but there are very few beds available for such purposes.

In such circumstances, a number of individuals are being inappropriately detained in prisons throughout the country. However, the lack of capacity within the prison system to meet the mental health needs of this group of people has been evidenced. In 2011 and 2015 the European Committee for the Prevention of Torture (CPT) reported that “Irish prisons continue to detain people with psychiatric disorders too severe to be properly cared for in a prison setting”⁶⁰¹.

The CPT identified that in one prison in particular, a number of individuals continue to be held in special observation cells for considerable periods of time.⁶⁰² In the case of one person, they were held in close supervision or a safety observation cell for eight and half months in the course of less than a year.⁶⁰³ This practice is contrary to what is outlined in the Irish Prison Rules (2007), but would also appear to breach the individual’s constitutional rights outlined in the 2012 Kinsella judgement.⁶⁰⁴ In this judgement it was concluded that 11 days in a “padded” cell constituted a violation of the prisoner’s constitutional right to the protection of the person and hence of Article 40.3.2 of the Constitution. The Committee for the Prevention of Torture has criticised the inappropriate use of special observation cells and encouraged Irish authorities to continue to improve access to psychiatric care in prisons.⁶⁰⁵

Kennedy advocates for a “model that provides local, low security resources which will reduce the strain on medium and high security resources.”⁶⁰⁶ In addition, this should be supported by an adequately resourced multidisciplinary primary care infrastructure”.⁶⁰⁷

⁶⁰¹ CPT (2011). CPT (2015).

⁶⁰² CPT (2015).

⁶⁰³ Ibid.

⁶⁰⁴ See *Kinsella v The Governor of Mountjoy Prison* [2012] 1 I.R. 467 Hogan J.

⁶⁰⁵ CPT (2011).

⁶⁰⁶ Kennedy (2006) “The future of forensic mental health services in Ireland”. *Irish Journal of Psychological Medicine* 23(2) 45-46.

⁶⁰⁷ McDaid, D., Wiley, M., Maresso, A. and Mossialos, E. (2009) “Ireland: Health System Review: Health Systems in Transition” 11 (4) 128-132.

Assisted decision-making

Recommendation 3: The Department of Justice should explore how assisted decision making supports can be made available to people with severe mental health difficulties who are engaged in the criminal justice system.

Action: Government should ensure that such provisions are included in the development of the new codes of practice on the Assisted Decision Making (Capacity) Act 2015.

Rationale

The United Nations Convention on the Rights of Persons with Disabilities places an obligation on states parties to

“ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages”.⁶⁰⁸

“In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.”⁶⁰⁹

If people with mental health difficulties are not to be discriminated against, then the protections set out in the UNCRPD must be implemented to ensure individuals are supported to actively engage in criminal justice proceedings. Furthermore, for those who lack capacity, specific decision making supports should be provided and individuals should have an equal right to avail of capacity legislation as any other individual. This means that individuals who are subject to the Mental Health Act, 2001 and the Criminal Law Insanity Act, 2006 should have a right to supported decision-making to maximise their legal capacity during the proceedings provided for in the Acts.

Mental health services within the prison system

Recommendation 4: Mental health services should be developed throughout the entire prison service, including through the implementation of the *New Connections* report and the provision of a range of talking therapies.

Action: The number of approved psychologist posts should be increased to a minimum of one psychologist to every 150 prisoners.⁶¹⁰

Action: Research should be undertaken to more thoroughly describe the prevalence of mental health difficulties in the criminal justice system.

Action: Enhanced screening procedures across the entire prison campus should be carried out by persons trained in the assessment of mental health difficulties.

⁶⁰⁸ UN General Assembly (2007).

⁶⁰⁹ Ibid.

⁶¹⁰ This is in line with international standards, as outlined below.

Action: Mental health peer supports should be developed and delivered across all prisons nationally.

Action: The IPS should consult with individuals who have used the High Support Unit^{611,612} introduced in several Irish prisons, including Mountjoy, to determine the most appropriate short-term care for prisoners who are in an acutely disturbed phase of mental distress. This should be carried out in accordance with the full implementation of the recommendations of the CPT on the development of high support units in prisons across Ireland.

Rationale

In 2015, an independent evaluation of the psychological services within the Irish Prison Service was published. At that time it was identified that the level of resourcing for psychology across the prison system was well below accepted international standards as well as international practice.^{613,614} As of 2015, there were 16 full-time psychologists working in the IPS.⁶¹⁵ In addition to the lack of resources assigned to psychology within the IPS, the review identified a number of additional areas where psychology required further development.⁶¹⁶

In response to the *New Connections* report, the IPS has developed a Psychology Service Strategy for 2016-2018 with the aim of developing psychological services for the prison population. Furthermore, actions have been progressed by the IPS in order to implement recommendations of the report and to enhance psychological supports in prisons across the country.⁶¹⁷ As recently as February 2017, the IPS through the Public Appointments Service interviewed for a number of staff grade psychologists, in order to enhance resources. 6 Assistant Psychologists were recruited by

⁶¹¹ To complement the Central Mental Hospital in-reach services, High Support Units (HSUs) have been established in several Irish prisons to provide expert, supportive, short term input for prisoners who are in an acutely disturbed phase of a mental illness or require observation for a physical illness. The HSU should provide a more controlled and supportive environment for a vulnerable prisoner as a short term intervention. The first HSU was established in Mountjoy Prison in December 2010. In its first year of operation 96 prisoners passed through the unit and a study reported a 59% reduction in the average monthly use of special observation cells compared to the year before the HSU opened.

⁶¹² In October 2011, the Psychiatric In-reach Service at Mountjoy Prison received the 'Health in Prison – Best Practice Award' from the World Health Organisation (WHO) in recognition of the success of the High Support Unit.

⁶¹³ Typically, the level of resourcing for psychology meets the minimum range of 1 psychologist for every 150 offenders, or even better.

⁶¹⁴ The International Association of Correctional and Forensic Psychology (IACFP) recommend the following staffing standards. "The minimum ratio of a full-time qualified mental health care professional (licensed psychologist or other mental health care professional) to adult inmates is 1 for every 150 to 160 general population inmates". At that time there was just 16 psychologists equating to approximately one psychologist per 220 prisoners.

⁶¹⁵ Porporino, J.F. (2015).

⁶¹⁶ 1) The absence of specific policies or standards within the IPS that require psychologists to intervene with particular kinds of prisoners, in a certain way or at a given time. The review highlighted concerns at that time that psychology is "often neither organisationally embedded nor supported" within the IPS. 2) IPS Psychology appears to deliver services predominantly through a model of referral, where only those prisoners identified by others as needing psychological intervention are availing of supports. The review recommends that intervention with prisoners be more proactive and work to meet additional need. 3) IPS Psychology appears to have no organised, strategic approach for delivering group based interventions. The review recommended that an analysis should be carried out on how such interventions can be implemented effectively. This is currently underway. 4) The lack of a joined up approach between probation, psychology and addiction services is problematic in terms of delivery of care. For example, psychology is not especially involved in the intensive drug treatment programme at Mountjoy and prisoners who graduate from the programme are not followed through in any formal way.

⁶¹⁷ For example, IPS reports that waiting lists for psychological supports have been reduced (the IPS psychology service waiting list for triage of individuals in custody with mental health difficulties is currently 6-8 weeks); one staff grade psychologist was redeployed on a full-time basis to the Dóchas Centre as of March 2016. Previously there was no such post in place. The IPS is currently in the process of recruiting a senior psychologist for the Dóchas Centre; a psychology resource has been provided to Cloverhill in 2016, where previously there was a gap; since 2016 following the redeployment of staff, Cork has 1.8 psychologists and 1 Assistant Psychologist (which is in line with international best practice standards) where previously the service had been under-resourced.

the IPS on a one-year contract in August 2016, with a further 9 Assistant Psychologists due to be recruited in August 2017.⁶¹⁸

Mental Health Reform promotes the full implementation of the recommendations of the *New Connections* report in order to adequately meet the psychological needs of the prisoner population. In addition, it is of paramount importance that a range of talking therapies are developed and made available across the prison system.

The lack of psychological and other talking therapy supports can be seen in the over-reliance on medication to treat mental health difficulties among the prisoner population to date.⁶¹⁹ In the latest CPT reports, serious concerns were highlighted over the prescription of medication in Irish prisons and the lack of adequate supervision or follow-up assessments. The CPT found that there was an over-reliance on pharmacological treatment and an underdevelopment of non-pharmacological interventions. The CPT highlighted that, contrary to World Health Organisation (WHO) standards, prisoners who had self-harmed or attempted suicide were not considered to require psychiatric assessment with rarely any psychological support provided.⁶²⁰

The Irish Penal Reform Trust has strongly advocated that where prescribed medication is required, this should not be used in isolation, but should be administered in accordance with other therapeutic interventions such as one-to-one sessions with a psychiatrist or psychotherapist. IPRT recommends that the Irish Prison Service and mental health experts work together towards the development of non-pharmacological interventions throughout the entire prison system.⁶²¹

Of serious concern, highlighted in a HIQA report, in June 2016, is the unsafe medication administration practices at Oberstown campus where 0% of staff had training in medication management. Staff who administer medication should have up-to-date training.

The principle of equivalence of healthcare maintains that healthcare in the prison context should be equal to that in the community setting. As highlighted in previous empirical research,⁶²² there is a need for better access to health services, including occupational therapy, psychology and other talking therapies in the prison environment. The IPS Psychology Service should implement “a more strategic, proactive model for service delivery along clear pathways of care that include a range of supports, including individual, short-term, group-based interventions and various motivational and self-help oriented approaches”.⁶²³

“This requires developing a proper and well conceptualised sentence plan for psychological intervention that is linked with other services and monitored/adjusted as circumstances and the prisoner’s response requires. The aim would be to give offenders more access to the right intervention, at the right time, in combination with other services, and in the best sequence to reduce the risk for re-offending. There must also be a recognition that particular groups of

⁶¹⁸ Information provided by IPRT.

⁶¹⁹ Evidence from drug testing in Irish prisons indicates that a significant proportion of prisoners were using prescribed medication, i.e. benzodiazepines: 43.7% of the sample tested positive for benzodiazepines in Mountjoy prison, 54.2% in the Dóchas centre and 39% in Limerick prison. While some of this drug use may have been obtained through the black market, the considerable proportion of prisoners accessing and using this drug may also be attributed to the practice of over-prescribing benzodiazepines by doctors in Irish prisons.

⁶²⁰ CPT (2011).

⁶²¹ IPRT (2012).

⁶²² Kennedy, H.G., Monks, S., Curtin, K., Wright, B., Linehan, S.A., Duffy, D.M., Teljeur, C. and Kelly, A. (2005) *Mental health in Irish prisoners. Psychiatric morbidity in sentenced, remanded and newly committed prisoners*. National Forensic Mental Health Service, Dublin. Available at

http://www.drugsandalcohol.ie/6393/1/4338_Kennedy_Mental_illness_in_Irish_prisoners.pdf.

⁶²³ Porporino, J.F. (2015).

prisoners are at higher risk of developing mental health difficulties, e.g. life sentenced prisoners, sex offenders, women prisoners, young males and prisoners with a dual diagnosis”.⁶²⁴

Mental Health Reform recognises that such efforts are in train and encourages its ongoing development.

With respect to the development of High Support Units in prisons across Ireland, the CPT has made clear recommendations that the Irish Government allocate the appropriate resources necessary. As set out by the CPT, this involves High Support Units not only being visited on a regular basis by a mental health team but also that the staffing complement (within the High Support Unit) include mental health workers and prison officers with special training to work with individuals with mental health difficulties. In addition, a structured programme of activities should be offered to all prisoners accommodated within a HSU.⁶²⁵

The CPT reported that during its 2014 visit (to prisons across Ireland), there was “a complete lack of structured activities” for individuals in the High Support Unit in Mountjoy, many of whom had a severe and enduring mental health difficulty. “There was no occupational therapy, individual or group psychotherapy or recreational therapy; only pharmacotherapy”.⁶²⁶ At that time, a psychiatrist visited the HSU once a week and was supported by a community psychiatric nurse; however, the three prison officers who staffed the Unit had not received any specific training on how to provide care to individuals with mental health difficulties. In the High Support Unit in Castlerea, there was no visiting psychiatrist or mental health team.

Recommendation 5: A range of community mental health supports should be made available to individuals following their release from prison. Such supports should include the availability of a range of talking therapies.

Action: The IPS and HSE Mental Health Division should develop a protocol for effective inter-agency collaboration to support individuals released from prison to access community mental health supports. This should be complemented by improved discharge planning that takes account of the mental health needs of the individual.

Action: The IPS psychology service should provide community follow up to people released from prison, where necessary.

Action: The HSE Mental Health Division should provide training and guidance to community mental health staff on working with individuals who have previously been engaged in the criminal justice system and encourage staff/services to proactively work with this group of individuals.

