A VISION FOR Change

REPORT OF THE EXPERT GROUP ON MENTAL HEALTH POLICY

"The Greek name for a butterfly is *Psyche*, and the same word means the soul. There is no illustration of the immortality of the soul so striking and beautiful as the butterfly, bursting on brilliant wings from the tomb in which it has lain, after a dull, grovelling, caterpillar existence, to flutter in the blaze of day and feed on the most fragrant and delicate productions of the spring. *Psyche*, then, is the human soul, which is purified by sufferings and misfortunes, and is thus prepared for the enjoyment of true and pure happiness."

"The Age of Fable" by Thomas Bulfinch (1796-1867)

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Contents

Each citizen should have access to local, specialised and comprehensive mental health service provision that is of the highest standard.

A Message from the Minister of State

Good mental health is an integral component of general health and well-being, allowing a person to fully realise his or her abilities. With a balanced mental disposition, people are more effective in coping with the stresses of life, can work productively and fruitfully and are better able to make a positive contribution to their communities. We owe it to our citizens to ensure that everyone is facilitated, in as far as possible, in achieving and maintaining, optimum mental health.

I am delighted to welcome this Report, aptly titled *A Vision for Change*, which sets out a comprehensive policy framework for our mental health services for the next 7-10 years.

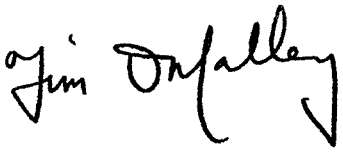
I established the Expert Group on Mental Health Policy in August 2003 in recognition of the need to review long-standing policy in this area and to formulate a blueprint for a modern, comprehensive, world-class service to meet the mental health challenges facing our society - not least of which is our significant suicide rate, particularly among young people.

I was convinced from the outset that a collaborative approach between service users and carers, professionals and health service providers represented the best way forward and I appointed the Expert Group accordingly. I am delighted to see that this approach has borne fruit and that *A Vision for Change* has been endorsed by all the members, without exception.

This Report proposes a framework of mental health service delivery with the service user at its centre. The emphasis is firmly on recovery and on facilitating active partnerships between service users, carers and mental health professionals. Its recommendations are innovative and some of them are challenging. However, I have no doubt that their implementation will bring about far-reaching change and modernisation in the Irish mental health services, which will be to the benefit of everyone concerned.

The Government's on-going investment in community-based mental health services, the legislative reforms of the Mental Health Act, 2001 and the publication of this Report all confirm that the area of mental health is now receiving the attention it deserves. I am hopeful that these developments will facilitate further advancements within our services and that the lives of those who suffer mental illness, and their families, will be improved and enhanced by our efforts.

I would like to thank the Chairperson of the Expert Group, Professor Joyce O'Connor, all the members of the Group and the associated support staff for their tireless work and commitment to this task over the past two and a half years. I have no doubt that this fine Report will have a significant influence on the development of our mental health services into the future.



Tim O'Malley T.D.
Minister of State at the Department of Health & Children with special responsibility for mental health

Foreword

Mental health concerns everybody. We attain it through the attachments and the supportive relationships we form at each stage of our personal development, through learning to cope with challenging and difficult aspects of life, and finding ways to belong and to contribute to others in line with our core values and aspirations.

Mental health can be undermined by emotional distress, an unavoidable feature of every human life that can become a sustained and disabling experience for some people, particularly those disadvantaged by constitutional and psychological vulnerabilities or by their social circumstances. As a consequence, people can lose their sense of well-being and capacity to function and may require specialist intervention. Mental health services are designed to make available this support and expertise at every stage from childhood to later life.

A Vision for Change proposes a framework for promoting mental health at all levels of society and for delivering specialist care to everyone who needs it. It recognises both the strengths and inadequacies of existing services and outlines a strategy for building on the innovations heralded by *Planning for the Future*. It details a series of actions for developing a comprehensive person-centred model of mental health service provision.

Extensive consultation with service users, families and service providers informed this policy. Of vital importance was the fact that individuals receiving services contributed critically to every stage of the report's development. The most pressing priority they voiced was the need for an accessible and user-friendly mental health service where they can be respected as active partners in their own recovery, and where they can avail of a range of interventions that will enable them to remain meaningfully involved in their own communities. Service providers highlighted their priorities too, articulating a clear need for adequate resources to enable them to respond to the full medical, psychological and social needs of service users and their families.

This policy proposes that solutions for people with mental health needs lie in establishing effective partnerships, between health service managers and health care providers on the one hand, and service users and their carers on the other, in a community-wide context. It proposes specific ways in which managers and professionals can blend their expertise more effectively, forge working relationships with resources that already exist to support service users in the broader community, and involve service users as legitimate collaborators in their own recovery.

In drawing up this policy, the Expert Group considered the various core values that are intrinsic to the design and delivery of a quality mental health care service: services should be person-centred and adapted to each individual's needs and potential; services should be delivered by skilled professionals working together in community-based multidisciplinary teams, where the contribution of each member is valued and where skills and expertise are combined to design and deliver integrated care plans; the range of interventions offered should be comprehensive and should reflect best practice for addressing any given mental health problem. A 'recovery' approach should inform every level of the service provision so service users learn to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks, and pursue dreams and goals that are important to them and to which they are entitled as citizens.

A Vision for Change was commissioned in response to a widespread felt need for an improved mental health service. It identifies the critical structural, human and financial resources required to make this a reality. By recruiting the creative cooperation of everyone involved and harnessing the tremendous resources of expertise and compassion already embedded in our mental health system, the opportunity to build a mental health service in which we can all take pride is now possible.

Joyce O'Connor
Chairperson
Expert Group on Mental Health Policy

Glossary of abbreviations

CBT	Cognitive Behavioural Therapy
CME	Continuing Medical Education
CMHC	Community Mental Health Centre
CMHT	Community Mental Health Team
DMB	Difficult to manage behaviour
DSH	Deliberate self-harm
FMHS	Forensic Mental Health Service
GP	General Practitioner
HSE	Health Service Executive
MHCA	Mental health catchment area
NAPS	National Anti-Poverty Strategy
NDA	National Disability Authority
NEPS	National Educational Psychology Service
OECD	Office for Economic Cooperation & Development
SPHE	Social Personal Health Education
WHO	World Health Organisation
WTE	Whole-time equivalent

A note on terminology

Many terms are used to describe mental health difficulties and there is much debate on the subject.

The term *mental health problem* has been used throughout this document to describe the full range of mental health difficulties that might be encountered, from the psychological distress experienced by many people, to serious mental disorders and illnesses that affect a smaller population.

The term *mental illness* is used to refer to specific conditions such as schizophrenia, bipolar disorder and depression.

Preface

1. INTRODUCTION

The National Health Strategy *Quality and Fairness: A Health System for You*[1] is the defining document on health policy in Ireland. It describes a vision of health services in the coming years and defines the actions necessary to achieve this. In the Health Strategy, it was recognised that there was a need to update mental health policy and a commitment was made to prepare a national policy framework for the 'further modernisation of mental health services'.

The Minister of State of the Department of Health and Children with special responsibility for mental health, Mr. Tim O'Malley, appointed an Expert Group in August 2003 which at its first meeting agreed the following terms of reference:

1. To prepare a comprehensive mental health policy framework for the next ten years
2. To recommend how the services might best be organised and delivered
3. To indicate the potential cost of recommendations.
4. To consult widely as part of this process.

2. THE WORK OF THE EXPERT GROUP

The members of the Expert Group, which met 23 times (a total of 30 days) between 2003 and 2005, were drawn from all the mental health professions, from voluntary groups and from service users, in order to reflect all the stakeholders in mental health. The members were

Professor Joyce O'Connor, President, National College of Ireland (Chair)

Dr. Tony Bates, Principal Psychologist, St. James's Hospital, Dublin

Mr. Edward Boyne, Psychotherapist, Dublin & Galway

Mr. Noel Brett, Former Programme Manager for Mental Health and Older People, Western Health Board

Dr. Justin Brophy, Consultant Psychiatrist, Wicklow Mental Health Service

Mr. Brendan Byrne, Director of Nursing, Carlow Mental Health Service

Ms. Kathy Eastwood, Senior Social Worker, West Galway Mental Health Services

Ms. Mary Groeger, Occupational Therapy Manager, North Cork, Mental Health Services, Southern Health Board

Dr. Colette Halpin, Consultant Child and Adolescent Psychiatrist, Midland Health Board

Mr. Michael Hughes, Director of Nursing, Wicklow Mental Health Service and former Assistant to the Inspector of Mental Hospitals

Dr. Mary Kelly, Consultant Psychiatrist Intellectual Disability, Daughters of Charity/Brothers of Charity, Limerick

Dr. Terry Lynch, GP and Psychotherapist, Limerick

Mr. Paddy McGowan, Former Director, Irish Advocacy Network

Ms. Bairbre Nic Aongusa, Principal, Mental Health Division, Department of Health and Children

Dr. John Owens, Chairman, Mental Health Commission

Mr. John Saunders, Director, Schizophrenia Ireland

Dr. Dermot Walsh, Former Inspector of Mental Hospitals 1987-2004 and Mental Health Research Division, Health Research Board

Mr. Cormac Walsh, Former Mental Health Nursing Advisor, Department of Health and Children

The Expert Group was supported in its work by Dr. Fiona Keogh, Research Consultant, and by Marie Cuddy (Secretary to the Group), Ailish Corr and Joan Byrne of the Mental Health Division, Department of Health and Children.

In accordance with the terms of reference an extensive consultation process was undertaken. This included the publication of a request for written submissions, the circulation of a questionnaire seeking the views of those currently using mental health services, two consultation days for stakeholders (one in Dublin and one in Limerick), and the commissioning of a study involving individuals who were in-patients and who might not otherwise have had an opportunity to make their views known. The results of this wide consultation process were collated and published[2,3] and also used to inform this report. The written submissions were also posted on the Expert Group's web site at ***www.mentalhealthpolicy.ie***. A list of the individuals, groups and organisations who made written submissions is in Appendix 1.

The Expert Group also convened 19 advisory sub-groups to provide further, detailed input on various aspects of the report. Over one hundred individuals were involved in these multidisciplinary sub-groups, which included service users and carers where possible. These advisory sub-groups provided considerable assistance to the Expert Group. The membership of the advisory sub-groups is listed in Appendix 2.

Executive Summary

A Vision for Change details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.

An expert group, which combined the expertise of different professional disciplines, health service managers, researchers, representatives of voluntary organisations, and service user groups developed this policy. A broad consultation process was undertaken between the expert group and service users and providers, through invited formal submissions and through public meetings. The results of this consultation process were published in 2004 and critically informed the policy described in this document.

A Vision for Change builds on the approaches to mental health service provision proposed in previous policy documents. It proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It proposes a person-centred treatment approach which addresses each of these elements through an integrated care plan, reflecting best practice, and evolved and agreed with service users and their carers. Special emphasis is given to the need to involve service users and their families and carers at every level of service provision. Interventions should be aimed at maximising recovery from mental illness, and building on the resources within service users and within their immediate social networks to allow them to achieve meaningful integration and participation in community life.