Rationale

IPRT has previously recommended that investment in community based services is necessary in order to prevent individuals with severe mental health difficulties from becoming involved in the criminal justice system. It is also necessary to ensure proper support for individuals returning to the community following release from prison and to reduce recidivism among this group of individuals.⁶²⁷

⁶²⁴ Ibid.

⁶²⁵ CPT (2015).

⁶²⁶ Ibid.

⁶²⁷ IPRT (2012).

In research previously carried out by IPRT,⁶²⁸ many service providers commented on the ongoing inadequacy of mental health care provision and the difficulties of linking ex-prisoners with services upon release. A number of service providers stated that they were not adequately equipped to work with this group of individuals, either due to a lack of expertise or the lack of opportunities to link in with other services providers.

The Parole Board Annual Report 2015 showed that three prisoners who were recommended to the Minister for release were refused due to the lack of available community mental health supports that could meet their needs.⁶²⁹

As outlined in MHR's *Nine Years On* report, feedback from the Irish Association of Social Workers is that local community mental health teams are reluctant to take back patients or accept individuals who have become involved with the criminal justice system.

It has been recognised that "female offenders" are an especially vulnerable group of "offenders", with significant emotional difficulties, demanding an enhanced, gender-responsive level of care that can help build some degree of self-confidence, self-sufficiency, and resilience. Women should be identified early and diverted from the criminal justice system with the necessary supports, as recommended by the CPT. Where women are identified at a later stage, supports should be provided in prison, but critically, should continue upon their release with appropriate, multi-faceted, multi-agency aftercare. The Community Return Programme with women has not shown the degree of success expected and a large proportion of female prisoners (approx. 60%) are returned to prison.^{630,631}

The current lack of coordination between agencies results in people who have been imprisoned, in particular those with severe mental health difficulties, leaving prison without any proper link to support services. This means that these individuals are more susceptible to return to the criminal justice system. Increased communication and after care within the community is required between the various agencies in order to prevent this from recurring. Specialised services for subgroups of individuals, such as those who are homeless or who have substance misuse problems, should be adequately targeted, funded and resourced.

For example, given the high prevalence of dual diagnosis among the prisoner population, IPRT has previously identified the need to develop supports for both prisoners and ex-prisoners to address such difficulties.⁶³²

Recommendation 6: Prison conditions must be improved to promote the mental health and well-being of the prisoner population and to prevent the development and/or exacerbation of existing mental health difficulties.

⁶²⁸ Martynowicz, A. and Quigley, M (2010) "It's like stepping on a landmine..." - *Reintegration of Prisoners in Ireland* available at http://www.iprt.ie/files/%E2%80%9CIts_like_stepping_on_a_landmine%E2%80%A6%E2%80%9D%E2%80%93_Reintegration_of_Prisoners_in_Ireland.pdf.

⁶²⁹ The Parole Board (2015) *The Parole Board Annual Report 2015*. Dublin: Department of Justice.

⁶³⁰ Porporino, J.F. (2015) p. 23.

⁶³¹ 85% of women prisoners have addiction issues and 60% mental health difficulties according to the latest studies see http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf.

⁶³² Martynowicz, A. & Quigley, M. (2010).

Rationale

Following its report of 2010, the Committee for the Prevention of Torture⁶³³ was highly critical of overcrowding and poor living conditions in several Irish prisons. As observed by the Chair of the Irish Prison Officers Association, “persistent overcrowding leads to higher levels of suicide rates. Overcrowding and the elimination of ‘slopping out’ must be addressed in order to enhance and facilitate positive mental health among Irish prisoners”.⁶³⁴ As of January 2017, there were 49 (1%) prisoners slopping out, 21 in Limerick Prison and 28 in Portlaoise Prison. A further 1,527 (42%) of prisoners were required to use the toilet in the presence of others.⁶³⁵

The number of prisoners on restricted regimes is significant. As of January 2017, latest figures indicate that:⁶³⁶

- 121 prisoners are currently in their cell for 19 hours per day
- 49 prisoners are in their cells for 20 hours per day
- 186 prisoners are in their cells for 21 hours per day
- 65 prisoners are in their cells for 22 hours per day
- and 7 prisoners are in their cells for 23 hours per day

This practice is detrimental and damaging to any prisoner’s mental health. Furthermore, the CPT has recommended that the maximum period an individual spends in solitary confinement is 15 days, pointing out that beyond this, the psychological damage becomes irreversible.⁶³⁷ On 21st January 2016, 51 people in Irish prisons were being held in solitary confinement for 22 hours a day. 24 of these had been held in solitary confinement for more than 100 days, and 9 had been held for more than a year.⁶³⁸

The IPRT has previously reported that “isolation or solitary confinement reduces socially and psychologically meaningful contact to a level that is too low for many prisoners to remain mentally healthy”. “The adverse health effects associated with isolation range from insomnia and confusion to hallucinations and mental illness”. “These health risks can arise after only a few days and can increase with each additional day spent in isolation”.⁶³⁹

Research from the US found that almost a third of the prisoners studied in solitary confinement experienced illusions or hallucinations, while over half reported a progressive inability to tolerate ordinary stimuli. Many of the confined prisoners also suffered from panic attacks, paranoia and difficulty with concentration or memory.⁶⁴⁰

⁶³³ CPT (2011).

⁶³⁴ O’Keeffe, C. (2008) “Overcrowding causes suicides and disease, claim prison officers”, *The Irish Examiner* <http://www.irishexaminer.com/story/ireland/gbkfgbgsn/rss2>.

⁶³⁵ See Census Prison Population January 2017 – Cell occupancy – In-Cell Sanitation. Available at <https://www.irishprisons.ie/index.php/information-centre/statistics-information/census-reports/>.

⁶³⁶ See Census of Restricted Regime Prisoners January 2017. Available at <https://www.irishprisons.ie/index.php/information-centre/statistics-information/census-reports/>.

⁶³⁷ UN (18 October 2011) “Special Rapporteur on Torture Tells Third Committee Use of Prolonged Solitary Confinement on Rise, Calls for Global Ban on Practice” press release. Available at <http://www.un.org/press/en/2011/gashc4014.doc.htm>.

⁶³⁸ <http://www.iprt.ie/contents/2987>.

⁶³⁹ http://www.iprt.ie/files/IPRT_Briefing_on_Solitary_Confinement.pdf.

⁶⁴⁰ Grassian, S., “Psychiatric Effects of Solitary Confinement” (2006) 22 *Journal of Law & Policy* 325.

IPRT has previously advocated that solitary confinement should be absolutely prohibited for prisoners with mental health difficulties. Access to full and varied regimes for all prisoners across the prison system is vital to promote positive mental health.

Recommendation 7: Integrated Sentence Management (ISM) should be reviewed and extended and adequately resourced by the State in order to improve the mental health outcomes of all prisoners.

Rationale

The CPT recommends that a sentence plan be drawn up for all prisoners, with particular attention paid to the needs of persons sentenced to life imprisonment and other prisoners serving lengthy sentences.

Porporino in his recent review of the Irish Prison Service concluded that

“A well-functioning Sentence Planning and Sentence Management process is the glue that holds together any rehabilitative oriented correctional process. Neither psychology, nor any other service, can function adequately when this is not taken care of”.⁶⁴¹

He suggests a redefined role for ISM coordinators and the appointment of ‘psychological assistants’ (as sentence planning specialists for longer-term offenders), to significantly “refocus and refresh the ISM process”.⁶⁴²

The author continues that ISM should be developed in the context of an “Integrated Release Planning (IRP) process” that targets the more than 92% of sentenced committals to the IPS who are serving sentences of two years or less (75% of these are serving sentences of less than three months). This is a group that requires some support in release planning and preparation from the initial point of admission.

For those individuals who are serving sentences of two years or longer (959 committals in 2013), there should be a focus on much more deliberate and “comprehensive sentence planning and vigilant case management”. The IPS Psychology service should develop a proactive approach to engaging with this group of prisoners to ensure comprehensive and effective intervention. An ISM for longer term offenders, particularly those serving indeterminate sentences, should include early identification of mental health concerns or possible adjustment problems in prison. For example, the rate of psychosis for life sentenced prisoners is 6.1% compared to 1.8% in fixed term prisoners.

⁶⁴¹ Porporino, F. (2015).

⁶⁴² Ibid.

Chapter 9: Special categories of service provision

Mental Health Reform recommends that Government uphold the existing recommendations in *A Vision for Change* on special categories of service provision. This involves the development of mental health services for people who need supports not typically provided by generic mental health services, including homeless people, people with co-morbid mental health difficulties and substance abuse problems, people with eating disorders, members of the deaf community and people with co-morbid mental health difficulties and intellectual disability.⁶⁴³

In addition to the existing recommendations set out in *A Vision for Change* the revised policy should make the following recommendations.

Mental health and intellectual disability (MHID)

Following a comprehensive literature review carried out by Mental Health Reform on mental health and intellectual disability it must be stated that the current evidence base for the organisation and delivery of mental health care for people with intellectual disability is inconclusive and inconsistent.^{644,645} Nevertheless, models of existing service delivery and research on these models, while insufficient to provide a firm evidence base, can *inform* service development and delivery. Mental Health Reform recommends drawing on elements of existing service models in other jurisdictions, as well as research evidence (albeit limited) to inform policy and practice in the Irish context.

Recommendation 1: The development of a shared care/inter-disciplinary approach to meeting the mental health needs of adults and children with co-occurring mental health and intellectual disabilities. This involves effective integration between specialist MHID teams and mainstream mental health services (with enhanced capacity to meet such needs).

Action: The HSE Mental Health Division should develop and implement a plan to ensure that there is capacity within mainstream mental health services to meet the mental health needs of adults and children with co-occurring mental health and intellectual disability who do not have high-support needs, through targeted training programmes and on-tap support from MHID teams.

Action: The HSE Mental Health Division should continue to develop specialist MHID services to provide support to all adults and children with co-occurring mental health difficulties and intellectual disability who require high support.

Action: The HSE Mental Health Division should develop a protocol for effective joint working between specialist MHID services and mainstream mental health services, having particular regard to emergency mental health services, assertive outreach/home treatment services and acute mental health admission units.

Action: Specialist intellectual disability services should provide training to mainstream mental health staff, care staff and other services on working with individuals with co-occurring mental

⁶⁴³ AVFC (2006).

⁶⁴⁴ Royal College of Psychiatrists (2015). *Community-based services for people with intellectual disability and mental health problems*. Literature review and survey results. Faculty Report, p. 12.

⁶⁴⁵ A recent narrative review concludes that purely generic models of care for people with intellectual disabilities who experience mental health difficulties are not appropriate and similar to Hemmings et al. (2014) that integration of the expertise from specialist services within mainstream services is potentially the best solution. This is described as mainstream services being supported by specialist intellectual disability teams.

health and intellectual disability. Joint training programmes (in terms of participation and design) should also be provided for staff working in both general and specialist services in order to promote integration and collaboration.

Action: Implementation of the National Disability Authority and HSE guide to making health and social services accessible should be progressed as a matter of priority.

Action: Full implementation of the Mental Health Commission's⁶⁴⁶ code of practice for persons working in mental health services for people with intellectual disabilities should be progressed. This code of practice expands on sections of the Mental Health Commission's Quality Framework for Mental Health Services in Ireland⁶⁴⁷ produced in 2007.

Action: Consideration should be given to the NICE guidelines on MHID in the development of services for people with mental health and intellectual disability in Ireland.

Action: These actions should take into account adults and children with a combination of autism, mental health and intellectual disability.

Rationale

Despite a lack of evidence on the prevalence of mental health difficulties among people with intellectual disabilities in Ireland, international research suggests this rate of prevalence may be four to five times higher in comparison to the general population. Mental health difficulties also tend to be under-diagnosed in people with an intellectual disability due to lack of capacity within the services (otherwise known as diagnostic overshadowing).

Despite indications of high mental health need among people with intellectual disabilities, there are concerns that such need is not being adequately met. The National Intellectual Disability Database (NIDD), for example, captures indirect information on the use of and recorded need of psychological and psychiatric services among people with intellectual disabilities. According to 2015 figures, 36% of individuals registered on NIDD required either an enhancement or a new service involving a psychologist, and 14% from a psychiatrist.⁶⁴⁸ There are additional concerns that the NIDD does not capture information on individuals who have a mild intellectual disability. Such individuals may require mental health supports; however, no data is available to effectively respond through service planning and delivery.

Overall, the literature suggests that people with intellectual disabilities in Ireland face difficulties in getting access to appropriate mental health services due to deficits in integrated care and care pathways. These issues are related to how disability services have traditionally been provided, with disability specific organisations providing a "wrap around" or "cradle to grave" service encompassing early intervention services, residential support, day programmes and health care. This has resulted in poor integration with generic mental health services (through primary care, community and inpatient mental health services).

⁶⁴⁶ Mental Health Commission (2010). Code of Practice - Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities. http://www.mhcirl.ie/File/COP_Guid_ID.pdf

⁶⁴⁷ Mental Health Commission (2007). Quality Framework. Mental Health Services in Ireland. <http://www.mhcirl.ie/File/qframemhc.pdf>.

⁶⁴⁸ Health Research Board (2016) Annual Report of the National Intellectual Disability Database Committee, p. 17.

The last comparative study on mental health service delivery for people with intellectual disabilities⁶⁴⁹ carried out in 2000 compared mental health service models for people with intellectual disability across Europe (including Austria, Greece, Ireland, UK and Spain). Results indicated that mainstream mental health services were unable to respond to the demands generated by the mental health needs of people with intellectual disabilities. In addition, findings indicated a lack of clarity around meeting these needs. Policy and legislation also seemed to be a barrier to adequate mental health services for people with an intellectual disability. Specifically, policy and legislation tended to separate the disability and mental health services.

In addition, the development of specialist mental health and intellectual disability services throughout the country, as set out in AVFC in 2006, has received little attention, with staffing levels of MHID adult and child and adolescent posts remaining worryingly low.

There are different types of service models which have been adopted in international jurisdictions in order to enhance the mental health care provided to people with intellectual disabilities.

In summary, the overarching theme from the literature is the debate between the two poles of specialisation and generic services. Four sub-themes emerging from the literature include:

- criticism of siloed services - There is a risk that such a structure divides the strands of support needed by the individual, leading to gaps in service provision. Expert consensus does not endorse the separation of services for people who have a diagnosable mental health difficulty and those people who have “challenging behaviour”, but rather supports local services that enable an individual with intellectual disability to access mainstream and specialist mental health services as appropriate
- criticism of generic only mental health services for people with intellectual disabilities - A recent narrative review (synthesising literature, opinion from clinical experience, statutory reports and secondary sources) concludes that purely generic models of care for people with intellectual disabilities who experience mental health difficulties are not appropriate. It further concludes that integration of expertise from specialist services within mainstream services is potentially the best solution. This is described as mainstream services being supported by specialist intellectual disability teams
- recommendation for specialist mental health services for people with intellectual disabilities
- recommendations on integration between specialist mental health services and mainstream services - Further literature moves on from simply criticising reliance on generic mental health services alone, and recommending specialisation, to recommending improved joint working with mainstream mental health services. Integration and collaboration between specialist mental health services and mainstream services (both health and social care) includes joint training programmes (in terms of participation and design) for staff working across these groups

To summarise the literature on models, it would seem a good mental health service for people with intellectual disabilities has specialisation, with good integration between the specialist elements of the service and mainstream (i.e. primary and secondary) mental health services, and avoids silos of service provision. The more recent, interdisciplinary models such as Fair Horizons (Single Point

⁶⁴⁹ Holt, G., Costello, H., Bouras, N., Diareme, S., Hillery, J., Moss, S., Rodriguez-Blazquez, C., Salvador, L., Tsiantis, J., Weber, G., Dimitrakaki, C. (2000). “BIOMED-MEROPE project: Service provision for adults with intellectual disability: A European comparison”. *Journal of Intellectual Disability Research*, 44(6), 685-696. doi:10.1046/j.1365-2788.2000.00312.x.

of Entry) and the Wobbly Hub and Double Spokes Models appear to offer a more individualised and personalised experience for people with intellectual disabilities attempting to navigate the mental health system.

The Psychological Society of Ireland has identified that individuals with mental health and intellectual disability should be supported through a stepped care model, whereby MHID needs are met at all levels of the system (primary, secondary and tertiary care). Without capacity at primary care level (to include effective integration between Primary Care ID and mainstream primary care) to respond to low level needs, the capacity of community mental health and specialist MHID teams to effectively respond to adults and children with moderate to severe mental health and intellectual disabilities will be adversely affected.

Recommendation 2: Research should be conducted to determine the best service model for people with a co-occurring mental health difficulty and intellectual disability, in order to identify an evidence-based approach that would best meet the mental health needs of adults and children with MHID living in Ireland. ⁶⁵⁰

Rationale

With respect to intellectual disability and mental health it appears that research has focused on an individual/practice level, considering particular components of service delivery as opposed to the whole system. While studies on the best way to provide support, care and services to people with mental health and intellectual disabilities at an individual level can inform service delivery, they do not provide a roadmap for an overall service model. Further research is required to develop a firm evidence base with the aim of informing policy and practice and achieving systemic change.

It is important that the voice of people with mental health and intellectual disabilities is included in any future research, since to date existing studies have tended to focus on the perspectives of clinicians and service providers. Furthermore, stakeholder consultation should be carried out involving people with intellectual disabilities throughout the entire policy cycle (particularly policy formulation, implementation, evaluation), drawing on UK experience.⁶⁵¹

Recommendation 3: People with a mental health and intellectual disability should have equal access to a range of talking therapies, including psychological supports.

⁶⁵⁰ International research highlights specific recommendations in the area of research, including guided service delivery, use of academic centres to develop evidence base for service provision, further research into effectiveness of outcomes related to clinical models, research active services with respect to (a) characteristics of people using services (b) consumption of service resources (c) unmet need (d) and comparison of service user outcomes in specialist versus generic / mainstream mental health services.

⁶⁵¹ The Joint Commissioning Panel for Mental Health (JCP-MH) has produced a guide aimed primarily at commissioners in the UK responsible for mental health services for people with intellectual disabilities. The “top ten” recommendations for commissioners in this guide include the centrality of the person with an intellectual disability and their family in service planning, delivery and evaluation, and recommends that mental health service quality should be measured from the perspective of the person with an intellectual disability and their family. It further emphasises the importance of local services and providing mental health support as far as is practicable in the person’s local community (avoiding “out of area placements” as discussed above). The UK consultation process on assessment and treatment in mental health facilities of people with intellectual disabilities (among other groups) may provide a useful template to guide stakeholder consultation in Ireland on a new mental health policy instrument, having particular regard to MHID.

Action: Research should be conducted in Ireland to determine the best way to deliver psychological and other talking therapies to people with a co-occurring mental health and intellectual disability.

Rationale

There is an increasing policy emphasis on making health services, including psychological therapies, available to people with intellectual disabilities on an equal basis with others. It is also accepted policy in Ireland that people with a mental health difficulty should have access to talking therapies. However, research has identified a number of barriers to providing accessible psychological supports for people with intellectual disabilities, including:

- a lack of knowledge and awareness of mental health and emotional problems experienced by people with intellectual disabilities
- some reluctance on the part of therapists to provide these interventions to people with intellectual disabilities
- lack of good quality evidence to guide practice with this group of individuals
- difficulty of making an economic case for the use of psychological therapies over psychopharmacological therapies⁶⁵²

People with intellectual disabilities have traditionally faced barriers to accessing psychological therapies, due to a perception that they could not benefit from such supports. Inequitable access to therapies has led to some extent to the exclusion of people with intellectual disabilities from research on the effectiveness of psychological (and other talking) therapies, and thus to a dearth of research for evidence-based practice in this area.⁶⁵³ There is a need for very specific research to address this gap and produce clear and comprehensive guidance on supporting the psychological needs of individuals with mental health and intellectual disabilities. Experts in the area recommend funding for national/international collaboration to facilitate effective research with the potential to influence change. Specific areas to be considered include:

- The development of more robust methods and instruments to assess mental health in intellectual disability and to develop specialist assessments of those with higher support needs
- Better quality evidence on the efficacy and effectiveness of psychological [and other talking] therapies
- Research that has a clear focus on service model design and evaluation and which might lead to better outcomes for people with intellectual disabilities

Any revised mental health policy in Ireland should include the need to provide a range of talking therapies to people with an intellectual disability, where appropriate. Professional training institutions and the HSE should take the necessary steps to build capacity to fulfil such policy.

⁶⁵² Taylor, J.L., Lindsay, W.R., Hastings, R.P. and Hatton, C. (Eds.) (2013) *Psychological Therapies for Adults with Intellectual Disabilities*. London: Blackwell.

⁶⁵³ Experts in the area of psychological therapy and intellectual disability cite specific accommodations that have been found useful for people with intellectual disabilities. These include a good knowledge of the client group; technical expertise; using the Socratic (interactive, questions and answers) method; home work/relapse prevention and finally the importance of including caregivers and relatives, as engaging the individual's social network leads to systemic changes for the person.

Recommendation 4: The development of mental health services and supports for people with intellectual disabilities should be based on a population health approach, taking into account the social determinants of mental health, and the life opportunities afforded to people with intellectual disabilities.

Rationale

An increasing Irish policy emphasis on population health, as articulated in Healthy Ireland is congruent with the social determinants of mental health model, which emphasises the need to consider the “upstream” or “social determinants” of mental health, such as housing and income, instead of a narrower focus on health services alone.

The literature indicates that people with intellectual disabilities are more likely to be exposed to specific negative environmental conditions that are termed “upstream determinants”⁶⁵⁴ of mental health difficulties. Upstream determinants of mental health specific to people with intellectual disabilities include a lower socioeconomic position, poverty, “disablism” (both systematic/institutionalised and bullying/hate crime), discriminatory systems and practices. The awareness of upstream social determinants on psychological distress for people with intellectual disabilities is of fundamental importance.⁶⁵⁵

In Ireland, upstream determinants of mental health difficulties particularly relevant to people with intellectual disabilities are housing and income, with such individuals typically being disadvantaged in terms of choice and control over both. Many receive social and housing supports from the State (either directly or indirectly), with many (disability specific) services being reported to be congregated, overly professionalised and segregated.⁶⁵⁶ In contrast to the general adult population, people with intellectual disabilities are less likely to have the opportunity to move from the family home and access private rental or owned accommodation on an equal basis. Recent data shows that, almost two thirds of adults with an intellectual disability are normally resident in a home setting (with parent, other relative or foster carers full time or availing of part time residential support services). Of the remainder, the vast majority (87%) are availing of residential support where there is often no/little choice about co-residents (community group homes, residential services such as nursing homes). Just 5% of people with intellectual disability are living in an independent or self-directed support arrangement.⁶⁵⁷ In addition, MHR’s membership has reported that there are other challenges to securing housing for people with co-morbid mental health and intellectual disability, with many remaining in acute units for far longer than is necessary.

The National Housing Strategy for People with a Disability⁶⁵⁸ aims to address the inequality of access to the full range of housing options for people with disabilities. However, the National Implementation Framework⁶⁵⁹ report notes the significant financial implications arising for the local government sector in respect of the utilisation of mainstream housing supports by people with disabilities. It would be reasonable to conclude that people with (intellectual) disabilities are

⁶⁵⁴ Definition from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2494954/>.

⁶⁵⁵ Emerson, E., & Jahoda, A.J. (2013). “Social and Psychological Factors as Determinants of Emotional and Behavioral Difficulties” in Taylor, J.L., Lindsay, W.R., Hastings, R.P. and Hatton, C. (Eds.) (2013) *Psychological Therapies for Adults with Intellectual Disabilities*. London: Blackwell, p. 15-30.

⁶⁵⁶ Department of Health (2011) Report of Disability Policy Review. Prepared by Fiona Keogh PhD on behalf of the Expert Reference Group on Disability Policy. Dublin, Department of Health.

⁶⁵⁷ Main residential circumstances and overall level of residential service provision 2014, National Intellectual Disability Database 2014 Supplementary Tables and Figures.

http://www.hrb.ie/uploads/tx_hrbpublications/NIDDC_Annual_Report_Tables_and_Figures_2014.pdf.

⁶⁵⁸ Department of the Environment, Community and Local Government (2011).

⁶⁵⁹ Department of Environment, Community and Local Government & Department of Health (2011).

vulnerable to considerable barriers in accessing local authority housing, in terms of waiting list lengths, and location/quality of accommodation available. In addition, this group of people face significant difficulties in accessing the labour market, necessitating dependence on social welfare payments, ultimately increasing vulnerability to poverty.

UK commissioning guidance expands the remit of mental health promotion from disability specific services to general services, citing access to these general services, including housing, education, transport and employment, as key determinants of mental health. Various terms such as “upstream determinants” or “social determinants” of health, consideration of how these factors can be addressed is essential in any review of a mental health policy and is congruent with a population based approach to health,⁶⁶⁰ as endorsed by Healthy Ireland.

Mental health services and supports for people from the deaf community

Recommendation 5: Mental health services should ensure that they are culturally appropriate and accessible to members of the deaf community (adults and children).

Recommendation 6: There should be a specialist, national mental health service adequately resourced for the deaf community.

Action: The HSE Mental Health Division should ensure that mental health staff are appropriately aware, skilled and knowledgeable in responding to the needs of individuals who are deaf. This should be achieved through the delivery of training for mental health staff, in addition to ongoing supervision and support.

Action: The HSE Mental Health Division should commit to developing assertive outreach initiatives from mental health services to people who are deaf throughout the country, to be made available to people who are deaf, living in the community and at risk of mental health difficulties.

Action: The HSE Mental Health Division should ensure that interpreters are appropriately qualified for a mental health service context, and that interpretation supports are provided free of charge to the individual.