Specialist expertise should be provided by community mental health teams (CMHTs) - expanded multidisciplinary teams of clinicians who work together to serve the needs of service users across the lifespan. CMHTs should serve defined populations and age groups and operate from community-based mental health centres in specific sectors throughout re-configured mental health catchments areas. These teams should assume responsibility for self-governance and be accountable to all their stakeholders, especially service users, their families and carers. Some of these CMHTs should be established on a regional or national basis to address the complex mental health needs of specific categories of people who are few in number but who require particular expertise.

To monitor service developments, ensure service equity across the HSE and evaluate performance of CMHTs, it is critical that systems of gathering information on mental health be established locally and nationally. In addition, mental health service research should be encouraged and funded to evaluate the effectiveness of proposed innovations and to improve our understanding of the unique and changing mental health needs of our community.

The mental health service should be organised nationally in catchment areas for populations of between 250,000 and 400,000. Organisation and management of services within each catchment should be coordinated locally by Mental Health Catchment Area Management Teams and managed nationally by a National Mental Health Service Directorate within the HSE. The National Directorate should be comprised of mental health service managers, clinicians and service user representatives, charged with responsibility to coordinate and implement the recommendations of this report. It is proposed that the Directorate should also establish a national manpower planning and training structure to review education and training needs for the mental health service to ensure that the increased manpower required for the proposed mental health system can be provided.

This policy envisions an active, flexible and community-based mental health service where the need for hospital admission will be greatly reduced. It will require substantial funding, but there is considerable equity in buildings and lands within the current mental health system, which could be realised to fund this plan. Therefore, this report recommends that steps be taken to bring about the closure of all mental hospitals and to re-invest the resources released by these closures in the mental health service. A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.

KEY RECOMMENDATIONS OF *A VISION FOR CHANGE*

- Involvement of service users and their carers should be a feature of every aspect of service development and delivery.
- Mental health promotion should be available for all age groups, to enhance protective factors and decrease risk factors for developing mental health problems.
- Well-trained, fully staffed, community-based, multidisciplinary CMHTs (Community Mental Health Teams) should be put in place for all mental health services. These teams should provide mental health services across the individual's lifespan.
- To provide an effective community-based service, CMHTs should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families.
- A recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Care plans should reflect the service user's particular needs, goals and potential and should address community factors that may impede or support recovery.
- Links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalised.
- The mental health services should be organised nationally in catchment areas for populations of between 250,000 and 400,000. In realigning catchment boundaries, consideration should be made of the current social and demographic composition of the population, and to geographical and other administrative boundaries.
- Organisation and management of local catchment mental health services should be co-ordinated locally through Mental Health Catchment Area Management teams, and nationally by a Mental Health Service Directorate working directly within the Health Service Executive.
- Service provision should be prioritised and developed where there is greatest need. This should be done equitably and across all service user groups.
- Services should be evaluated with meaningful performance indicators annually to assess the added value the service is contributing to the mental health of the local catchment area population.
- A plan to bring about the closure of all mental hospitals should be drawn up and implemented. The resources released by these closures should be protected for re-investment in the mental health service.
- Mental health information systems should be developed locally. These systems should provide the national minimum mental health data set to a central mental health information system. Broadly-based mental health service research should be undertaken and funded.
- Planning and funding of education and training for mental health professionals should be centralised in the new structures to be established by the Health Services Executive.
- A multi-professional manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this policy. This plan should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers.
- An implementation review committee should be established to oversee the implementation of this policy.
- Substantial extra funding is required to finance this new Mental Health Policy. A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.
- *A Vision for Change* should be accepted and implemented as a complete plan.

Vision

Service providers should work in partnership with service users and their families, and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services.

CHAPTER ONE

Listening to what we heard: Consultation with services users, carers and providers

1.1 INTRODUCTION

The first step in formulating this policy was to consult with a wide range of people involved with mental health in Ireland. It was clear from the start that the success of any project to change the mental health system would necessarily depend on engaging with the views of service users and their carers, and with those of service providers.

Dignity

1.2 CONSULTATION

A wide-ranging and comprehensive consultation process was undertaken to help develop this policy. This process enabled service users and providers to describe their experience of mental health services and to articulate their view of the changes needed to provide an effective, more user-friendly, mental health service.

The extent and the effectiveness of the consultation process ensured that the vision expressed in the resulting policy is one genuinely shared, and one that can ultimately be implemented.

1.3 THE CONSULTATION PROCESS

The consultation process with service users and providers included the following elements:

1. Public advertisements were placed in the national newspapers inviting interested parties to make written submissions to the Expert Group on Mental Health Policy. These elicited 154 submissions from a range of stakeholders including service users, families and carers, voluntary groups, professional groups and service providers.

2. Questionnaires were distributed to service users throughout the mental health services. Some 369 completed questionnaires were returned.

3. Stakeholders were invited to one of two seminars, one in Dublin and one in Limerick, and over 200 individuals attended.

4. The Irish Advocacy Network was commissioned to carry out an in-depth survey of 100 service users.

1.4 FINDINGS OF THE CONSULTATION PROCESS

Findings from this consultation process have informed the development of every part of this policy and have been published in two separate reports: *Speaking Your Mind*[2] and *What We Heard*[3].

Overall, there was a universal call for significant change at all levels of service from training of health practitioners, to involvement of service users in service planning, and for delivery of community-based interventions that are accessible and effective in promoting recovery and re-integration. A number of consistent themes permeated every part of the consultation process and these are summarised below.

The most frequently cited issues were:

- The need for **multidisciplinary** teams that operate in a truly integrated way and offer a wide range of treatment options to the service user.
- The need to adopt a **recovery** perspective at all levels of service delivery. While recovery does not necessarily imply a cure, it does suggest that the individual can live a productive and meaningful life despite vulnerabilities that may persist, equipped with the necessary self-understanding and resources to minimise relapse. Service users also wanted services to treat them with **dignity and respect**.
- The need for services to be built around responding to the practical **needs** of its users, and the need to recognise that service users are primarily held back from recovery by practical problems of living rather than by their symptoms.
- The need for greater access to psychological or 'talk' therapies. The demand for **psychological and social therapies** and the evidence for their effectiveness has been growing in recent years and the consensus among users and service providers was that they should be regarded as a fundamental component of basic mental health services, rather than viewed as additional options that are not consistently available.
- The need for services to become **community-based**, offering assessment and evidence-based best practice interventions as close as possible to where the user lives. Whilst it was recognised that acute hospitalisation will always be required to serve a minority who need intervention in safe, therapeutic settings, there was a desire to see an expansion of mental health service options established in local communities so that **comprehensive** care can be provided. For example, crisis and respite facilities, early intervention and specialist rehabilitation services.
- The need for formalised **links** between specialised mental health services and primary care and mainstream community agencies to support the care and integration of individuals within their local communities was a recurrent theme. The need to clarify boundaries and access arrangements between primary and specialist care services was also mentioned.
- The need for service users to be viewed as **active participants** in their own recovery rather than as passive recipients of 'expert' care. Effective recovery and meaningful care plans depend on the cooperation and support of users and carers, and the expertise of service users who have overcome mental illness is a valuable resource – both as advocates and as contributors to service planning.
- The need to ensure that an improved mental health policy is **funded** in a manner that enables it to deliver its service objectives competently, accompanied by a reciprocal need for clarity about clinical governance, leadership, quality and standards, accountability and ensuring value for money in the use of public funds.

- The need for mental health services to be responsive to the specific mental health needs of service users, delivering best practice and evidence-based treatment interventions in an integrated way through community-based, multidisciplinary teams. Both service users and providers were agreed on many of the reforms and innovations needed to invigorate mental health services.
- The need for **integration** into mainstream community life to be the ultimate goal of recovery, to be achieved through involvement of users and carers with an expanded range of service structures that link well to primary care, local voluntary organisations and relevant community agencies. Services should be accessible, user-friendly, and available when individuals need them most.

1.5 VISION

The vision embodied in this policy is to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual. This mental health system should deliver a range of activities to promote positive mental health in the community; it should intervene early when problems develop; and it should enhance the inclusion and optimal functioning of people who have severe mental health problems. Service providers should work in partnership with service users and their families, and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services.

1.6 VALUES AND PRINCIPLES

Values are at the heart of this policy; they inform and underpin the service philosophy that it proposes. It is sometimes suggested that abstract principles and values are not that relevant to practical policy decisions or to how we deliver mental health services, but the consultation findings contradicted this view, as have other research exercises along the same lines. For example, 'being treated with dignity and respect' was identified as one of the most important features of a quality mental health service in a consultation exercise conducted by the Mental Health Commission[4].

It is important not to underestimate the human interaction that is at the heart of mental health treatment and care. This interaction is an expression of individual and organisational values. An example of how values can be brought into the everyday delivery of care, to the benefit of service users and of those providing the service is given in Annex 1.

The following core values and principles, honour the findings of the consultation process and underpin this mental health policy.

In the framing of this mental health policy, great care was taken to incorporate the themes that emerged from the consultation process. These themes are fundamental to the vision for mental health services, the values that underpin that vision and the framework for a mental health system that is outlined in the following chapters.

RECOMMENDATION 1.1: The principles and values described here and underpinning this policy should be reflected in all mental health service planning and delivery.

Citizenship	The individual is at the centre of the mental health system. The human rights of individuals with mental health problems must be respected at all times (further details on human rights are in Annex 1).
Community care	People with mental health problems should be cared for where they live and if inpatient care is necessary it is to be provided in the least restrictive setting.
Coordination	Services must be coordinated and integrated to meet the full range of social, psychological and physical care needs of individuals with mental health problems. The structure and organisation of mental health services should facilitate and encourage continuity of care. Seamless mental health services should be available in a continuum stretching from the community at large to primary care and specialist mental health services.
Comprehensive	A range of specialist mental health services should be available such as child and adolescent mental health services, adult mental health services, mental health services for older people and more. All specialist mental health services should provide the full range of interventions in a variety of suitable settings.
Partnership	Service users and carers should be involved in a meaningful way with the planning and delivery of their care. A partnership approach should be taken to the planning, development, delivery, evaluation and monitoring of mental health services, with the inclusion of all stakeholders. It is through partnership that trust is built for all involved.
Effectiveness	A system which meets the needs of the individual and their carer is an effective system. There must be an evidence-based approach to service development to ensure the highest standard of care and the optimum use of resources. It is important to take a broad definition of evidence* and to be inclusive of all knowledge that may help improve mental health services.
Accountability	Clinical and corporate governance should be put in place to ensure the accountability of mental health services.
Quality	Mental health services and the treatment and care offered in them should be of the highest standard.
Early intervention	The mental health system should be based on the principle of early intervention, through the provision of mental health promotion at all levels of the mental health framework, and through a focus on early intervention with individuals in mental health services.
Equity	Within the mental health system, resources and services to the population should be provided on the basis of need, using the principle of proportionality. This approach is chosen in preference to providing services on the basis of the principle of equality, which provides the same to everyone regardless of need. The share of the national health budget for mental health must reflect the high prevalence of mental illness and mental health problems. Mental health resources must be distributed equitably across mental health services. The mechanism of resource allocation to mental health services should be transparent so that equity can be objectively determined.
Accessibility	Mental health services must be accessible to all who require them; this means not just geographically accessible but that services should be provided at a time and in a manner that means individuals can readily access the service they require.
Inclusive	Mental health services should be inclusive of all the people in Irish society and should be delivered in a culturally appropriate way.
Respect	Service users and their carers should be respected as individuals and treated with dignity at every level of service provision.
Recovery	A recovery approach to mental health should be adopted as a cornerstone of this policy.
Non-discriminatory	Equal opportunities for housing, employment and full participation in society must be accorded to individuals with mental health problems.
Population health approach	The mental health needs of the total population should be considered in this policy. This approach acknowledges that there is a range of factors which can influence mental health, including physical, psychological, social, cultural and economic.