Action: The HSE Mental Health Division should implement the recommendations of the HSE National Guidelines on Accessible Health and Social Care Services,⁶⁶¹ which set out guidance for health professionals, including mental health professionals on caring for people who are deaf. The guidelines provide advice on communicating with people who are deaf and on the provision of interpretation services.

Action: The HSE should establish remote interpretation services to be made available in emergency departments across the country to ensure that people who are deaf are adequately supported if they present with mental health crises.

⁶⁶⁰ “The health outcomes of a group of individuals, including the distribution of such outcomes within the group [...] includes health outcomes, patterns of health determinants, and policies and interventions that link these two.” Kindig, D., & Stoddart, G. (2003). “What Is Population Health?” *American Journal of Public Health*, 93(3), 380–383, p. 380

⁶⁶¹ Health Service Executive, National Advocacy Unit; National Disability Authority (2014) *National Guidelines on Accessible Health and Social Care Services*, Dublin: HSE.

Rationale

Approximately seven per 10,000 people in the general population (i.e. 3,000-3,500 people in the Republic of Ireland) have severe to profound deafness at any one time, with onset of deafness before language has been established.⁶⁶² Among this group of people with deafness from early childhood, approximately 40-50% of individuals are likely to experience mental health difficulties at some time in their lives.⁶⁶³ In comparison, the lifetime prevalence of mental health difficulties among the general population is significantly lower at 25%.

Gaps in current mental health service provision, for members of the deaf community include the following:

- difficulties for people who are deaf in accessing appropriate services across the country
- a lack of appropriate communication between mental health professionals and people who are deaf
- a failure by services to diagnose and treat people who are deaf with mental health needs
- misdiagnosis, inappropriate treatment and excessive duration of hospital stays for people who are deaf
- higher rates of detention of deaf people with mental health difficulties in secure services, relative to the hearing population
- a lack of awareness among generic services of both the availability of and the need for specialist support in mental health service provision for deaf people
- Irish Sign Language (ISL) not being recognised, meaning access to interpreters is limited, and there are often cost implications for deaf people who require such services
- an absence of assertive outreach for people who are deaf and require mental health care

Mental Health Reform considers that there is a severe lack of appropriate and accessible mental health services in Ireland for individuals who are deaf. It recommends that the aforementioned gaps are addressed as a matter of priority, to ensure that the mental health needs of people who are deaf are adequately met and that their human right to the highest attainable standard of mental health is fulfilled. It is clear that since the publication of *A Vision for Change*, services which are required for the most marginalised in our society, including people who are deaf, have received the least amount of development. This has proved to only further isolate and exclude those individuals who are most at risk and most in need of support.

Dual diagnosis (mental health and addiction)

(For the purposes of this section, dual diagnosis is defined as individuals with a dual diagnosis of mental health and substance misuse difficulties.)

This section should be read in line with the new suicide prevention framework *Connecting for Life* as it relates to people with [or at risk] of substance misuse.

⁶⁶² Information provided by DeafHear.

⁶⁶³ Ibid.

Recommendation 7: All community mental health teams should provide mental health treatment for individuals with a dual diagnosis of mental health and substance misuse difficulty. Specialist dual diagnosis teams should be established to cater for exceptional circumstances when clients cannot be treated within a generic community mental health team.

Action: The HSE Mental Health Division should provide training for mainstream mental health staff in dual diagnosis treatment and care.

Action: The HSE Mental Health Division should continue to develop specialist dual diagnosis services as recommended in *A Vision for Change* and develop a plan for effective collaboration and joint working between specialist and generic mental health teams.

Rationale

The experience of co-occurring mental health and substance misuse difficulties may be considered to be more the norm than the exception. The international literature indicates high rates of co-occurring disorders that are increasing steadily over time.⁶⁶⁴ Substance misuse treatment programmes typically report that 50 to 75 percent of clients have co-occurring mental health difficulties, while clinicians in mental health settings report that between 20 and 50 percent of their clients have co-occurring substance misuse disorders.⁶⁶⁵ The data on prevalence of dual diagnosis in Ireland is weaker; however, similar rates have been found. In 2011, the Mental Health Commission identified that dual diagnosis rates are reported between 30% and 80%.

Multiple morbidity is also common among individuals with dual diagnosis. In a study on mental health centres and substance misuse services in the UK, approximately one third of the drug treatment population and half of the alcohol treatment population had a co-occurrence of several psychiatric disorders or substance misuse disorders.⁶⁶⁶ However, nearly 40 per cent of “drug service users” had not received help for their mental health difficulties and just over 40 per cent of mental health service users reported drug use and/or hazardous or harmful levels of alcohol use in the past year.⁶⁶⁷

The requirement for general mental health services to be appropriately equipped and competent in providing care to individuals who present with dual diagnosis (complemented by specialist services in cases of severe mental health and addiction) is illustrated by the prevalence of co-occurring conditions. Moreover, dual diagnosis supports are required at all levels of the care system (ranging from primary to specialist services), dependent on the needs of the individual.

The multi-faceted nature of dual diagnosis must also be considered, including higher levels of physical, social and psychological difficulties, and increasing costs to the individual, family/supporters/carers, the health care system and wider society. Individuals with dual diagnosis

⁶⁶⁴ Jackson-Koku, G. (2001). “Mental Illness and substance misuse: a nursing challenge”. *British Journal of Nursing*, 10, 242-246.

⁶⁶⁵ Sacks, S., Sacks, J., De Leon, G., Bernhardt, A.I., and Staines, G.L. (1997b). “Modified therapeutic community for mentally ill chemical “abusers”: Background; influences; program description; preliminary findings”. *Substance Use and Misuse* 32(9):1217–1259.

⁶⁶⁶ Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N., Paterson, S., Shanahan, W., Seivewright, N., and Ford, C. (2003) “Comorbidity of substance misuse and mental illness in community mental health and substance misuse services”, *The British Journal of Psychiatry*, 183 (4),p. 304-313.

⁶⁶⁷ Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N., Paterson, S., Shanahan, W., Seivewright, N., and Ford, C. (2003).

are also at increased risk of deliberate self-harm and suicide,⁶⁶⁸ increased relapse rates and severity,⁶⁶⁹ higher rates of hospitalisation,⁶⁷⁰ longer duration of admission,⁶⁷¹ violent behaviour and offending,⁶⁷² and a higher incidence of homelessness⁶⁷³, economic deprivation and unemployment. In essence, individuals with dual diagnosis experience poorer health and related outcomes and greater disability.

Despite the high level of need, as outlined above, individuals presenting with dual diagnosis are often excluded from services due to a lack of understanding of co-morbid mental health, addiction and related problems. In 2002, the National Advisory Committee on Drugs (NACD) commissioned a national study to determine how dual diagnosis was managed in statutory addiction and mental health services throughout Ireland. The study found that some organisational structures excluded people with dual diagnosis from receiving treatment, with both addiction (58%) and mental health services (43%) reporting specific exclusion criterion. Furthermore, 76% of respondents reported that they did not offer a dual diagnosis service and there was no coordination of care.⁶⁷⁴

It is in this context that the introduction of clearly defined, coordinated pathways of care is required. The development of more responsive models of service delivery is also necessary, in order to recognise and respond to the diversity of individual circumstances and needs.

Recommendation 8: A national protocol should be developed to ensure effective inter-agency communication and collaboration between mental health and addiction services across all sectors (i.e. public, private and community and voluntary sectors).

Recommendation 9: The role of the community and voluntary sector in providing dual diagnosis supports should be formally recognised. This should be complemented by the provision of adequate resourcing of the sector.

Recommendation 10: The ‘No Wrong Door’ policy to treatment of people with a dual diagnosis of mental health and substance misuse difficulties should be adopted.

Action: The HSE, in collaboration with relevant agencies, should develop a protocol for inter-agency working between mental health and addiction services. This may include shared care planning and delivery. Both sectors should be mandated and funded to identify and support individuals with dual diagnosis.

⁶⁶⁸ Arensman, E., Wall, A., McAuliffe, C., Corcoran, P., Williamson, E., McCarthy, J., Duggan, A., Perry, I.J. (2013) Second Report of the Suicide Support and Information System. 6-7. National Suicide Research Foundation 2013. HSE.

⁶⁶⁹ Holland, M. (1998). "Substance use and mental health problems: meeting the challenge". *British Journal of Nursing*, 7, 896-900.

⁶⁷⁰ Coffey, R., Graver, L., Schroeder, D., Busch, J., Dilonardo, J., Chalk, M., and Buck, J. (2001). "Mental Health and Substance Abuse Treatment: Results from a Study Integrating Data from State Mental Health, Substance Abuse, and Medicaid Agencies". DHHS Publication No. (SMA) 01-3528. Rockville, MD: Substance Abuse and Mental Health Services Administration- more than 20 times the rate for substance abuse-only clients, and 5 times the rate for mental disorder-only clients.

⁶⁷¹ Menezes, P.R., Johnson, S., Thornicroft, G., et al. (1996). "Drug and alcohol problems among individuals with severe mental illness in South London". *British Journal of Psychiatry*, 168, 612-619.

⁶⁷² Scott, H., Johnson, P., Menezes, G., et al. (1998). "Substance misuse and risk of aggression and offending among the severely mentally ill". *British Journal of Psychiatry*, 172, 345-350.

⁶⁷³ Odell, S.M., Commander, M.J. (2000). "Risk factors for homelessness among people with psychotic disorders". *Social Psychiatry and Psychiatric Epidemiology*, 35, 394-401.

⁶⁷⁴ MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G. and Philbin, M. (2004) *Mental Health and Addiction Services and the Management of Dual Diagnosis*. Dublin: National Advisory Committee on Drugs.

Action: The HSE should ensure that this protocol is disseminated to all mental health and addiction services and is made readily available to all staff.

Action: Mental health and addiction services should ensure that appropriate supervision and support is provided to staff to achieve effective implementation of this protocol. Compliance among services with this protocol should be monitored by the HSE at a national level.

Action: Funding should be allocated for the appointment of clinical nurse specialists in dual diagnosis throughout the country.

Rationale

The Expert Group on *A Vision for Change* recognised the need for collaborative working across sectors of care to better meet the needs of individuals with dual diagnosis. The policy states:

“Effective treatment will require that both mental health services and addiction services have a twin-pronged, coordinated approach to addressing the key components of individual clinical presentation.”⁶⁷⁵

A number of additional policy documents clearly articulate the need for integrated care in the context of mental health and addiction, including the HSE’s Mental Health Division Operational Plan 2015,⁶⁷⁶ the HSE’s Primary Care Operational Plan 2015,⁶⁷⁷ the second report of the Suicide and Support and Information System 2013,⁶⁷⁸ *Connecting for Life*,⁶⁷⁹ the Steering Group Report on a National Substance Misuse Strategy (2012)⁶⁸⁰ and the HSE’s report on Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services.⁶⁸¹

Despite the recognised benefits of inter-professional working in many areas of health and social care, there is a shortage of coordinated and comprehensive services for those with dual diagnosis, which is leading to increased costs in service utilisation and poorer outcomes for the individual. Historically, mental health and addiction services have been developed and delivered as separate entities, with little collective action in meeting the needs of people with dual diagnosis, including in policy and service delivery. To date, mental health and substance misuse difficulties continue to be identified and managed in isolation of each other.^{682,683}

⁶⁷⁵ AVFC (2006) p. 148.

⁶⁷⁶ The Action Plan includes a commitment to progressing mental health actions in partnership with social exclusion arising from the Substance Misuse Strategy.

⁶⁷⁷ This action plan includes a commitment to develop joint protocols between mental health and drug and alcohol services for patients with severe mental health illness and substance misuse problems.

⁶⁷⁸ This report states that active consultation and collaboration between the mental health services and addiction treatment services be arranged in the best interests of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

⁶⁷⁹ Action 4.1.2 commits to providing a coordinated, uniform and quality assured service and deliver pathways of care for those with co-morbid addiction and mental health difficulties (Lead HSE MH)

⁶⁸⁰ Action 10 - Develop joint protocols between mental health services and drug and alcohol services with the objective of integrating care planning to improve the outcomes for people with co-morbid severe mental illness and substance misuse problems.

Action 11 - Establish a forum of stakeholders to progress the recommendations in *A Vision for Change* in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams to facilitate the required development of an integrated approach to service development.

⁶⁸¹ HSE National Vision for Change Working Group (2012).

⁶⁸² McGabhann, L., Moore, A., and Moore, C. (2010) “Dual diagnosis: evolving policy and practice within the Irish healthcare system”. *Advances in Dual Diagnosis*. 3(3) p. 17-28.

⁶⁸³ Workshops held by Dual Diagnosis in 2010 with mental health and addiction staff showed that there is a commonly expressed frustration with the lack of team working and understanding between different agencies and professionals. There was also discussion of the difficulty for addiction staff in making referrals to CMHTs. Participants expressed a need for improved communication links, referral protocols and integration between different agencies.