* The *Health Evidence Network* defines evidence as 'Findings from research and any other knowledge that could be useful in decision-making on public health and health care.' *World Health Organisation 2005*[5]. The evidence-based approach has informed the development of this policy. There is a generally accepted listing of levels of evidence:

Level I	Service user or carer group opinion
Level II	Descriptive surveys of clients
Level III	Intervention studies which are non-randomised
Level IV	Randomised controlled trails
Level V	Systematic reviews

Evidence at Levels I and II should not be discounted in favour of evidence at Level V. Rather, there should be cross-referencing of evidence so that, for example, service user views inform the content and conduct of randomised trials, or are considered in conjunction with the results of such trials. It should also be noted that there is a dearth of evidence on many aspects of mental health, from the prevalence of mental health problems to the organisation of mental health services to the type of interventions that might be used.

CHAPTER TWO

Policy Framework

2.1 MENTAL HEALTH POLICY

Mental health policy defines a vision of the future and helps establish a framework for action that will realise that vision. A mental health policy consists of an organised set of values and principles that gives direction to government and service providers as to the structures, elements and management systems required for mental health services. As well as creating a systematic framework and plan for mental health, a mental health policy can help raise awareness, secure resources for services and coordinate actions across many different sectors[6].

Popula

2.2 WHAT DO WE MEAN BY 'MENTAL HEALTH'?

There are many different definitions and descriptions of mental health. Concepts of mental health include, for example, the ideas of subjective well-being, personal autonomy, and the ability to realise one's potential in life. Different cultures have different definitions of mental health, or can place varying degrees of importance on different aspects of mental health. The understanding of mental health used in this policy, includes the awareness that mental health is broader than an absence of mental disorders; that poor mental health affects our ability to cope with and manage our lives, particularly during personal change and through key life events, and decreases our ability to participate fully in life; and that mental health is an essential component of general health, which it underpins[7].

Mental health and mental well-being are therefore part of everyday life, in that mental well-being is influenced, both positively and negatively, in every area of life; in families, schools, the workplace and in social interactions.

Mental health problems affect society as a whole. This emphasis on the social importance of mental health (and therefore the importance of a society-wide response to mental health) is increasingly emphasised by the World Health Organisation (WHO):

> 'for all individuals, mental, physical and social health are closely interwoven … As our understanding of this interdependent relationship grows, it becomes ever more apparent that mental health is crucial to the overall well-being of individuals, societies and countries.'[8] (p. 7)

2.3 WHY IS MENTAL HEALTH IMPORTANT?

Mental health is important because good mental health enables people to lead a fulfilled life and to relate satisfactorily to those around them. The consequences of mental health problems for an individual or family can be considerable and wide-ranging. Work life, social life and family life can be greatly affected. The consequences for society as a whole are also substantial:

> 'Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies.'[9] (p. 1)

From a population perspective, mental health problems have a high prevalence, have a wide-ranging impact on the individual and others, and are costly to the economy.

The number of people affected by mental health problems at any one time is high – about one in four individuals will have a mental health problem at some point in their lives[10]. Most of these people will not need specialist mental health care or admission to a psychiatric unit.

The WHO has calculated the global burden of disease and found that mental disorders rank second in the global burden of disease, following infectious diseases[11]. In fact, mental disorders exact a greater toll on the health of the world's population than AIDS, TB and malaria combined. Five of the ten leading causes of disability worldwide are mental health conditions such as depression and schizophrenia, and the impact of mental health problems at a population level continues to grow.

n-based

The economic costs of mental health problems are also considerable. These were estimated to be at least 3–4% of GNP across the member states of the EU[12]. The total financial cost of mental ill health in Northern Ireland has been estimated at Stg£2.8 billion (approximately €3.7 billion)[13]. The largest proportion of the cost occurs outside the health sector, for example through lost employment and absenteeism. Typically these social costs account for 60–80% of the total economic impact of major mental health problems. The scale of the impact of mental health problems on work is often not appreciated. For example, 31.9 million lost working days in France were attributed to depression[14]. There can be substantial costs for family carers as they may have to provide many hours of support

each day to the family member with a mental health problem. There can also be an economic impact over very long periods, especially where childhood mental health problems are in question.

2.4 A MODEL OF MENTAL HEALTH

A 'model' for understanding mental health needs to be formulated, because the way mental health is viewed (i.e. the model used) determines society's approach to emotional distress and mental health problems. If there is no understanding of what factors influence mental health, we cannot hope to prevent mental health problems, to promote better mental health, or to deal effectively with mental health problems.

The **biopsychosocial** model incorporates key influences on the mental health of the individual and highlights the interconnection and interdependence of people's biological, psychological and social functioning.

The artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental health[10]. It is now recognised that mental and behavioural disorders are the result of a complex interaction of all three causal factors of mental health problems and the biopsychosocial model gives due regard to them. As a result, appropriate emphasis can be given to the interventions in each of the three spheres when developing an integrated care plan for each individual.

A concern expressed by service users during the consultation process arose from over-emphasis on the 'bio' part of the model (what some referred to as 'the medical model'), to the detriment of the psychological and social parts. This can result in lost opportunities for the provision of effective psychological and social interventions for individuals. Many service users reject the biological approach when it is presented in isolation, or as the 'only option'[2,3,4]. The danger here is that potentially effective biological/medical interventions will be rejected by individuals who may benefit from them.

While mental health professionals have generally embraced the biopsychosocial model, they tend to do so with different emphases, depending on their particular discipline and the training they have received. The lack of emphasis on the psychological and social aspects of mental health treatment and care has arisen partially because of constraints within the service system, such as the lack of a multidisciplinary perspective, and lack of available psychosocial therapies. These issues are addressed later in this policy document.

2.5 SERVICE USERS AND CARERS

One of the messages that came from the consultation process, particularly from some sub-groups, was the importance of the language to be used in this policy, and care has been taken to hear that message (see "A Note on Terminology" in the Foreword section). For example, the term 'patient' was not acceptable to many individual mental health service users, especially given that most of the interventions involving them are provided in the community.

As well as being empowering or dis-empowering, language can also be stigmatising and dehumanising. Describing a person only in terms of their illness – for example describing someone as 'a schizophrenic' rather than as a person with schizophrenia –reduces them to a stereotype and robs them of their personal identity. This use of stereotyping language in mental health is as damaging as that used for race, disability, and sexual orientation. Language that stigmatises has been harmful to many people with mental health problems and has contributed to them feeling socially excluded and rejected. It is important that language is used more skillfully, so as to reshape attitudes to mental health problems and the people who experience them.

Terms currently in use to describe people who experience mental health difficulties, include patients, clients, consumers, experts by or through experience, survivors, people with mental illness, and service users. The term **service user** was chosen as the most appropriate to use, as it includes people who were either current users or past users of services.

People who have a supportive relationship with service users are also described in a variety of ways. The terms used include carer, family member, significant other and ally. It was agreed that the term to be used in this report is **carer** as this describes both people who are family members and also non-family members such as friends, neighbours, colleagues who have a supportive and caring role in relation to service users.

2.6 MENTAL HEALTH PROFESSIONALS

Mental health treatment and care does not rely on high-tech equipment or facilities. More than any other specialty, mental health service provision is reliant on human beings, the professionals who deliver the service as part of a multidisciplinary team.

Central to this process is the establishment of a therapeutic alliance between the individual, the mental health care team and the service user's carer. This relationship must be facilitated and supported in a very practical way through the working arrangements of the mental health services, to ensure flexibility, availability and continuity of care.

Everybody who provides mental health services, especially those in the front line, needs to be made aware that their work is highly valued. Mental health staff are no different to service users and carers in that they share the same need to be respected, valued, listened to and involved. Their need for training and supervision must also be recognised and provided for. More detail on training and education is provided in Chapter Eighteen.

2.7 FRAMEWORK

The challenge in formulating a policy framework for mental health is to create a framework that is relevant to the current mental health system and those working within that system, that meets the needs of service users and their carers, and can feasibly implement the vision and objectives of the policy.

A comprehensive mental health policy must also address the mental health needs of the population as a whole, and it must address these needs across the lifespan of the individual.

2.7.1 A POPULATION-BASED MENTAL HEALTH POLICY FRAMEWORK

The knowledge that mental health problems can affect anyone, underlines the need for mental health to be considered at the population level. This universality of mental disorders is very well expressed in the WHO report *Mental Health: New Understanding, New Hope* [10]:

> 'Mental and behavioural disorders are found in people of all regions, all countries and all societies. They are present in women and men at all stages of the life course. They are present among the rich and the poor, and among people living in urban and rural areas. The notion that mental disorders are problems of industrialised countries and relatively richer parts of the world is simply wrong. The belief that rural communities, relatively unaffected by the fast pace of modern life, have no mental disorders is also incorrect.' (p. 23)

It is not enough for a comprehensive mental health policy to make recommendations relating solely to specialist mental health services; it must also 'deliver mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems'[9]. A comprehensive framework such as the one advanced in this policy needs

to take into account the entire 'mental health system' – all parts of the health and social services where mental health care is delivered, whether through groups in the community, in primary care, in schools or in specialist mental health services.

2.7.2 A LIFESPAN APPROACH TO MENTAL HEALTH

This policy adopts a lifespan approach to mental health. A lifespan approach enables us to view each individual in their own context, at their own point in life.

The spectrum of mental health is dynamic and changes throughout the life of an individual in response to life experiences. Individuals live and function in an environment made up of family, friends, community and society. Their mental health is influenced by this environment; how supportive or unsupportive it is, the richness of experience it facilitates, and many other features.

While the impact of developmental processes in children is generally appreciated, as the rapid changes they make in the early years of life are readily observed, there tends not to be the same appreciation of the same developmental processes in teenagers, adults and older people. The fact is that people continue to develop and change throughout life. People have different capacities for sustaining mental health at different stages of life. The different stages of life can also be associated with vulnerability to specific mental health problems. Even with the same mental health problem, the needs of an individual can be very different depending on the current stage in life. For example, the needs of an adolescent with schizophrenia are very different to those of an adult with schizophrenia, and different again to those of an older person with schizophrenia.

2.8 THE POLICY FRAMEWORK

Figure 2.1 gives a diagrammatic illustration of the framework that this policy proposes. The pyramid represents the total population. Individuals move through different levels of support and service, from informal care and support in their own community to primary care to mental health services, based on their mental health needs.