In an evaluation of a pilot project in North Tipperary designed to improve services for individuals with dual diagnosis through integrated service provision,⁶⁸⁴ the authors identified that there is a clear consensus within Irish and international literature that integration between mental health and addiction services is “sorely needed and long overdue”. The ultimate aim of the project is to develop a model to enhance outcomes for service users, as treating mental health and addiction issues in isolation has proven to be largely unsuccessful to date. Results from the project include significant reductions in waiting lists for addiction counselling, improved access to and engagement in treatment, and improved outcomes in areas such as motivation to change, alcohol and/or drug use, overall well-being, self-esteem/confidence, social isolation and anxiety, sense of purpose and managing difficult emotions.⁶⁸⁵

Additional benefits to integrated service provision include a reduction in inappropriate referrals and presentations to both mental health and addiction services, the sharing of knowledge and expertise between mental health and addiction teams, enhanced competency in dual diagnosis across both sectors and improved pathways of care for individuals who present with dual diagnosis.⁶⁸⁶

The authors propose a model of service delivery that includes the following:⁶⁸⁷

- mental health and addiction staff working in collaboration [in the same location] with the individual as a means of coordinating substance abuse and mental health interventions and to treat the whole person more effectively
- the introduction of a policy of “No Wrong Door”, where the individual will be referred to the appropriate supports dependent on their needs regardless of where they enter the system. This should be supported by clearly defined care pathways
- the need for integrated treatment in a system which often excludes individuals with diverse and complex presentations from care, based on strict diagnostic criteria. For example, the criteria for accessing a mental health service may exclude those who misuse substances and vice versa. Without access to specialist [and/or appropriately competent] services, people with a dual diagnosis, who may already find it difficult to engage with services, will not only continue to have serious health and social care needs, but are even more likely to be resistant to approaching services in the future
- the use of the recovery approach to integrate mental health and addiction services⁶⁸⁸

This project also aims to promote a model of shared care, whereby the needs of individuals with dual diagnosis can be adequately addressed (including through identification, treatment and/or referral) across primary⁶⁸⁹ and secondary care services. This should be complemented by

⁶⁸⁴ During 2013/2014, the addiction counsellor and psychiatric registrar in Nenagh community mental health service ran a pilot project for service users referred to addiction counselling in the CMHT. The project included screening/triaging, assessment, motivational and recovery based group programme led by counsellor and registrar, psychiatric reviews, group evaluations and a peer support aftercare group. They utilised strategies and techniques from motivational interviewing, cognitive behavioural therapy and community reinforcement approach, in keeping with evidence-based and best practice guidelines for management of co-occurring conditions.

⁶⁸⁵ HSE (2015) “No Wrong Door” A Mid-West Integrated, Community, Recovery and Evidence-Based Treatment Resource For Those Struggling With Co-Occurring Conditions, Dublin: HSE, p. 10.

⁶⁸⁶ Ibid, p. 15.

⁶⁸⁷ HSE (2015).

⁶⁸⁸ The similarities and shared values between addiction and mental health recovery are striking, and literature suggesting the use of the recovery concept as an organising principle for bridging the divide between the two domains is now growing and gaining an evidence base.

⁶⁸⁹ In a study on primary care in the UK during 1993-1998 the prevalence of co-existing drug and psychiatric conditions increased by 62 per cent in England and Wales, with the rates of drug problems and psychoses, schizophrenia, and

formalised care pathways and established collaborative partnerships between mental health and addiction services, primary care⁶⁹⁰ and other relevant agencies (housing, education, justice)⁶⁹¹ to enhance accessibility and improve individual outcomes.

Recommendation 11: Capacity should be built within addiction services to ensure that the mental health needs of individuals with a dual diagnosis accessing such services are appropriately met. This includes referral to mental health services, where necessary.

Action: The HSE should ensure that staff working in addiction services are appropriately trained in identifying, supporting and referring to mental health services (if necessary) individuals with a dual diagnosis.

Action: Addiction services should be monitored and evaluated as to their effectiveness in supporting individuals with a dual diagnosis.

Action: Addiction services (both residential and non-residential) should be independently regulated.

Rationale

In a recent survey⁶⁹² with people with self-experience and professionals on the priorities for improvements in dual diagnosis supports, respondents identified that the capacity of addiction services should be enhanced to identify and respond to the mental health needs of individuals accessing the services. The latter should be equipped (with the assistance of mental health professionals) to provide comprehensive supports.

Mental Health Reform considers that while it may be more appropriate for some individuals with dual diagnosis to have their needs met in a mental health service setting, it is important that addiction services have the capacity to identify, respond to (including through referral) and support the (low level) mental health needs of individuals. There are some addiction services that provide counselling supports, such as the Finglas Addiction Support Team; however, there are many services that do not. Moreover, addiction services must be skilled in providing integrated support (with mental health services) for this vulnerable group of individuals and it is therefore necessary that they have a clear understanding of mental health and the relationship between mental health and substance misuse.

More broadly, there appear to be challenges in the delivery of addiction services. In June 2009, the Comptroller and Auditor General (CAG) completed a value-for-money review on treatment services for illegal drug addiction. The review indicates that treatment planning, interventions and outcomes must be improved for individuals accessing services. It makes specific recommendations relating to:

paranoia increasing by 147 per cent, 128 per cent and 144 per cent, respectively. An examination of screening rates showed that 24% of screening assessments for dual diagnosis took place in primary care services.

⁶⁹⁰ Respondents of the NACD study identified a need to liaise much more effectively with general practitioners (GPs) in relation to dual diagnosis, as they felt most people with dual diagnosis were ending up being cared for by GPs.

⁶⁹¹ Individuals with dual diagnosis may present or come into contact with a range of different services. It has been identified that the social complications may be such, that many people will not present to health services. Therefore, a wide range of social care professionals need to be aware of dual diagnosis and of the importance of inter-agency collaboration.

⁶⁹² Dual Diagnosis Ireland (2015) *Priorities for Improvements in Dual Diagnosis Services*, unpublished.

- improved data collection
- improvements in information accuracy, the development of more accurate waiting lists and monitoring of different treatment forms, drop-out rates, treatment effectiveness and client outcomes
- setting performance targets
- developing a national framework for care planning and management⁶⁹³

It is essential that these recommendations are implemented if the needs of clients with dual diagnosis are to be met more effectively.

Recommendation 12: Research should be undertaken on the prevalence of dual diagnosis in Ireland.

Rationale

There is a lack of data on the prevalence rates of people with mental health and substance misuse difficulties. As cited above, the Mental Health Commission has estimated that between 30%-80% of people with mental health difficulties have a co-morbid mental health and substance misuse problem. This gap in research needs to be addressed if a meaningful response based on need and effective use of resources is to be implemented.⁶⁹⁴ This should be supported by further evidence on dual diagnosis (to date research has focused largely on either mental health or substance misuse) and the introduction of monitoring mechanisms to identify individuals with dual diagnosis as they engage with various different services.

Homelessness and mental health

This section should be read in line with the Department of Environment, Community and Local Government's 20-point action plan on homelessness, Housing First, the Homeless Strategy, the Social Housing Strategy, in addition to Mental Health Reform's and Dublin Simon's report on homelessness and mental health.

Recommendation 13: The development of a national protocol to improve access to mental health services among homeless people.

Action: The HSE Mental Health Division should coordinate the development of appropriate referral pathways between homeless sector services and mental health services for people who have different types of mental health difficulties.

Action: A joint protocol should be developed on effective inter-agency working between mental health services, homeless services and addiction services.

Action: The HSE Mental Health Division should provide guidance to mental health services on accommodating people from the homeless community in terms of service delivery, including with

⁶⁹³ Comptroller and Auditor General (2009) *Special Report: Drug addiction treatment and rehabilitation*. Dublin: Department of Community, Rural and Gaeltacht Affairs. Available at: <http://audgen.gov.ie/viewdoc.asp?DocID=1142&CatID=5&StartDate=1+January+2009> (accessed 14th February 2016).

⁶⁹⁴ It is estimated that more than €200 million per annum is spent inappropriately maintaining dual diagnosis clients in prisons who have not received appropriate treatment.

respect to appointment times, extending assertive outreach services and the provision of crisis interventions.

Action: The HSE Mental Health Division should develop a national programme to address self-harm and suicidal ideation/behaviour among members of the homeless community. This should be developed in consultation with key stakeholders.

Action: Homeless services should be adequately resourced in order to address the mental health needs of individuals accessing their services, including through appropriate referrals to specialist services and through low level interventions. This should include Wellness Recovery Action Plan (WRAP) training for staff and the establishment of peer support programmes.

Rationale

National and international evidence suggests that severe mental health difficulties are more prevalent among homeless people than the general population. Dublin Simon's Health Snapshot for 2013 showed that 71% of its clients had a diagnosed mental health difficulty, of whom 22% had a diagnosis of psychosis or schizophrenia. The Dublin Simon prevalence of psychosis or schizophrenia is consistent with international evidence on prevalence of severe mental health difficulties among homeless people, which is around 25%⁶⁹⁵ but is much higher than the prevalence expected in the general population, where usually about 1% of the adult population will have a diagnosis of schizophrenia. These figures are also supported by a study by O'Reilly, et al. on health and homelessness in Dublin and Limerick, which found that 51.5% of participants had a mental or emotional health difficulty that prevented carrying out normal daily activities, while 58% had at least one mental health diagnosis.

One likely reason for the high prevalence of psychosis and schizophrenia diagnoses among homeless people is the interplay between severe mental health difficulties and housing need. Research conducted in the Tallaght inpatient mental health service found a high proportion of individuals with a housing need, with an average of 38% of inpatients and 98% of long stay/delayed discharge inpatients. The study also found that there was a discharge to homeless services every 9.4 days.⁶⁹⁶

Commitments to the provision of services that support the mental health needs of people who are homeless are set out in relevant Irish^{697,698,699} and international policy and law.^{700,701} This includes

⁶⁹⁵ College of Psychiatry Ireland (2011) "Specialist Mental Health Services for Homeless People: Position Paper EAP02/2011", available at www.irishpsychiatry.ie and National Coalition for the Homeless (USA) (2009).

⁶⁹⁶ Cowman, J. (unpublished) "Prevalence of housing needs among inpatients: An audit of housing needs, over one year, in the acute mental health unit in Tallaght Hospital".

⁶⁹⁷ Ireland's current mental health policy, *A Vision for Change*, includes a dedicated chapter on special categories of mental health service provision. The Expert Group recommended the development of mental health services for people who need supports not typically provided by generic mental health services, including homeless people. Specifically, the Expert Group recommended the following:

- The Community Mental Health Team (CMHT) with responsibility and accountability for the homeless population in each catchment area should be clearly identified
- Two dedicated multidisciplinary CMHTs for homeless people should be established - one for North Dublin and one for South Dublin
- Homeless CMHTs should be based in, and operate from, community mental health centres
- Homeless CMHTs should provide assessment, treatment and care on an assertive outreach basis
- Two day centres and one day hospital should also be provided for these teams
- One crisis house of ten beds for those not requiring admission to acute psychiatric beds should be established
- The use of acute psychiatric beds if required, from the overall complement for the Dublin area
- The establishment of a database in order to explore the issue of homelessness, analyse how services are currently dealing with it, and make recommendations as to requirements for effective service provision and implementation of same.

increasing access to appropriate mental health services and supports and ensuring appropriate discharge planning and follow on care, such as access to housing.

Despite this recognition at national and international level, homeless people continue to experience significant barriers to accessing appropriate mental health care. Mental Health Reform's Homeless Sector Advisory Group has described:

- gaps in the availability of crisis support. The recommended route for accessing crisis mental health services out of hours is to attend an Emergency Department; however, homeless sector groups have advised that this is not an appropriate or realistic option for homeless people who are unlikely to wait the many hours necessary to get seen through an Emergency Department
- a lack of follow-up of homeless people after discharge from inpatient services. Concern has been expressed about a lack of discharge planning for individuals discharged from inpatient settings, including the Central Mental Hospital
- difficulties getting access to specialist mental health services if the person has a substance misuse/alcohol misuse problem
- an over-reliance on homeless services to meet the mental health needs of the homeless population, with a lack of resources for the homeless sector to respond to such needs

In MHR's report *Homelessness and Mental Health: Voices of Experience* the following concerns were reported by both people with self-experience and staff member participants:

- lack of accessibility of current mental health services
- lack of availability of continued, long term supports for people after they are independently housed
- lack of availability of safe, secure and permanent housing, which was reported as essential to facilitating service users' sustained recovery
- strict catchment-area boundaries which create geographical barriers to mental health services for individuals who may have originated in one catchment area but now, due to homelessness, reside in a different area or have no fixed home and are therefore rejected from one or another catchment area's mental health service
- experiences of stigma and discrimination within the mental health services, including lack of validation of their mental health needs and a sense of not being provided with the same quality of care as other service users

A Vision for Change also set out specific recommendations to ensure the housing needs of people with mental health difficulties are met.

⁶⁹⁸ *Connecting for Life*, the national suicide prevention strategy also includes commitments to reduce suicidal behaviour and improve mental health among priority groups, including members of the homeless community.

⁶⁹⁹ Other policies and strategies that include commitments to improving mental health supports for homeless people, include the DECLG's 20 Point Action Plan, Rebuilding Ireland and the HSE's Mental Health Operational Plan 2017.

⁷⁰⁰ The right to the highest attainable standard of physical and mental health, which applies to all people, is set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by Ireland in 1989.

⁷⁰¹ In the context of homeless people, states are required to take steps to ensure that this right is enjoyed by vulnerable groups. For example, the UN Committee on Economic, Social and Cultural Rights has stated that:

"... health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds."

- negative prior experiences, including the provision of inadequate or inappropriate support, feelings of mental health needs being discounted or not taken seriously enough, being speedily discharged with no/little outpatient supports and a lack of trust in counsellors
- over-reliance on medication
- difficulties in accessing supports at primary care level due to absence of medical cards

Mental Health Reform has set out a number of recommendation in its report on homelessness and mental health which should be implemented by the Department of Health and the HSE as a matter of priority.

Mental health and LGBTI people

Recommendation 14: Improve the mental health outcomes for LGBTI people by reducing the risks associated with mental health difficulties, enhancing resilience and improving access to mental health services and supports. Often gender binary norms exclude gender fluid individuals from services.

Action: The HSE Mental Health Division should continue to invest in building the capacity and skills of mental health professionals on LGBTI specific issues, through targeted training and educational programmes.⁷⁰²

Action: The professional bodies should include a component on mental health and LGBTI in core curriculum for trainee students. In addition, existing professionals should be educated in this area through CPD courses.

Action: The National Office for Suicide Prevention should implement actions in *Connecting for Life* to ensure a cross sectoral approach to addressing suicide and self-harm among LGBTI people.

Rationale

A Vision for Change states that “there is a small but significant number of people in Ireland who have additional needs when they develop a mental health problem. For example.... gay and lesbian individuals....require specific knowledge and understanding on the part of those delivering mental health services, in terms of their culture and other characteristics”.⁷⁰³ However, the Expert Group did not make a specific policy recommendation about the LGBTI community.

The updated mental health policy should contain specific policy to underpin improvements in the mental health outcomes of LGBTI people. Mental health policy should also take account of the commitments in the new suicide prevention framework, *Connecting for Life*, that identifies LGBT individuals as a group at increased risk of suicidal behaviour. The strategy includes a specific goal to target approaches to reduce suicidal behaviour and improve mental health among priority groups, including members of the LGBT community.⁷⁰⁴

The particular mental health needs of LGBTI people are demonstrated in a recent study that indicates that while a large proportion of this group (approximately 70%) are experiencing positive

⁷⁰² Consideration should be given to existing LGBT and mental health guidelines and training programmes.

⁷⁰³ AVFC (2006) p. 40.

⁷⁰⁴ NOSP (2015).

well-being, a significant number experience mental health difficulties.⁷⁰⁵ Across LGBTI groups, between 12-35% of participants in the study recorded scores indicating severe or extremely severe depression, anxiety and stress. Importantly, such difficulties were most prevalent among the youngest age group (14-18 years) followed by 19-25 year olds. Rates of severe or extremely severe depression, anxiety and stress for the 14-18 year old group were four times higher than the rates reported for the 12-19 year old cohort in the My World survey of Irish adolescent and young people (Dooley and Fitzgerald 2012).

Rates of suicide and self-harm for the LGBTI community are outlined in chapter 5.

It is worth noting that across LGBTI identity, intersex individuals indicated the highest levels of depression, anxiety and stress, followed by transgender and bisexual participants. This pattern was also reflected in rates of self-harm, suicidal ideation and attempted suicide.

Despite the high prevalence and severity of mental health difficulties among LGBTI people, in particular among the younger population, specific LGBTI-related barriers to accessing mental health services have been identified. Such barriers include:

- a lack of awareness and understanding among mental health practitioners of LGBTI issues and lack of appropriate language and terminology
- a fear among individuals that their LGBTI identity would be seen as the issue

Related to these barriers is the low level of help-seeking behaviour among LGBTI people. 40% of those who self-harmed and 30% of those who attempted suicide did not seek any help.

A number of recommendations have already been developed to improve the mental health outcomes of LGBTI people, including:

- the development of specific initiatives targeting self-harm, suicidal behaviour, anxiety, depression and substance misuse among young LGBTI people. Such initiatives should be realised through a partnership approach between LGBTI organisations and statutory and voluntary agencies in the mental health, health promotion, addiction and youth sectors. This could potentially be supported through the local and regional structures formed as part of the Connecting for Life Strategy
- continued efforts within the LGBTI community to reduce stigma associated with mental health difficulties and accessing mental health services. The LGBTI community has a role to play in promoting existing mental health services among the younger LGBTI community, including statutory, voluntary and community services, and how to access them
- the implementation of current and future health and well-being policies should pay particular attention to the needs of LGBTI people, for example the Healthy Ireland Framework and the upcoming HSE Mental Health Promotion Plan
- the development of a comprehensive programme to build resilience and promote positive mental health in addition to promoting help-seeking behaviour
- the building of knowledge and skills of professionals and service providers, including in the area of mental health. Education and training should include the following content:

⁷⁰⁵ Higgins, et al., (2016) *The LGBT Ireland Report: national study of the mental health and well-being of lesbian, gay, bisexual, transgender and intersex people in Ireland.*

- sexual orientation, gender identity and LGBTI terminology
 - research findings on LGBTI mental health and well-being
 - specific risks for lesbian, gay, bisexual, transgender and intersex people
 - specific needs of transgender and intersex people
 - LGBTI-inclusive practice guidelines
 - importance of ensuring sexual orientation and gender identity are included as part of routine assessment
- regulation bodies with responsibility for approval and accreditation of professional education programmes ensuring that LGBTI content is part of the curricula for all health, social care and education practitioners
 - the evaluation of initiatives and interventions aimed at improving the mental health outcomes of LGBTI people, using robust methods to assess their impact and long-term effectiveness (particularly in relation to suicide and self-harm)

Recommendations have been identified in other areas to reduce the mental health risks and build resilience and coping mechanisms among LGBTI people. Despite some positive change in LGBTI students' experiences in schools, continued experiences of anti-LGBTI bullying in school is directly related to poorer mental health outcomes and higher levels of reported self-harm and suicidal behaviour. Outside of school, LGBTI people across the lifespan continue to experience incidents of victimisation, discrimination and harassment and can be subject to negative attitudes among a minority of the population. The impact negative language, attitudes and behaviours have on the mental health and well-being of LGBTI people is significant.

“Given the findings on the elevated levels of psychological distress among LGBTI people in Ireland (and in particular young LGBTI people), further efforts are needed to address the harmful effects of stigmatisation of LGBTI identities and the associated experiences of rejection and discrimination. To address this, there is a need to promote mental health protective factors through the continued building of an LGBTI-affirmative society that embraces the diversity of sexual orientation, gender identity and sex characteristics.”⁷⁰⁶ There is no doubt that this must be complemented by improved access to mental health services and supports that takes account of LGBTI specific needs.

⁷⁰⁶ Ibid.

Chapter 10: Accountability/governance/manpower

There have been significant developments in the accountability and governance framework for mental health services since publication of *A Vision for Change*. Since 2006, the HSE has substantially re-organised the management system for mental health services, including:

- Appointment of a National Director for Mental Health with overall responsibility for the mental health budget and delivery of mental health services
- Establishment of a National Division of Mental Health with its own management team, incorporating the roles of:
 - National Director
 - Clinical Lead
 - Operations Lead
 - Quality Lead
 - Head of [Service User and Family Member/Carer] Engagement
- Establishment of the Office of [Service User and Family Member/Carer] Engagement
- The development of the CHO structures in the HSE, including multidisciplinary area management teams which include service user/family/carer engagement leads

The HSE has also substantially improved the quality of information regularly published about mental health services and resources. Such information includes:

- National Service Plans which contain budget, expenditure and human resource information
- Mental Health Division Operational Plans incorporating national and CHO-level information on budgets, expenditure, human resources, service teams and facilities, etc.
- quarterly (previously monthly) performance reports against a number of key performance indicators
- the first national performance report on HSE mental health services⁷⁰⁷

However, efficient planning and monitoring of the mental health services has been hampered by the lack of routine data about service delivery and outcomes, in the context of having no national electronic information system for community-based mental health services. It is also important for the effective operation of area management teams to have individuals in leadership roles with management competencies.

Governance over implementation of *A Vision for Change* has also been hindered by the absence of an independent monitoring group, which was not renewed after 2012.

In this context, Mental Health Reform recommends substantial updating of the recommendations in *A Vision for Change* on accountability, governance and manpower.

MHR recommends retaining:

⁷⁰⁷ See HSE (2016) *Delivering Specialist Mental Health Services: 2014-2015*, HSE Mental Health Division.

- the organisation and management of mental health services through multidisciplinary mental health catchment area management teams
- service user/family/carer leads on area management teams and within the national Directorate for Mental Health

The revised policy should also reflect the following recommendations:

Recommendation 1: A detailed implementation plan should be developed within 6 months of completion of the review on *A Vision for Change*. This process should be led by the Department of Health with involvement from other relevant Government departments.

Rationale

The Expert Group on *A Vision for Change* recommended that the policy should have an implementation plan “phasing in the new systems and standards of care over an agreed period” (the recommended term being seven years).⁷⁰⁸

This was echoed by the Independent Monitoring Group (IMG) on *A Vision for Change* from its establishment and in 2012, and by the Mental Health Commission in 2009.⁷⁰⁹ Despite consistent recommendations by the Group and other stakeholders the IMG reported on the failure of Government to produce objective based, costed and time lined annual, or multi annual implementation plans. The Group stated that:

“The absence of...an implementation plan has made it difficult to put in place a consistent framework for the development of all mental health specialties and has led to a lack of coherency in the planning and development of community based services”.⁷¹⁰

The absence of an implementation plan is in stark contrast to the Housing Strategy for People with Disabilities, for which the accompanying implementation plan has made monitoring and reporting on progress much more feasible. The delay between publication of *A Vision for Change* and the development of a partial, 2009 HSE Implementation Plan also resulted in initial implementation of the policy without a clear road map and much of the momentum for change lost.

The revised mental health policy should be complemented by the timely publication of a clear implementation plan with detailed information on each of the recommendations to ensure its successful implementation. According to the Mental Health Commission this includes:⁷¹¹

- timeframes, including the different phases for implementation
- roles and responsibilities of those involved in implementation
- resources, including funding and human resources

⁷⁰⁸ AVFC (2006) p. 177.

⁷⁰⁹ Mental Health Commission (2009) *From Vision to Action? An Analysis of the Implementation of A Vision for Change*, Dublin: MHC.

⁷¹⁰ Independent Monitoring Group (2012) *A Vision for Change - the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on Implementation 2011*, p. 3. Available at http://health.gov.ie/wp-content/uploads/2014/04/final_6th_annual_report.pdf.

⁷¹¹ Mental Health Commission (2009) p. 14.

- risk management, including how any potential barriers to implementation will be addressed and the consequences of these barriers not being overcome
- monitoring and reporting requirements

In implementing a complex, multi-layered policy, it may also be necessary to have an overall plan for the complete policy and sub-plans or action plans which deal with specific complex areas within the plan. These strategies should have the same format, with sufficient detail on timeframes, roles and responsibilities, resources, risk management and monitoring.⁷¹²

The Mental Health Commission had previously called for such a plan in its analysis on implementation of *A Vision for Change*. The Commission further identified that service users and other key stakeholders should be involved in the implementation process, including in the development of an implementation plan.⁷¹³

It is crucial to the effective implementation of the revised policy that the key recommendations are seen as inter-related and interdependent and that they are implemented as a complete plan. A piecemeal approach to implementation will undermine the potential for real and complete change in our mental health services. As stated by the Expert Group “the interdependence of the key recommendations [in *A Vision for Change*] is such that a failure to implement all of these recommendations in appropriate sequence will result in a less than effective mental health system.”⁷¹⁴

Recommendation 2: Key performance indicators that show delivery of the national mental health policy should be developed within one year of the review and reported on regularly to ensure accountability in mental health service provision. KPIs should cover mental health facilities, resources (funding and staffing), quality of service and mental health outcomes for service users.⁷¹⁵

Rationale

The HSE Mental Health Division, in collaboration with other HSE divisions and relevant stakeholders, should develop a set of Key Performance Indicators (KPIs) based on performance targets/benchmarks related to national mental health policy. KPIs should be developed in accordance with international good practice^{716,717} and should demonstrate the extent to which services are fulfilling mental health policy, as well as human rights standards.⁷¹⁸ The HSE Mental Health Division should include indicators that reflect fulfilment of the principle of ‘recovery’. In addition, “transformation indicators” that monitor achievement of policy goals as well as “ongoing indicators” that monitor ongoing performance and accountability in the mental health services

⁷¹² Ibid.