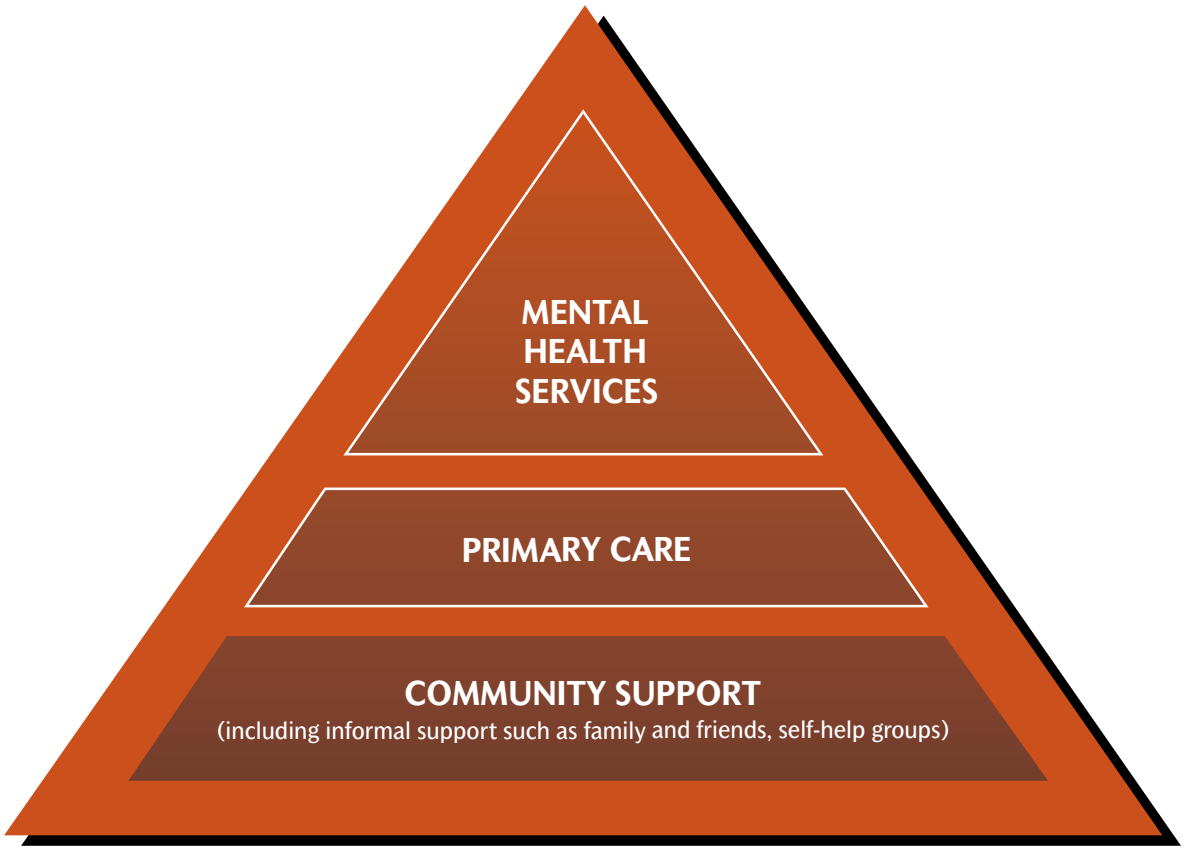
These elements of the mental health system are not mutually exclusive but are closely integrated and rely on each of the other elements. For example, an individual who is attending a mental health service still needs the support of their family, community and their GP.

Box 2.1 describes how individuals with symptoms of depression might typically present in the different elements of the model.

Box 2.1: Depression in the population

An illustrative example is the continuum of symptoms of depression in the population. There is a relatively high level of the milder features of depression in the population (for example 'Monday morning blues'). These encompass the normal fluctuations of mood experienced by most people. These experiences usually become resolved by themselves or with the help of supportive family members and friends, and may be experienced by up to 16% of the population. A smaller number of individuals can be affected for longer periods of time and at greater severity. An episode of depression may have significant impact on the life of the individual and may prevent them from partaking in their everyday activities. People affected in this way may contact their GP for help. Most individuals affected in this way are treated by their GP and do not progress any further through services. A very small number of individuals may be affected so severely that they need to be referred to a mental health service. For a further, even smaller number, a period in hospital (usually brief) may be required.

Figure 2.1: A framework for a comprehensive mental health policy
(Adapted from WHO,6)

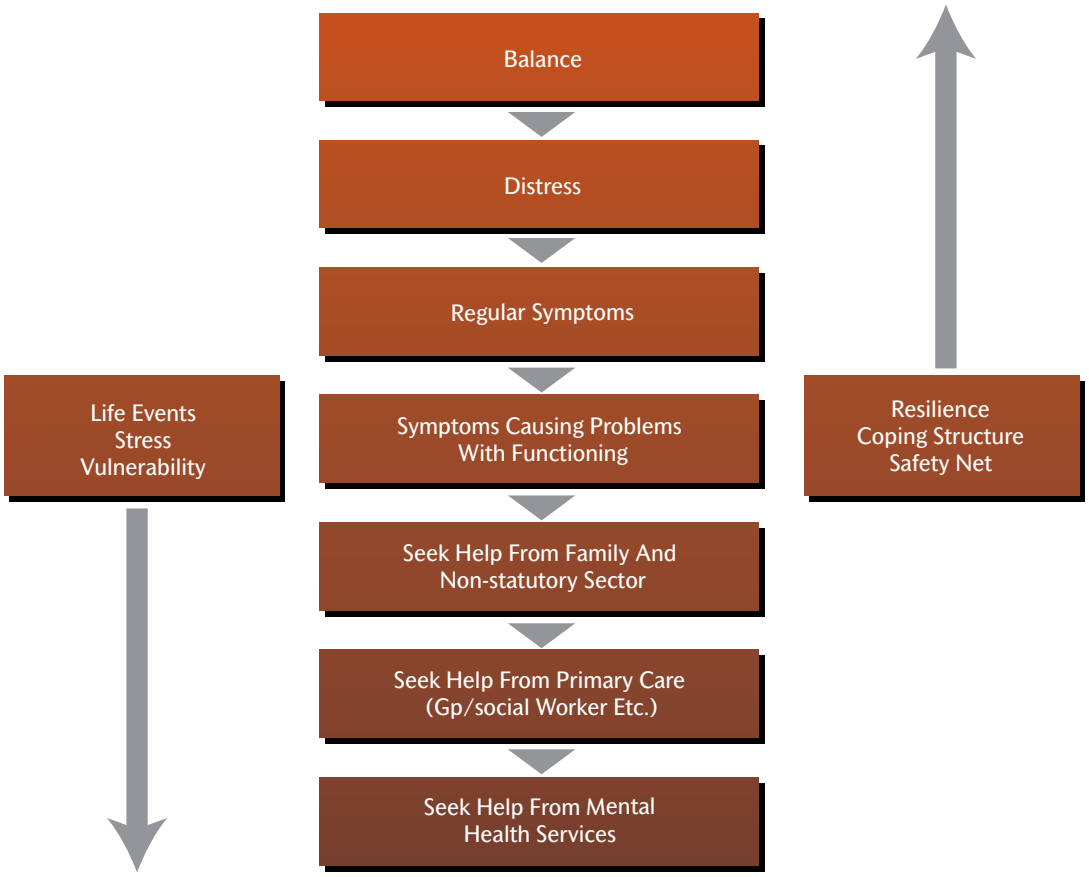


2.8.1 THE COMMUNITY AND INFORMAL CARE

For most people affected by mental health problems, these difficulties usually resolve themselves after a time. Informal care and support offered by family and friends – and perhaps having a confidant – can be a great help. A person can take simple steps, such as getting more sleep and making similar minor lifestyle changes. Self-help and support groups, and a host of other community groups and resources, may also play an important role. Mental health problems or emotional distress experienced at this level are usually related to the type of problems that anybody can encounter through the course of life; job loss, relationship difficulties, bereavement and similar life events.

Figure 2.2 shows a typical pathway through care for someone in psychological distress. This diagram is a somewhat idealised and simplified portrayal of what happens for some people. There are many points along the pathway which may prevent an individual from receiving the help they need or several steps may be missed.

Figure 2.2: Possible pathway through services
(from McKenzie et al., 2004[15])



2.8.2 THE COMMUNITY AS A PARTNER

It is increasingly being recognised that the community itself is a valuable resource in dealing with many health problems, including mental health problems. The Western world, including Ireland, can learn from less-well-off nations about mental health interventions that these countries have chosen to use from necessity and lack of material resources, but which offer useful ways of harnessing community potential, particularly for handling the type of emotional distress that can be common in the general population.

For example, mental health services have been described[15] that use the support of families and communities to improve outcomes in mental health, such as increased social support for new mothers, a stepped-care approach to treating depression in primary care, and a community-based rehabilitation model. These models have been tested and shown to be at least as effective as more sophisticated and expensive models. The core elements of these programmes were community involvement in the planning and delivery of services, harnessing of social support, and involvement of providers with a diversity of skills in stepped services[16].

Some of the difficulties in implementing these models in wealthier countries would require overcoming 'considerable barriers in the form of system inertia, multiple funders, funding that creates disincentives to

provide alternative services, professional vested interests and boundaries, stigma, loss of the sense of community, breakdown of the family, and lack of resources for the treatment and prevention of mental disorders compared with medical conditions'[16].

Some of these barriers are addressed in Chapter Four of this document, which looks at social inclusion, and particularly the social exclusion that can occur when an individual has a mental disorder. The same chapter also discusses the importance of the community as a resource in enhancing mental well-being and in dealing with mental health problems. Chapter Five describes mental health promotion in detail and discusses the many different programmes and interventions that can be undertaken to prevent mental health problems, enhance mental well-being and address the needs of specific groups. Examples of evidence-based interventions and programmes in mental health promotion are presented throughout this policy.

2.8.3 PRIMARY CARE AND MENTAL HEALTH

If a person has been experiencing emotional distress for some time, and is unable to resolve it themselves, or with the help of an informal network, they usually consult someone in primary care (for example their GP) for help. Figure 2.2 illustrates this stage in the pathway through services. However, there are many factors that can influence how the person moves through this pathway. For example, an individual may not want to go to their GP, or if they do, they may not want to, or feel able to discuss their mental health concerns with the GP. They may present their psychological distress in terms of physical symptoms. In this situation, the GP must investigate the physical symptoms described and it is often only through a process of elimination that the GP can arrive at a diagnosis related to mental health. It is also possible that the GP may not pick up their symptoms as signs of psychological distress.

Primary care is a very important part of the mental health framework for two reasons:

- Most mental health problems are dealt with in primary care without referral on to specialist services. Primary care is therefore the main supplier of mental health care for the majority of the population.
- The GP in primary care is also the main access point to specialist mental health care for most of the population.

Chapter Seven discusses primary care and mental health in detail.

2.8.4 MENTAL HEALTH SERVICES

The usual pathway to specialist mental health services is through the GP. When people need mental health treatment and care that the GP cannot provide, they are referred to their community mental health service.

Mental health services across the individual's lifespan are described in Chapters Ten to Fifteen. These mental health services deal with the smallest part of the population affected by mental health problems; this is reflected by the fact that they are at the narrow point of the pyramid in the population model (figure 2.1). However, these individuals are also the people with the greatest need for mental health treatment and care. Mental health services are more complex in their organisation than the services or interventions that feature in the other elements of the population model.

For this reason, a detailed framework for mental health services is being presented. This service framework fits into the overall policy framework as described in the pyramid model for the population. Underpinning this overall policy framework and the service framework outlined below, are the values and principles described in Chapter One. These will be honoured and taken into account at all times.