⁷¹³ Ibid.

⁷¹⁴ AVFC (2006), p. 216.

⁷¹⁵ Amnesty International and Indecon (2010) *Accountability in the delivery of A Vision for Change - A Performance for Mental Health Services Assessment Framework* available at <https://www.amnesty.ie/sites/default/files/report/2010/05/Accountability%20in%20the%20Delivery%20of%20A%20Vision%20for%20Change%20May%202010.pdf>.

⁷¹⁶ The WHO has developed guidance on mental health planning and performance assessment.

⁷¹⁷ A review by Indecon reflects international good practice in defining performance measures within a number of domains including acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency and safety.

⁷¹⁸ Right to Health, Article 12, ICESCR and Article 25, UNCRPD.

should be developed.⁷¹⁹ In this context, the HSE Mental Health Division should take account of the suite of KPIs proposed by Indecon in its report of 2010.⁷²⁰

In 2009, Indecon completed a review of Government's progress on implementation of *A Vision for Change*. 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 the implementation of *A Vision for Change*.⁷²¹

TCD's Centre for Health Policy and Management produced an analysis of implementation of *A Vision for Change* in 2011 that included a set of recommendations on implementation planning. 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. It also recommended that performance indicators and related targets reflect best practice internationally. Data should include more detailed and higher frequency data on funding and expenditures by service area and on a regional basis, in addition to more detailed data on human resources by skill mix at regional and catchment area level.

Indecon believes that effective performance indicators⁷²² will 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.

The WHO's guidance⁷²³ and the UN's human rights framework can inform the creation of an appropriate framework for performance assessment, supported by well-chosen indicators. To date international evidence shows more widespread and detailed usage of performance indicators in mental health services than is currently the case in Ireland.⁷²⁴

Recommendation 3: The introduction of a national, electronic mental health information system within 3 years of completion of the review to enable the planning, implementation and evaluation of service activity.

Action: The HSE should prioritise the development of an electronic mental health information system that can report against KPIs, with a target date for completion of three years from the publication of the policy review.

⁷¹⁹ Amnesty International and Indecon (2010) p. 17.

⁷²⁰ Amnesty International and Indecon (2010).

⁷²¹ 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. Amnesty International and Indecon (2010) p. 16.

⁷²² Performance indicators can be used to measure various aspects of the mental health system, according to the WHO's guidance, including: Needs – including definition of service requirements of different groups within the population; Inputs – pertaining to the financial, human and other resources required to carry out the activities of the mental health services; Processes – the activities of the mental health services in transforming inputs into outputs; Outputs and Results – the outputs resulting from the combination of financial and human resources, and activities of mental health services, in terms of service provision and results achieved from the perspective of the service user while utilising the service; and Outcomes – the identifiable long-term benefits of mental health interventions for service users.

⁷²³ See The WHO Mental Health Policy and Service Guidance Package. Available at http://www.who.int/mental_health/policy/essentialpackage1/en/

⁷²⁴ Indecon, op. cit.

Rationale

Mental Health Reform and Amnesty International have identified common challenges across the EU countries regarding the availability and reliability of data. While all European countries systematically collected hospital information data, data on community mental health services was not comprehensively collected.⁷²⁵ The report *Policies and practices for mental health in Europe* echoes this finding and highlights that very few countries have provided meaningful information on community-based services and mental health in primary care services.⁷²⁶ This lack of data seems to be a common and major obstacle, yet the governance of mental health systems relies on accurate and timely information for effective service planning, implementation and monitoring.

In Ireland, adequate information is not currently routinely collected at the national level which reflects the balance of care towards community-based provision. While data on Irish psychiatric units and hospitals are routinely collected, the corresponding information for community services is not available at the national level. Neither is data routinely collected on the numbers of people resident, entering or leaving HSE community residences nor the number of people using mental health day services such as day hospitals and day centres. The Mental Health Commission regularly publishes reports on some individual mental health facilities but these do not allow conclusions to be drawn at a national level.

Moreover, there is a complete absence of data collection on the number of people accessing particular mental health treatments, for example, psychological and other talking therapies and the waiting lists for such supports, as well as a lack of information on the outcomes of mental health service delivery.

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.⁷²⁷ The HSE's Operational Plan for 2016 included an intention to progress a National Mental Health ICT Framework Programme, as well as to progress the National Mental Health Electronic Health Record project. Nevertheless, the Mental Health Division stated at that time that:

“Specifically, the delivery of the plan is impeded by the lack of a robust performance management culture supported by good data in Mental Health Services. This is exacerbated by the absence of a single national Mental Health Information system and the dependence on a multitude of recording systems and processes.”⁷²⁸

The development of an appropriate, electronic 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. In addition, reporting of more and more accurate data⁷²⁹ provides the opportunity to make comparisons and exchange good practice with other countries.

⁷²⁵ Faedo, G. & Normand, C. (2013) Amnesty International Ireland and Mental Health Reform: *Summary and Commentary on the TCD Report: Implementation of 'A Vision for Change' for Mental Health Services* available at <https://www.mentalhealthreform.ie/wp-content/uploads/2013/04/AI-and-MHR-Summary-and-Commentary-for-TCD-Report.pdf>.

⁷²⁶ WHO (2008) *Policies and practices for mental health in Europe: meeting the challenges* available at http://www.euro.who.int/__data/assets/pdf_file/0006/96450/E91732.pdf.

⁷²⁷ Faedo, G. & Normand, C. (2013).

⁷²⁸ HSE Mental Health Division Operational Plan 2016, p. 6.

⁷²⁹ Euro Observer (2009), Mental health policies in Europe, Volume 11, Number 3.

It is clear that there is widespread support from national and international experts, the Mental Health Commission and from within the HSE for a national electronic mental health information system. Given the more than €850 million spent on mental health services every year, the Government should ensure the development of such a system as a matter of urgency.

Recommendation 4: An independent monitoring group to monitor the implementation of the national mental health policy should be appointed within the first year of publication of the revised mental health policy.

Action: Government should appoint an independent monitoring group within the first year following publication of the revised mental health policy and this group should produce an annual, independent report on implementation of the policy.

Rationale

The Expert Group on *A Vision for Change* recommended that an independent monitoring group be appointed by the then Minister for Health and Children to oversee the implementation of the mental health policy. The Group identified that this would help to ensure a continuous focus on the implementation process, including through bi-annual meetings and the publication of annual reports. It was further recommended that implementation of the policy should be reviewed formally after seven years in the light of progress made and the changing needs and priorities for service provision.⁷³⁰

An Independent Monitoring Group was established in 2006 and there have been a total of six IMG reports, the last covering 2011. The IMG's tenure lapsed in 2012 and governments have not appointed a successor Group since that date.

It is imperative that an independent monitoring group is appointed and sustained to ensure the effective implementation of the revised mental health policy and implementation plan. As originally included in AVFC, the Monitoring Group should engage with and listen to the recommended stakeholder groups throughout the implementation process.⁷³¹ This independent Monitoring Group should be established as soon as this revised policy has been adopted by Government, as was the case in 2006.

This advice has been echoed by the Ombudsman for Children in his report to the UN Committee on the Rights of the Child who stated that

“*A Vision for Change* is no longer subject to independent monitoring, this gap should be addressed with the establishment of a new independent monitoring mechanism.”⁷³²

Recommendation 5: Public expenditure on mental health services should be increased to 10% of the health budget within 10 years to comply with international standards on mental health funding as a proportion of the overall health budget.

⁷³⁰ AVFC (2006), p. 219.

⁷³¹ AVFC (2006).

⁷³² Ombudsman for Children (2015) Report of the Ombudsman for Children to the UN Committee on the Rights of the Child on the occasion of the examination of Ireland's consolidated Third and Fourth Report to the Committee, Dublin: Ombudsman for Children's Office, p. 35.

Rationale

The recent Sláintecare report recommends that mental health spending increase to 10% of overall health spend. This figure was previously identified by health economists in Ireland.⁷³³

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%.⁷³⁴

However, in 2017, the total revenue budget for mental health was €853.7 million. If fully realised, this level of expenditure would equate to only 6% of the overall (current expenditure) health budget of €14.15 billion. 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.⁷³⁵

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.⁷³⁶

Despite an increase in mental health spending of €88.6 million between 2011 (€686.2 million) and 2015 (€774.8 million), allocated funding for the development of mental health services has remained below recommended levels. In addition to the recommendation as set out in *A Vision for Change*,

Mental Health Reform, in collaboration with its members, has identified numerous areas of the mental health system which require targeted investment. Taking account of the continued difficulties in the recruitment of nurses and doctors to mental health services, one approach to be taken by Government is increasing the recruitment of allied health professionals to community mental health teams.

A Vision for Change 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.). While there have been difficulties in recent years in recruiting nurses, doctors and some specialist clinical psychology posts, there is scope to recruit the other allied health professionals into community mental health teams, thus progressing the move towards more recovery-orientated mental health services and at the same time potentially freeing up some nurses for roles that they uniquely can fulfil (e.g. acute inpatient care). The total number of allied health professionals is still well below *A Vision for Change* recommended levels.

The development of talking therapies for people with mental health difficulties is also much needed and long overdue. One way to address this continued gap is to extend the Counselling in Primary Care (CIPC) service to people on low incomes. In the context of difficulties in recruitment of medical staff, this service would not rely upon nurses or doctors. There is also scope to expand the valuable voluntary sector community-based supports that have suffered cuts during the economic crisis, including the development of peer-led mental health services

⁷³³ O Shea, E. & Kennelly, B. (2008) p.ix.

⁷³⁴ AVFC (2006).

⁷³⁵ 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.

⁷³⁶ Evelyn Ring "Low spend on mental health is criticised". *Irish Examiner* (Dublin) 10th October 2015, available at <http://www.irishexaminer.com/ireland/low-spend-on-mental-health-is-criticised-358584.html>.

It must also be recognised that increases in mental health expenditure will be required to maintain at a minimum existing level of service costs. The HSE Mental Health Division has identified that there will be a significant financial challenge for them to maintain 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.⁷³⁷ 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.⁷³⁸

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 €11 billion per year, much of which is related to loss of productivity.⁷³⁹ In 2008, it was identified that mental health difficulties cost the Irish economy around €3 billion or 2% of GNP annually, with most of the costs in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement.⁷⁴⁰ Moreover, the WHO has 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 work.⁷⁴¹ This evidence suggests that the individual and social returns from adequate investment in mental health in Ireland are likely to be “high and sustained”.⁷⁴²

In addition to an overall lack of funding, the distribution of mental health funding across the country has been uneven. In 2008, the Mental Health Commission identified that expenditure was historically based and tended to follow the old mental hospital system rather than being a response to local needs and demographic changes.⁷⁴³ There continues to be an uneven distribution of mental health spend by Community Healthcare Organisation (CHO) area in recent years with some higher population areas receiving lower funding per capita than less populated areas.⁷⁴⁴

While there have been difficulties in the recruitment of professionals to mental health services, additional investment is required to increase the number of staff in post to staffing levels recommended in *A Vision for Change*. At the end of March 2017 there were only 9,757 staff in post across the country delivering mental health services.⁷⁴⁵ This is 76% (approx.) of the staffing levels recommended in *A Vision for Change* and still almost 800 below the number of staff in place in 2008. It is also an increase of just 200 staff (or 2%) from March 2016.

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

⁷³⁷ HSE Mental Health Division Operational Plan 2017.

⁷³⁸ 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).

⁷³⁹ Department of Health (2013).

⁷⁴⁰ Kennelly, B., O’Shea, E. (2008).

⁷⁴¹ 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/>.

⁷⁴² Kennelly, B., O’Shea, E. (2008) p. vi.

⁷⁴³ Ibid. p. 6.

⁷⁴⁴ MHR’s *Nine Years On* report.

⁷⁴⁵ HSE Performance Assurance Report, January-March 2017.

staff).⁷⁴⁶ 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 HSE Mental Health Division, in its Operational Plan 2017, acknowledges that “the greatest internal challenge that faces the Division workforce is to recruit new talent while retaining current staff to support the transformation underway...”. “This is in addition to the potential for additional budget constraints, increased workload, rising costs, employee recruitment and retention, and the transfer of organisational knowledge.” “The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce, is particularly [challenging] in high-demand areas and specialties”.⁷⁴⁷

Increased staffing is crucial to the effective implementation of a revised mental health policy.

Recommendation 6: Flexibility in application of CHO boundaries should be ensured to enable service user choice of clinician.

Rationale

Currently mental health service users may have limited choice over the lead clinician responsible for their treatment. For example, over the years Mental Health Reform has received enquiries from individual service users about how they can transfer to another psychiatrist within the public mental health services. Under the current system, while it is possible for a service user to request such a change, fulfilment of their request is dependent upon the availability of another psychiatrist from within their catchment area. Given the important role that the therapeutic relationship between service user and clinician plays in facilitating recovery from a mental health difficulty, it is important that service users are able to avail of some choice about their psychiatrist.

Recommendation 7: Team managers should be appointed within each CMHT with specific management expertise.

Action: The job description of team managers must be carefully considered and developed in consultation with key stakeholders. This should be led by the HSE Mental Health Division.

Rationale

Despite commitments at national level⁷⁴⁸ to the appointment of ‘team coordinators’ within mental health teams, this post is not yet in place across the services. Unfortunately, no separate funding has been made available for this position, other than some back filling for a small number of posts in each area management team. There is no doubt that this type of post would enhance day to day operation of services, promote the effective coordination of referrals and provide oversight on policy compliance.

In addition to the absence of team managers (coordinators) across the services, MHR is concerned that the position of ‘team coordinator’ as set out in national policy and strategy has

⁷⁴⁶ HSE (2016).

⁷⁴⁷ HSE Mental Health Operational Plan 2017.

⁷⁴⁸ The HSE Mental Health Division Operational Plan states that that every CMHT will have a Team Coordinator in place and that 50% of teams will have undertaken the Enhancing Teamwork programme during 2015.

been weakened since publication of *A Vision for Change* in 2006. Currently, the position of 'team coordinator' is open to staff members of any grade, as opposed to a senior member of staff, as originally envisioned, and is based on a 2-year rotation. A team manager post (with the option to appoint from within current manager posts in service) is essential with a clear reporting relationship to a named person within the area management team.

In order to improve accountability and management structures, managerial roles within the mental health services must be afforded appropriate recognition and authority. Furthermore, staff appointed to such roles must be appropriately trained in management and equipped with the necessary management infrastructure, including the information and the tools (e-rostering, performance reviews, etc.).

No doubt there is need for separate accountability structures for quality of mental health care; however, chief leadership roles within mental health teams should be open to any discipline and vested in individuals with the most management competency. This role should be supported by a Head of Operations, i.e. team manager to take responsibility for the following areas:

- monitoring delivery of commitments in service/operational plans, e.g. numbers of people seen/cared for and within what timeframes
- network relations (to be responsible for developing and maintaining relationships, e.g. GPs, voluntary agencies, housing bodies, TUSLA, etc.)
- clinical quality (Clinical Governance and Risk)
- innovation & development (project management / managing new innovations)
- administration/finance/ICT/HR

In addition, Mental Health Reform has previously recommended that implementation of a team manager role would significantly improve both service user and family member experience of the mental health services. This would be facilitated through adequate structuring/enhanced team-working to ensure that individuals had ongoing contact with a single professional (key worker) from whichever discipline is most appropriate. The current challenges of key working can result in poor individual care/recovery planning, lack of implementation of such plans and ineffective liaison with service users and family members.

No doubt, the position of team manager, if implemented effectively, could enhance collaborative working between primary and secondary mental health services and between specialist services and the community and voluntary sector. Currently, such inter-agency coordination is ad hoc and requires clear direction at national level.

Conclusion

The upcoming review of Ireland's mental health policy provides an opportunity to develop a stronger policy framework for mental health service provision nationally. Mental Health Reform's submission sets out key recommendations across a wide range of themes for consideration by Government as part of its upcoming review, including in the areas of:

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

As outlined in Mental Health Reform's *Nine Year's On* report on implementation of *A Vision for Change*, it is clear that much of the policy as set out by the Expert Group is yet to be realised. There have been calls by many stakeholders, including political agents, for Government to consolidate its efforts in achieving full implementation of AVFC. Mental Health Reform is of the view that while *A Vision for Change* has retained much of its value, eleven years on from its publication a full and comprehensive review is required. As set out at the beginning of this document, there are sections of AVFC which are underdeveloped, resulting in gaping shortfalls across the mental health system in terms of individuals receiving the care that they require.

Mental Health Reform has long advocated that mental health services across the country need to meet the needs of all members of the community. In order for this to translate from mere aspiration to reality it is imperative that our national mental health policy is strengthened to afford all individuals the right to mental health care that they are entitled to under human rights law.

In terms of service user and family member engagement at all levels of the mental health system, the role of family supporters and carers requires greater recognition within mental health policy. In addition, protections are required for both service users and family members/carers, including the provision of (independent, statutory) advocacy supports, as well as direct access to an independent complaints process. The potential for peer supports also requires greater exploration, to be firmly underpinned by mental health policy, and further specification is needed on facilitating the cultural shift required to embed the recovery ethos at every level of the mental health system.

A Vision for Change was progressive in recognising the importance of social inclusion of people with mental health difficulties and in setting out specific policy in this area. However, given the extent of inequality faced by this group of individuals in every domain of life, it is imperative that the revised policy is explicit in setting out solutions to combat discrimination and inequality in areas such as employment and housing.

The Expert Group was also innovative in making *A Vision for Change* a whole-of-population mental health policy and incorporating a full chapter on mental health promotion. However, this section was less developed than others and a more developed positive mental health and well-being policy is required. This should include a greater emphasis on promoting perinatal and infant mental

health, in addition to supporting children and young people to develop positive mental health and well-being through school and college supports. Fundamentally, all Government policy should be “mental health proofed” to ensure that it protects and promotes the mental health of Ireland’s population, and in effect improves mental health outcomes.

The development of the full continuum of supports from primary to specialist mental health services for all people within the community, children, adults, older people, in addition to particular groups of individuals, requires much greater attention in revised mental health policy. In particular, the quantum and make up of a primary care mental health workforce needs to be specified urgently if an effective response to mental health in primary care is to be developed.

Furthermore, an evaluation of the role of the community and voluntary sector in providing mental health services, including out of hours crisis supports and related social supports, should be completed. The means by which the quality of C&V sector-provided supports can be monitored and assured also warrants consideration.

Alternative treatments such as arts therapies, trauma informed interventions and e-mental health supports should also be recognised in revised mental health policy, to enhance the level of choice available to individuals in terms of their mental health care at all levels of the system.

One of the significant shortfalls of *A Vision for Change* was that it did not adequately protect particular groups of individuals, including people with a dual diagnosis of mental health and addiction, members of the LGBTI community, people with mental health and intellectual disabilities and individuals from ethnic minority communities in terms of their right to access and avail of appropriate mental health care. Nor did it recognise the importance of gender sensitive mental health service delivery, which takes account of the particular needs of the individual’s chosen identity.

It is imperative that revised mental health policy identifies the particular needs of such groups, as well as enhancing protections for people with mental health difficulties engaged in, or at risk of coming into contact with the criminal justice system. Fundamental to this is developing the capacity of community mental health services to address such need.

The final chapter of this submission addresses issues of accountability, manpower and governance in the mental health services. Mental Health Reform has consistently raised concerns about the lack of implementation of *A Vision for Change*, largely due to the absence of an implementation plan, the dismantling of the Independent Monitoring Group and the failure by Government to implement a national mental health information system, which would provide for effective planning and development of Ireland’s mental health system.

In order to rectify mistakes of the past and ensure the successful implementation of any revised mental health policy, the aforementioned measures must be addressed as a matter of priority. This should be complemented by the development of effective management structures at all levels of the mental health system.

Overall, mental health needs to be recognised and afforded appropriate priority within the wider health agenda to reflect its significance in contributing to the burden of disease in Ireland. The WHO has recommended that states urgently acknowledge mental health as a global health priority and that mental health is afforded a significant proportion of the overall health budget.

It is in this context that a shift in paradigm is required in which the social determinants of mental health are prioritised within policy. The Special Rapporteur has recommended

“policy innovation at the population level, which targets social determinants and abandons the predominant medical model that seeks to cure individuals by targeting [mental health] disorders”

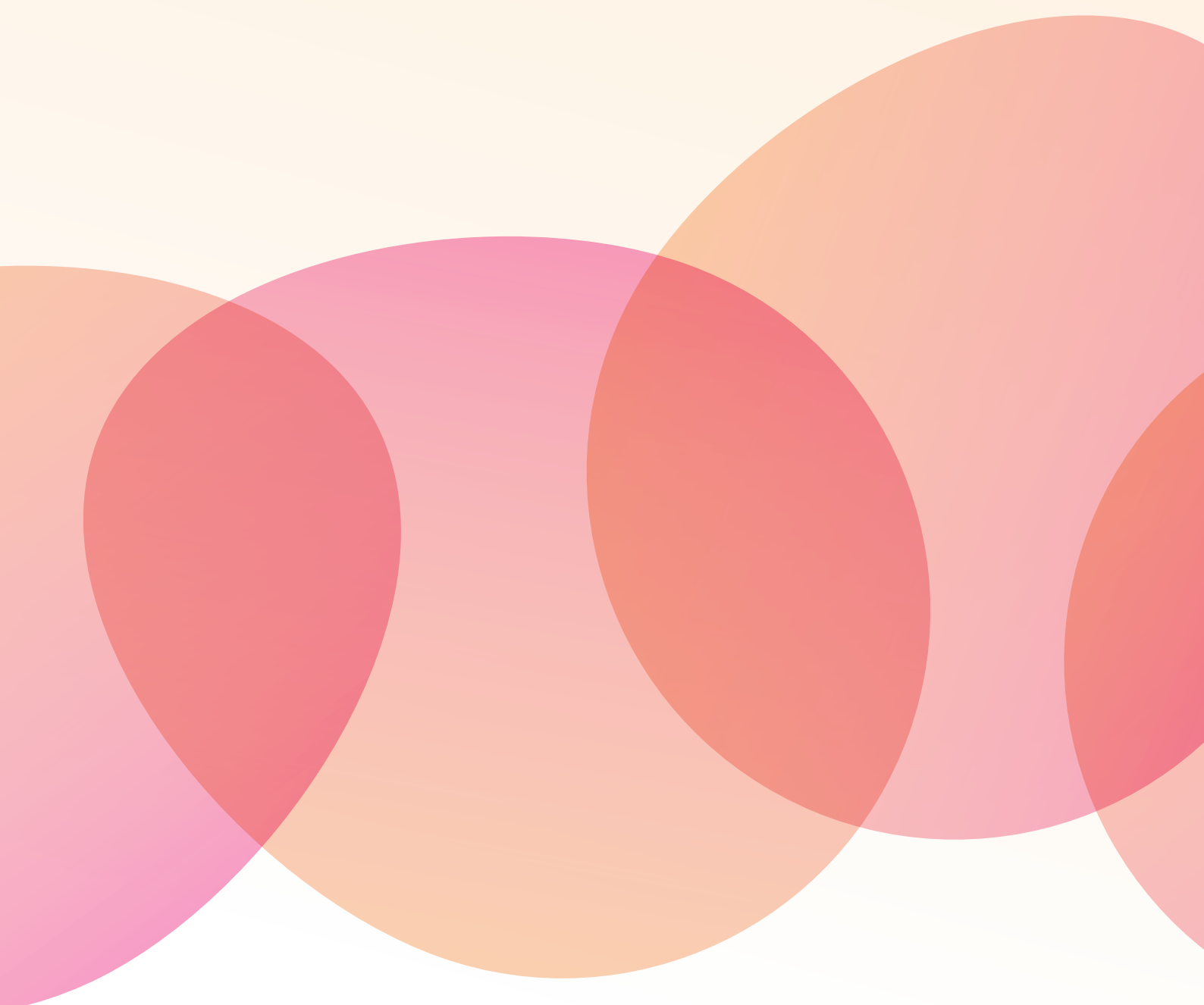
There is no doubt that mental health must be considered in the context of a whole range of social and economic policy areas. The WHO recognises that mental health influences a wide range of outcomes for individuals and communities. It is both a cause and a consequence of social and economic status. The WHO further identifies that in order to improve the mental health outcomes of the population, Government must focus on facilitating a Mental Health in All Policies approach in which policy makers across all sectors think in terms of mental health impact. The social, cultural and economic determinants of mental health must be addressed through a whole-of-Government approach in which mental health is considered in areas such as the wider health environment, primary care, housing, employment, education, justice and social protection.

No doubt there were challenges with respect to implementation of *A Vision for Change*, and there will be challenges once again in transforming our mental health system through revised mental health policy. This will be particularly relevant in the context of Brexit, in addition to changing demographics, including a growing youth and older population. Such changes are all occurring in the context of an increased demand on an already overstretched mental health system.

During this time, it is imperative that political will is sustained in driving Ireland’s mental health services into a modern, recovery-orientated and human rights compliant system. It is time that we left our painful legacy behind us and delivered a mental health service, underpinned by a strong policy and legislative framework, which supports people’s right to the highest attainable standard of mental health to the greatest extent.

We hope this report will prove valuable to the process of renewing Ireland’s mental health policy as we move into the next phase of reform. On foot of this submission, MHR will actively campaign for the recommendations contained within.



We look forward to continuing to work with the Minister for Mental Health, Government Departments, the HSE and other public agencies, our member NGOs, people who use mental health services, family supporters and professionals to achieve the vision of an Ireland where people with a mental health difficulty can direct their own care, based on their own choices and recover their well-being to live a full life in the community.



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