CHAPTER THREE

Partnership in care: Service users and carers

3.1 INTRODUCTION

As a necessary step towards more equal and fair communication between all mental health participants, service users and carers should be included as active partners in the planning and delivery of mental health services.

The consultation process highlighted a number of issues of particular concern to service users and carers. These issues are summarised in Chapter One and Annex Three. The terms service user and carer were defined in Chapter Two and are used throughout this report. Service users and carers are not a homogeneous group, although there are many issues which are common to both groups.

Partner

Service users have a unique insight into the experience of mental ill health and a greater awareness of the public perception of mental health and the provision of services. Their expertise is very different to the expertise of other stakeholders in mental health.

Family, friends, colleagues, neighbours and community members are important sources of support for service users and have their own unique insight into mental ill health and the provision of mental health services. The importance of the views of service users in formulating this policy is shown by the inclusion of service users at all levels of the process.

3.2 PARTICIPATION OF SERVICE USERS

Involving service users in mental health services goes beyond simply carrying out a consultation process. Service users must be at the centre of decision making at an individual level in terms of the services available to them, through to the strategic development of local services and national policy. To use a slogan of the disability rights movement: *'nothing about us, without us'*.

There are welcome changes in the area of user involvement and participation in some countries and services. Evidence from other countries shows [17,18]:

- increasing representation of service users on decision-making bodies
- involvement of service users in the planning, organisation, delivery and monitoring of services
- development of peer-provided services.

Many possibilities exist in Ireland also for service user and carer groups to become involved in the development and delivery of mental health care. These opportunities include assuming an advocacy/campaigning role on policy, legislation and mental health delivery; taking on an educational role aimed at sensitising the general public to the need to integrate people with mental health

ship

difficulties into community life and providing education and training to service users and carers; and delivering mental health services such as self-help services, drop-in centres, and assistance with activities of daily living and community reintegration.

RECOMMENDATION 3.1: Service users and carers should participate at all levels of the mental health system.

Figure 3.1 shows in diagrammatic form different ways service users can be involved, from being active partners in their own recovery, to involvement at a national advisory level.

3.2.1 INDIVIDUAL LEVEL

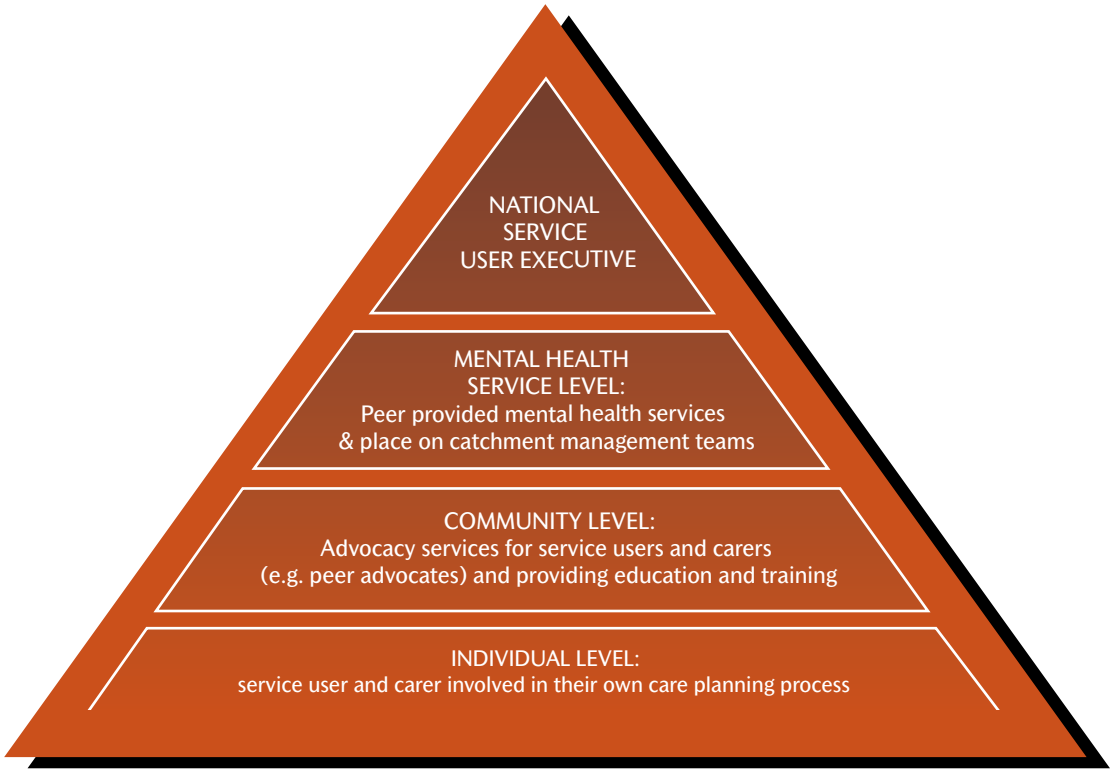
The most immediate way that a service user or carer can be involved in mental health care is through the development of their own care plan, in conjunction with a multidisciplinary team. This is described in greater detail in Chapter Nine.

3.2.2 ADVOCACY SERVICES

Strong evidence indicates that recovery (in this instance, recovering a meaningful social role) for service users is underpinned by the individual's ability to advocate for themselves. Self-advocacy involves not only speaking up for oneself, but also gaining confidence, supporting other people, not being afraid to 'ask', having specific skills and knowledge, and gaining new skills. Following a period of severe emotional distress a person may not be in a position to advocate for themselves; having access to someone who will act as advocate on one's behalf is important during this time.

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. But exercising this right is not possible at present for some service users as there are many areas in the country which do not have access to advocates, and there are so few in other areas that only in-patients currently have access to an advocate.

Figure 3.1: Model for service user involvement in mental health services



The advocate should be a peer who has had occasion to use the mental health services themselves and has received recognised training in advocacy. A peer advocate who has been through similar experiences finds it easier to empathise and build up rapport with service users. An advocate is there to provide a listening ear, information and support. Ideally the advocate will empower the service user to do things for themselves; to reclaim control over their own lives.

The advocate can inform the service user of social welfare benefits, housing and other matters of concern, or can point in the direction of this information. The advocate can present the service user with options that may be available to them (but should never prescribe a course of action as this is not part of the advocacy role). Advocates have as their priority the service user's interests and needs. Their own opinion of what is best for the service user should not enter the situation.

RECOMMENDATION 3.2: Advocacy should be available as a right to all service users in all mental health services in all parts of the country.

3.2.3 PEER-PROVIDED SERVICES AND SERVICE USER INVOLVEMENT

Peer-provided services are services that are run by service users and offer peer support and opportunities for re-integration and independence in the community. Research evidence shows that peer-provided services bring benefit to all stakeholders[19].

The benefits to service users include improvement in symptoms, increase in social networks and quality of life, reduced mental health service use, higher satisfaction with health, improved daily functioning and improved illness management.

Peer providers themselves benefit by experiencing reductions in their own hospitalisation and having opportunities to practice their own recovery, build their own support system and engage in professional growth.

Benefits to the mental health service delivery system include cost savings through decreased hospitalisation and reduced use of mental health services, a reduction in negative attitudes towards services, improved relationships with service users, improved mental health outcomes, and having the needs of those alienated from services addressed[19].

RECOMMENDATION 3.3: 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.

RECOMMENDATION 3.4: The adult education system should offer appropriate and supported access to information, courses, and qualifications to service users, carers and their representatives that would help to enhance and empower people to represent themselves and others.

3.2.4 CATCHMENT MANAGEMENT TEAMS

The most immediate way service users can influence the planning and delivery of local catchment mental health services is through being included on the local catchment area management team. This is discussed in greater detail in Chapter Sixteen.

3.2.5 NATIONAL SERVICE USER EXECUTIVE

Service users should be involved in implementing and evaluating the new mental health policy. This means involving them at all management levels and functions – including resource allocation – from local health offices up to and including the proposed National Mental Health Service Directorate and the Mental Health Commission Inspectorate. It should include the establishment of a National Service User Executive (NSUE). The role and function of the NSUE should be:

Role: To inform the National Mental Health Service Directorate and the Mental Health Commission on issues relating to user involvement and participation in planning, delivering, evaluating and monitoring services including models of best practice.

Function: To develop and implement best practice guidelines between the user and provider interface including capacity development issues.

RECOMMENDATION 3.5: A National Service User Executive should be established to inform the National Mental Health Service Directorate and the Mental Health Commission on issues relating to user involvement and participation in planning, delivering, evaluating and monitoring services including models of best practice; and to develop and implement best practice guidelines between the user and provider interface including capacity development issues.

3.3 HOW DO WE MAKE THIS HAPPEN?

Firstly, mental health service providers need to draw up service user involvement policies and create suitable forums to ensure they are implemented, and to declare an unequivocal commitment to act on the outcomes of user involvement.

User involvement costs money, so it is vital that adequate budget contingency should run parallel with clear policies for involvement, building capacity, and identifying personnel responsible for the implementation of these policies and programmes.

The following principles[20] for user involvement at all levels of the model in Figure 3.1 should guide action in this area:

- **Make user involvement the norm**: There needs to be a willingness and acceptance from professionals that service users have a right to be involved and this should be built automatically into their ways of working.
- **Support service user organisations**: Users need their own organisations and structures and meetings to give them a base from which to work. If there are no local service user organisations, help should be given to provide this capacity. Existing service users should be invited to send representatives to all local, regional and national consultations.
- **Examine and deal with power imbalances**: Imbalances of power between service users and professionals need to be acknowledged and addressed.
- **Outreach**: This means going to where the service users are. Professionals need to go to meetings that service users organise, rather than service users always having to send delegates to forums where they may be under-represented.
- **Facilitate service users making their own decisions about involvement**: Service users should be facilitated to decide what they want to do rather than having to adapt to others plans for them. Exceptions to this happen in the case of involuntary admission, but the principle of involvement should be maintained as far as possible.
- **Value the expertise of service users and assist them to develop new skills and confidence**: The existing experience, knowledge and skills of service users should be valued even though these may challenge those of some professionals. Service users value safe environments to broaden their experience, develop new skills and to build confidence.
- **Ensure fair remuneration for service users**: Service users should at a minimum be reimbursed for out-of-pocket expenses at the same rates as health professionals. Payment should be flexible and sensitive to the circumstances and the needs of the service user.
- **Training on different perspectives**: Professionals need to be educated in service user perspectives and involvement processes. Similarly, service users need to understand the perspective of the mental health professionals and the limitations of mental health services.
- **Service users and carers are not interchangeable**: Service users can often be made to feel disempowered by well-meaning carers, and in some instances may be in direct conflict with carers. Users and carers should not be considered as a homogenous group.

3.4 INVOLVEMENT OF CARERS

Carers provide an enormous amount of care in the home for people with mental health problems. While there is no substantial national research on caring and mental health, some evidence in this area can be derived from studies on caring in general, for specific groups[21] or local studies[22]. There is a need to formally recognise and support through practical means the crucial role of family care in mental health service provision[23].

The consultation process revealed that carers often feel excluded from the care of the service user (for example, in situations where they are not given any information), while at the same time being expected to provide shelter for the service user and look after their day-to-day needs.

Evidence from the consultation process and from other contacts highlights specific needs of carers. These centre around the need to be valued for their role and input. This means, for example, that a mental health service should consult with the carer – and inform the carer in

advance that the service user is being discharged into their care.

It is often appropriate and helpful for the carer, with the agreement of the service user, to be involved in the care planning process. The care plan should ensure that carers are not forced to assume an unsustainable level of care.

Carers reported that they need services themselves such as the provision of education, information and support, and access to respite care.

The provision of support to families is an integral component of the community-based mental health services provided by a Community Mental Health Team (CMHT). The service user and family-centred approach to the provision of mental health services by the CMHT should go a considerable way to bringing about change for carers. It will also mean much greater involvement for carers, with a consequent impact on their lives.

However, this model also means that greater practical support and measures should be provided by the team, including:

- inclusion in care planning, with the agreement of the service user
- inclusion in discharge planning
- provision of timely and appropriate information and education
- provision of planned respite care
- appointing a member of the multidisciplinary team to act as a keyworker, or designated point of contact, with the team and to ensure these services are provided
- ensuring home-based care is available at times of acute illness.

Broader supports that should be available from outside the mental health services include the provision of greater financial support to people who take on a caring role for an individual with a mental health problem. The carer's allowance should be much more widely available.

RECOMMENDATION 3.6: Carers should be provided with practical support/measures such as; 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 and should have a member of the multidisciplinary team to act as a keyworker/designated point of contact with the team and to ensure these services are provided.

3.5 CHILDREN OF SERVICE USERS

The experience of having a service user in the family can negatively impact on the development, health and education of children in the household[24]. Children may be undertaking a range of caring responsibilities, including household and financial management; care of other siblings and family members and administering medication[25].

The experiences and needs of children of service users must be addressed by the mental health services and by children's and youth services, through integrated action at national, regional and local levels. Support for families that have one or more member with experience of mental health difficulties must become an integral component of a comprehensive, family-centred approach to mental health provision, and adult mental health services should be 'child-friendly'.

Such an approach should take into account the needs of the children and should include:

- provision of practical support
- communication and liaison with community support services if necessary, with an emphasis on supporting the child and the family

- ensuring access to age-appropriate educational and social activities that support a positive experience of childhood.

Suitable support must be provided for these children from community care services, to ensure they benefit from the same life chances as other children. Family members who experience mental health difficulties should be supported in realising their full potential as parents and siblings.

RECOMMENDATION 3.7: The experiences and needs of children of service users should be addressed through integrated action at national, regional and local level in order that such children can benefit from the same life chances as other children.

3.6 CONFIDENTIALITY

Provided the service user agrees, the carer or other family members should be given information about the service user's situation if they request it. However, there are times when the information needs of carers and families may conflict with the service user's wish for privacy. While the right of confidentiality for the user must be respected, a way forward should be agreed to ensure that the needs of the carer and family are also met.

A person-centered approach to the delivery of care will both highlight and moderate these conflicting rights, offering measures such as advance directives that can be put into effect at times when the user may not be well enough to make informed decisions, identifying and working in partnership with the carer, and providing carers and families with information about the illness, with due regard to the sensitivities of the service user.

3.7 INFORMATION

It has been shown that inadequate information, or an absence of information, contributes to poor experiences by service users and carers [26,3]. Indeed many users and carers experience added stress and trauma and associated ill health because they do not know, or are unsure of, the diagnosis, and are given little information on many aspects of treatment and care.

Ongoing and timely communication of information relating to care options, medications, treatment options and therapies, legal rights and status, complaints procedures, availability of services, training, housing, benefits and entitlements, must be structured into the service provision system. Information should be available from a range of sources, both within and independent of the mental health services.

A decision by a service user to ask a family member or friend to request information on their behalf should be respected by professional staff. Information means more than mere dialogue, as it presents an opportunity for learning, for both the giver and receiver of information. Information flow must be multidirectional, involving service providers, service users, and carers in a partnership arrangement.

The right to information is fundamental to autonomy and self-determination. The manner of communication is crucial to ensure this does not become a paper exercise and should involve advocates or personal representatives where necessary. Different types of mental health information, and the systems for providing such information, are presented in Chapter Nineteen.

3.7.1 INFORMATION ON COMPLAINTS OR COMMENTS ON SERVICES

All mental health services should have procedures in place for complaints. Details on how to make a complaint, and on the procedures to be followed, should be made widely and easily available to all service users and carers. People should also be afforded the opportunity to make suggestions and offer positive comments, and these should also be fed back to service providers.

RECOMMENDATION 3.8: Mental health services should provide ongoing, timely and appropriate information to service users and carers as an integral part of the overall service they provide.

RECOMMENDATION 3.9: Information on the processes involved in making complaints or comments on mental health services should be widely available.

3.8 WIDER PARTNERSHIP

> 'The requirements for effective collaboration include, first and foremost, an acceptance by the agencies concerned of the need for collaborative efforts. Mental health agencies and the people involved in the planning and delivery of mental health services have to take a lead in explaining and convincing people in other sectors, especially those outside health, of this need. Some ways of enhancing collaboration include: involving other sectors in policy formulation; delegating responsibility for certain activities to agencies from other sectors; setting up information networks that involve agencies from other sectors; and establishing national advisory committees with representatives of relevant agencies from sectors outside mental health' [27]

The vision that guides this policy requires that mental health services be characterised and led by a partnership between all stakeholders. Everybody providing mental health services and engaged in other mental health activities (such as mental health promotion) needs to seek out and work with a variety of partners.

The fundamental partnership is between service users, carers and all those working in mental health services. However, a variety of partners need to be engaged in the wider community. These should include community support groups, voluntary organisations, schools, the local county council, the local chamber of commerce, and other key individuals such as religious leaders of all faiths.

The *Strategic Partnership Guide*[28] produced by the National Disability Authority (NDA) outlines twelve essential principles for effective partnership with people with experience of mental health difficulties and provides training materials and guidance on getting started in this process.

RECOMMENDATION 3.10: Service user involvement should be characterised by a partnership approach which works according to the principles outlined in this chapter and which engages with a wide variety of individuals and organisations in the local community.

3.9 RECOMMENDATIONS

1. Service users and carers should participate at all levels of the mental health system.

2. Advocacy should be available as a right to all service users in all mental health services in all parts of the country.

3. 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.

4. The adult education system should offer appropriate and supported access to information, courses, and qualifications to service users, carers and their representatives that would help to enhance and empower people to represent themselves and others.

5. A National Service User Executive should be established to inform the National Mental Health Directorate and the Mental Health Commission on issues relating to user involvement and participation in planning, delivering, evaluating and monitoring services including models of best practice; and to develop and implement best practice guidelines between the user and provider interface including capacity development issues.

6. Carers should be provided with practical support/ measures such as; 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 and should have a member of the multidisciplinary team to act as a keyworker/ designated point of contact with the team and to ensure these services are provided.

7. The experiences and needs of children of service users should be addressed through integrated action at national, regional and local levels in order that such children can benefit from the same life chances as other children.

8. Mental health services should provide ongoing, timely and appropriate information to service users and carers as an integral part of the overall service they provide.

9. Information on the processes involved in making complaints or comments on mental health services should be widely available.

10. Service user involvement should be characterised by a partnership approach which works according to the principles outlined in this chapter and which engages with a wide variety of individuals and organisations in the local community.

CHAPTER FOUR

Belonging and participating: Social Inclusion

4.1 INTRODUCTION

One of the strongest concerns voiced to the Expert Group throughout the consultation process, from service users and service providers alike, was the problem of stigma. Other issues included difficulties encountered by service users around securing housing and employment. These issues in the mental health field are often collectively discussed under the heading 'social exclusion'.

4.2 WHAT IS SOCIAL EXCLUSION?

Social exclusion is what happens when an individual cannot access education or employment, becomes dependent on state benefits as a result, and becomes further excluded from the services available to them and from society in general because of poverty and other factors. The cycle of exclusion, in this case for an individual with mental health problems, is presented diagrammatically in Figure 4.1

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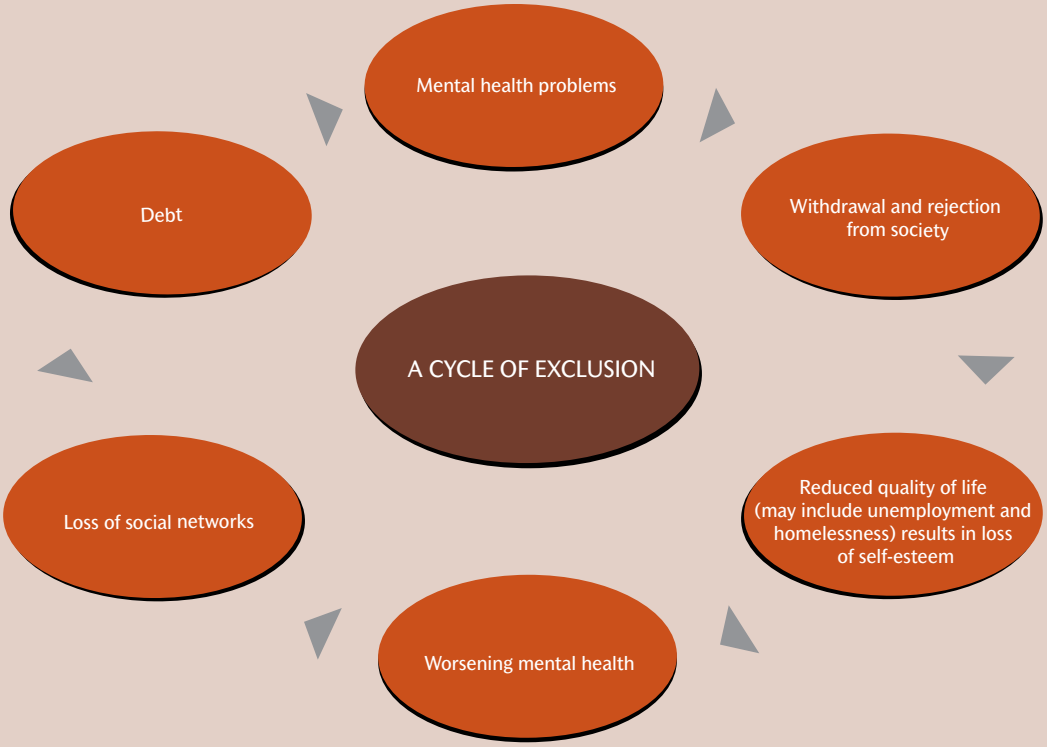
Tackling social exclusion can bring about significant improvements in the quality of life of individuals with mental health problems. While measures can be taken to **prevent social exclusion** (for example through the use of equality legislation), this policy takes a positive approach by presenting actions to facilitate and **encourage social inclusion**. These are two different but complementary ways of addressing the same challenge.

People with mental health problems are particularly vulnerable to social exclusion as the nature of these problems often means they are recurring, so that an individual may have repeated periods of illness and these may result in hospitalisation. Absence from work can lead to unemployment. The loss of a job is crucial, as it means both a loss of income and also loss of a social network and access to the wider social world. Loss of income can lead to debt and even homelessness.

A snapshot of what 'social exclusion' means for the lives of individuals is illustrated in the profile of those who took part in the survey of service users as part of the consultation process[3].

Figure 4.1: A cycle of exclusion

(From: Mental health and social exclusion, 2004[29])



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Most of the service users consulted were single (58%) and a further 16% were separated or divorced, 70% were dependent on welfare payments or had no income, and 47% had at best a Junior Certificate qualification.

Figures from England show that only 24% of adults with long-term mental health problems are in work – the lowest employment rate for any of the main groups of disabled people[30]. They also show that people with mental health problems are nearly three times more likely to be in debt, and that people with mental health problems carry more than double the risk of losing their job than those without.

RECOMMENDATION 4.1: All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.

4.3 STIGMA AND DISCRIMINATION

The *Surgeon General's Report on Mental Health*[31] in the United States describes very well the corrosive and pervasive impact of stigma:

> Stigma erodes confidence that mental disorders are valid, treatable conditions. It leads people to avoid socialising, employing or working with, or renting to or living near persons who have a mental disorder …

> stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation, and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society.

Stigma and discrimination are underlying causes of social exclusion and one of the greatest barriers to social inclusion. This is felt most acutely by people with mental health problems, and it was one of the issues highlighted continuously throughout the consultation process[2,3]. When service users were asked about proposals they might have for a new mental health policy many of them mentioned initiatives to tackle stigma. One respondent proposed the following: *'Education – more around mental health, more openness would remove stigma.'*

Stigma and discrimination can have an even greater effect on the life of service users than their mental health problem, as stigma can affect people long after their mental health symptoms have been resolved. Discrimination can also lead to relapses and can intensify existing symptoms[32].

4.3.1 ACTIONS TO TACKLE STIGMA

Actions designed to tackle stigma typically employ contact, education and challenge[33].

Contact actions

Greater **contact** with individuals with mental health problems, particularly through shared tasks, has been shown to reduce prejudice[34].

The visibility of service users, for example through the provision of services in community-based settings, has also been found to decrease stigma.

Contact itself can be a powerful educational tool.

Education actions

Educational campaigns have existed in Ireland for some time. For example, Mental Health Ireland runs a debating competition in secondary schools. Other anti-stigma programmes have been carried out elsewhere by the Department of Health in New Zealand[35] and by the National Institute for Mental Health in England, which launched a five-year plan to tackle stigma and discrimination in 2004[36].

Educational programmes that work typically target specific audiences, support local activity, and involve people with first hand experience of discrimination. For example, a public education programme for local residents beside a community-based group home resulted in these residents being three times more likely to visit the group home than others who had not received the education programme[29].

Challenge actions

A robust **challenge** needs to be mounted to all discriminatory practices and media misrepresentations of mental health problems. For example, Schizophrenia Ireland (SI) has taken action to "help prevent the discrimination and exclusion of those with schizophrenia … by challenging the way mental illness is reported or represented in the media'[37]. The *Media Watch* campaign carried out by SI is one way of doing this.

While it is preferable to bring about a change in attitude through involvement and education, there are also legislative means of tackling discrimination, specifically the Equal Status Act[38].

RECOMMENDATION 4.2: Evidence-based programmes to tackle stigma should be put in place, based around contact, education and challenge.

4.4 EDUCATION AND MENTAL HEALTH

Ensuring that children and adolescents remain engaged in the educational system is a crucial first step that can be taken to break the cycle of social exclusion.

Liaison and work between schools and mental health services is essential in this regard. For children who present a challenge to the school system, the provision of alternative school placements should be explored. Programmes such as the Youthreach programme are available, although rigid age eligibility can limit its usefulness as an alternative school placement.

Many of the issues mentioned in this chapter can contribute to children dropping out of school, for example poverty and homelessness. Addressing these problems emphasises the many factors that can promote social inclusion and have multiple benefits.

4.4.1 ADULT EDUCATION

The flexible provision of adult education programmes can help address the educational needs of adults with mental health problems, especially for those who may have dropped out of education early. Practical support to overcome barriers to education may be required, such as help with enrolment and travel expenses. Mentoring has also been found to be helpful[39].

RECOMMENDATION 4.3: The flexible provision of educational programmes should be used to encourage young people to remain engaged with the education system and to address the educational needs of adults with mental health problems.

4.5 POVERTY AND MENTAL HEALTH

The central importance of socio-economic factors in mental health – poverty in particular – has been noted by the WHO, which committed itself to addressing the issue of poverty and mental illness in 2005.

The WHO Regional Committee for Europe noted that:

> Poverty and mental ill health form a vicious circle: poverty is both a major cause of poor mental health and a potential consequence of it. Widening disparities in society or economic changes in individuals' life courses seem to be of particular importance here. Whether defined by income, socio-economic status, living conditions or educational level, poverty is an important determinant of mental disability and is associated with lower life expectancy and increased prevalence of alcohol and drug abuse, depression, suicide, antisocial behaviour and violence. … Raising awareness about the impact of political decisions and policy changes on the mental health of a population, especially with regard to unemployment and poverty and its association with depression, suicides and substance abuse, is one of the priorities for WHO's Mental Health Programme in Europe. *(WHO[40]).*

While there is some debate as to whether poverty directly causes mental illness or not, there is clear evidence that poverty affects the lives of people who experience mental illness in a variety of ways[41], including:

- not being able to afford appropriate accommodation or living in poor accommodation
- having a poor diet and lacking exercise
- not being able to progress towards paid work because they cannot afford suitable clothing, child care etc.
- having to rely on others, including family, to subsidise them
- being stigmatised because of poverty or mental illness
- being socially isolated.

There is strong evidence linking poverty and poor mental health. Studies have found that the prevalence of specific disorders such as schizophrenia[42] was strongly related to various social and demographic factors.

A large Irish study[43] examining unemployment, poverty and psychological distress, found the effects of unemployment and poverty to be cumulative, with the unemployed in poor households being five times more likely to have psychiatric symptoms.

Another Irish study also reported links between family burden in mental illness and poverty[22]. Poverty is also closely associated with greater use of mental health services. For example, there is an eight-fold difference in psychiatric admission rates between professional and unskilled groups in Ireland[44].

4.5.1 ACTIONS TO TACKLE POVERTY

There is already a body of public policy and associated actions to tackle poverty, outlined in the National Anti-Poverty Strategy. Actions must recognise the fact that poverty and deprivation are not uniform across the country and are manifested in different ways. Mental health services need to take account of local deprivation patterns in planning and delivering mental health care. For example, urban disadvantage may be manifest as poor households in urban areas, or urban communities with high concentrations of poverty. Many of these areas experience a range of inter-related problems such as long-term unemployment, separated families and low quality environment[45].

Rural disadvantage may take the form of poor households in rural areas but there are several problems that can disadvantage a rural community, including a lack of services, or a threat to services, because of declining population or dispersed population, a lack of employment opportunities, relatively poor transport, and a high incidence of isolation and loneliness[46].

Specific actions can be taken to inform people with mental health problems about the benefits they are entitled to. Assistance and advice need to be provided to ensure such individuals are supported by the social welfare system.

Rules governing the medical card system and the drug refund scheme should be reviewed so that people who require ongoing mental health treatment and care are not denied access to care due to income inadequacy.

Measures to ensure income maintenance for people with mental health problems should also be put in place, for example flexible provision of social welfare payments.

RECOMMENDATION 4.4: Measures to protect the income of individuals with mental health problems should be put in place. Health care access schemes should also be reviewed for this group.

RECOMMENDATION 4.5: Mental health services should take account of local deprivation patterns in planning and delivering mental health care.

4.6 EMPLOYMENT

Employment provides much more than income; it can provide a sense of dignity and purpose, along with opportunities to interact with others, develop social support networks, acquire skills and be useful. All of these boost confidence and self-esteem. It is not surprising therefore, that being out of work is associated with poor mental health. Unemployment can be both a cause and consequence of mental health problems.

The benefit of work for individuals with mental health problems has long been recognised by mental health professionals. Mental health services in Ireland operate several models of supported employment, including sheltered workshops, 'train and place' models, social firms and peer-provided services, such as the Clubhouse model (see Annex 11, section A11.3).

A cost-effectiveness study of different employment models in England found that supported employment and individual placement and support (IPS) or 'place and train' projects were significantly more effective than other approaches in enabling people with mental health problems to find and keep open employment[47].

Supported employment programmes are focused on immediate job search and help finding mainstream employment, with ongoing 'low-level' support (e.g. advice). IPS is also based on immediate job search and open employment, but has a very intensive support programme, e.g. ongoing time-unlimited support once in work, with workplace interventions provided when necessary to enable job retention.

4.6.1 ACTION TO ASSIST EMPLOYMENT IN INDIVIDUALS WITH MENTAL HEALTH PROBLEMS

There is evidence that supported employment models can greatly improve vocational and psychosocial outcomes for service users. These models put an emphasis on placing the service user in open employment, with high levels of support from members of the mental health team[48]. Studies of the IPS model have shown increased rates of competitive employment[49].

A component of individual care planning (described in Chapter Nine) is the type of employment, education and training required by the individual and how this might be achieved. Given the evidence for supported open employment and individual placement and support, these approaches should be given preference.

RECOMMENDATION 4.6: Evidence-based approaches to training and employment for people with mental health problems should be adopted and such programmes should be put in place by the agencies with responsibility in this area.

4.7 HOUSING

Shelter is one of the very basic needs of an individual, and the need for appropriate and stable housing is critical for people to work and take part in community life. As with unemployment, homelessness can be both a cause and consequence of mental health problems (see Chapter Fifteen).

With the closure of many mental hospitals, community residences were opened throughout the country to provide housing to people who had previously lived in hospitals. In addition, individuals who come in contact with mental health services who cannot live without some form of support are also housed. There are over 3,000 community residential places in Ireland. The role of these residences in providing mental health care is discussed in Chapter Twelve.

Mental health services have always been keen to support individuals using their services, and this has extended to providing housing in many cases. However, in many cases this has had the unfortunate effect of reducing the chances of an individual with a mental health problem being housed by their local authority, a right they have under the Housing Act[50]. This results not only in the exclusion of individuals with mental health problems, but also diverts mental health funds away from providing mental health treatment and care.

In addition, housing benefits are often not structured in a way that is sympathetic to individuals with recurring mental health problems (for example, if repeated or prolonged in-patient stays are required).

4.7.1 ACTIONS TO TACKLE HOUSING DIFFICULTIES

Local authorities must fulfil their obligations under the Housing Act[50] to provide housing to people in their area who require it. Mental health services should work in liaison with local authorities to ensure service users can access housing that is appropriate to their needs. Continued support by mental health services of these individuals can help them maintain their tenancy. Flexible provision of housing and other benefits should recognise the changing needs of people with mental health difficulties.

RECOMMENDATION 4.7: The provision of social housing is the responsibility of the Local Authority. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.

4.8 INCLUSIVE MENTAL HEALTH SERVICES

There are many people who require particular provisions within a mental health service (e.g. the provision of an interpreter, sign readers for people who are hard of hearing) or who are from different cultural backgrounds that require specific understanding. One of the core values of this policy is inclusion. The provision of inclusive and respectful mental health services should address these needs.

4.8.1 RESPONDING TO THE MENTAL HEALTH NEEDS OF MINORITY GROUPS

There is a small but significant number of people in Ireland who have additional needs when they develop a mental health problem. For example, travellers[51], gay and lesbian individuals[52], deaf individuals, and people from other countries and cultures, require specific knowledge and understanding on the part of those delivering mental health services, in terms of their culture and other characteristics. The employment of professionals from a wide variety of backgrounds and cultures in mental health services is a positive step that should be taken to respond to the needs of the diverse population in Ireland.

Service users from other countries and cultures may have specific vulnerabilities or difficulties that should be taken into account in the way mental health services are delivered. Culturally sensitive mental health services will be aware of the different understanding of such things as mental health, mental health services, healing, family structure, sexuality and spirituality that exist in other cultures.

Personal and family priorities are shaped by culture and cannot be assumed to be universal. Even our experience and understanding of different emotional states is bound up with culture[53].The concept of 'self' in Western cultures can be very different to that used in other cultures.

Mental health professionals need to be able to negotiate around issues such as how assessments are performed, the way diagnoses are made, and the appropriateness or otherwise of different sorts of interventions. This will require professionals who are sensitive to the diversity of human experience and who are able to relate to people from different communities in an open and respectful manner.

Community development models of mental health[54] are particularly useful in the provision of mental health services to culturally diverse groups. Services need to reach out actively to communities to find alternative paths to channel support to individuals and families.

Immigrant communities often have many different ways of dealing with distress: through prayer and spirituality, traditional healing and mechanisms of negotiating conflict through the extended family and service providers can learn from these approaches.

Community development supports these activities and stimulates others such as sporting, artistic and volunteering initiatives. The community development approach can be a useful way to engage with people from minority groups and is a useful complement to what is offered by mental health services.

4.8.2 THE PROVISION OF INTERPRETER SERVICES

Good communication is at the heart of mental health work. Therefore the question of language is extremely important. Good interpreters are vital not just for effective cross-cultural working, but also for ensuring access to mental health services by other individuals in the population, specifically deaf individuals and those for

whom Irish is their first language. Mental health work requires interpreters who are able to interpret the 'idiom' of the patient's distress as well as the actual words used. Interpreters must be able to empathise with the patient's position and ethnic and gender conflicts are to be avoided. Children or family members of the individual in question should not be used as interpreters.

RECOMMENDATION 4.8: Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters.

4.9 HOW TO BREAK THE CYCLE OF SOCIAL EXCLUSION

One of the fundamental principles of this report is 'recovery', in the sense that individuals can reclaim their lives to their best extent and be involved in society – to be 'socially included'. To achieve this, individuals need supportive mental health services, but they also need supportive communities where actions are taken to address basic needs such as housing, employment and education. The importance of building and supporting communities has been recognised in other policy areas, and found expression in the concept of 'social capital'.

4.9.1 WHAT IS SOCIAL CAPITAL?

Social capital is based on the concept of social connections as community resources. The Office for Economic Cooperation and Development (OECD) defines social capital as: 'networks, together with shared norms, values and understandings, that facilitate cooperation within or among groups'[55]. (p. 41). The term social capital implies that networks, social ties and mutual obligations have a dual function; they are accumulated over time and can be drawn upon and used in a way that produces personal, economic and social gain and they are shared or group-held resources and therefore constitute a social resource[56].

4.9.2 WHY IS SOCIAL CAPITAL IMPORTANT?

Research evidence suggests a generally positive gain from social networks and norms of cooperation. In a review of social capital, the OECD concluded that 'the evidence … of the benefits of access to social capital is sufficiently impressive to establish social capital as a dimension to be explored when looking at policies for dealing with poverty and social exclusion – indeed the very term social exclusion implies the denial of access to social capital'[55].

The *All Ireland Survey on Social Capital and Health*[57], reported benefits for health and mental health from social capital. Factors associated with inadequate social capital were found to have an independent negative effect on mental health: a lack of neighbourhood trust, a high level of problems in the local area, a poor level of local services, infrequent contact with friends and a lack of social support.

4.9.3 A MODEL FOR INCLUSION

As well as presenting a protective effect, social capital is a useful model for the involvement of service users and carers in their own care and may present a means of overcoming stigma and of improving mental health promotion through community action and empowerment.

Social capital can often be an unseen side-effect of other activities. For example, membership of a football team or sports club conveys much more than the benefits of physical exercise. The sense of belonging and the social contacts and support from such a group can be equally important, but are more difficult to identify and measure.

Similarly, the benefits of being in work are more than economic. The social contact and sense of shared purpose are other beneficial effects of working.

RECOMMENDATION 4.9: Community and personal development initiatives which impact positively on mental health status should be supported e.g. housing improvement schemes, local environment planning and the provision of local facilities. This helps build social capital in the community.

4.10 A FRAMEWORK FOR INTER-AGENCY ACTION

The *National Action Plan against Poverty and Social Exclusion 2003–2005*[45] outlines policy measures and specific actions designed to tackle poverty and social exclusion. Several vulnerable groups are mentioned and specific programmes and actions are outlined for these groups.

Unfortunately, people with mental health problems are not included in this Plan as a vulnerable group. There are targets for people with disabilities, but it is unclear whether people with mental health difficulties fall within this group. This means that not only are specific targets for people with mental health problems not identified (e.g. on employment), but it will be difficult to measure the effectiveness of this policy for people with mental health problems, as there are no specific targets to evaluate.

The *National Action Plan against Poverty and Social Exclusion* represents an important policy document in addressing social exclusion and in particular describes a number of institutional arrangements which provide a useful framework for action in this area, particularly as responsibility for action in many of these areas is in departments other than the Department of Health and Children.

There is a well developed structure of high-level committees and groups (described in Annex 4) that represents a key network to facilitate inter-agency cooperation or 'cross-cutting' work – sometimes described as 'joined-up government'. The proposed National Mental Health Service Directorate (described in Chapter Sixteen) should be represented on these bodies to ensure that measures to achieve the social inclusion of people with mental health problems are advanced.

RECOMMENDATION 4.10: The National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.

4.11 RECOMMENDATIONS

1. All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.

2. Evidence-based programmes to tackle stigma should be put in place, based around contact, education and challenge.

3. The flexible provision of educational programmes should be used to encourage young people to remain engaged with the education system and to address the educational needs of adults with mental health problems.

4. Measures to protect the income of individuals with mental health problems should be put in place. Health care access schemes should also be reviewed for this group.

5. Mental health services should take account of local deprivation patterns in planning and delivering mental health care.

6. Evidence-based approaches to training and employment for people with mental health problems should be adopted and such programmes should be put in place by the agencies with responsibility in this area.

7. The provision of social housing is the responsibility of the Local Authorities. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.

8. Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters.

9. Community and personal development initiatives which impact positively on mental health status should be supported, e.g. housing improvement schemes, local environment planning and the provision of local facilities. This helps build social capital in the community.

10. The National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.

CHAPTER FIVE

Fostering well-being: Mental health promotion

5.1 WHAT IS MENTAL HEALTH PROMOTION?

Mental health promotion is concerned with promoting well-being among all age groups of the general population and addressing the needs of those at risk from, or experiencing, mental health difficulties.

It is important to recognise that everyone has mental health needs, whether or not they have a diagnosis of mental ill health. Mental health promotion programmes that target the whole community also include and benefit people with mental health problems.

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Actions in this area target the population and focus on the protective factors for enhancing well-being and quality of life, together with early intervention and prevention of mental health problems (See Annex 5 for details).

There is a growing theoretical base and supporting body of evidence informing the development of mental health promotion practice[58, 59, 60, 61]. A recent report for the European Commission on the evidence for health promotion effectiveness, found ample evidence that mental health promotion programmes not only improve mental health and quality of life but also reduce the risk for mental disorder[62]. The report also confirms the impact of mental health promotion on the reduction of a range of social problems such as delinquency, child abuse, school drop-out, lost days from work, and social inequity.

5.2 HOW DOES MENTAL HEALTH PROMOTION WORK?

The goal of mental health promotion is the enhancement of potential, i.e. building psychological strengths and resilience, rather than focusing on reducing disorders. As a consequence, this approach is much more concerned with the process of enabling and achieving well-being and positive mental health and enhancing quality of life for the general population. The principles of participation, equity and partnership described in Chapter One are fundamental to this process.

Mental health promotion works at three levels. Each level is relevant to the whole population, regardless of age, social status or either physical health or mental health status.

These levels are concerned with

- **Strengthening individuals** – increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- **Strengthening communities** – increasing social inclusion and participation, improving neighbourhood environments, developing health and social services that support mental health, such as anti-bullying strategies at school, workplace health, community safety, and childcare and self-help networks.
- **Reducing structural barriers to mental health** – through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

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At each level, interventions can focus on strengthening factors known to protect mental health (e.g. social support) or on eliminating or reducing factors known to increase mental health risk (e.g. unemployment, violence).

Mental health promotion contributes to overall health gain. Interventions to reduce stress in the workplace, to tackle bullying in schools, to create healthy physical environments (housing, employment, etc) and to reduce fear of crime all contribute to health gain through improving well-being, in addition to any impact they might have on preventing mental disorders.

Mental health promotion also has a role in preventing certain mental health problems, notably depression, anxiety and behavioural disorders. Mental health promotion can improve quality of life for people with mental health problems and can enhance recovery.

RECOMMENDATION 5.1: Sufficient benefit has been shown from mental health promotion programmes for them to be incorporated into all levels of mental health and health services as appropriate. Programmes should particularly focus on those interventions known to enhance protective factors and decrease risk factors for developing mental health problems.

5.3 THE INDIVIDUAL RESPONSE TO STRESS

Over time, an individual will experience a number of major life events and stresses that may result in significant emotional distress. This is a fact of normal everyday life, but there is a wide variation in how people deal with this distress. For example, some people deal with a bereavement by drawing on their own interpersonal resources and get support from family and friends, without recourse to medical intervention. For various reasons, others may not cope so well and can become depressed to the extent that they come to the attention of their GP or are referred to a mental health service, with the result that they receive medical intervention such as anti-depressant medication.

The biopsychosocial model tells us that there are several factors at work: biological and psychological characteristics of the individual and features of the social context in which they live. Protective factors at the psychological and social levels have been identified, and so have potential risk factors that can influence the development of mental health problems in individuals (Table 5.1). There are effective interventions – aimed at reducing risk factors and enhancing protective factors – that can help the individual cope better with difficulties in life. Many of these interventions have come from the field of mental health promotion.

Table 5.1: Examples of mental health protective and risk factors for individuals

Protective factors

- secure attachment
- positive early childhood experiences
- good physical health
- positive sense of self
- effective life/coping skills
- basic needs being met
- opportunities to learn

Risk factors

- physical illness or disability
- family history of psychiatric problems
- low self-esteem
- low social status
- basic needs not being met, e.g. homelessness
- separation and loss
- violence or abuse
- substance misuse
- childhood neglect

Adapted from Jenkins et al. [63]

5.4 POLICY CONTEXT

Mental health is a resource that needs to be promoted and protected. In recent years there has been increased recognition of the importance of promoting positive mental health, not just among individuals experiencing mental health difficulties, but also across entire populations.

The World Health Organisation has advocated the promotion of positive mental health as an integral part of improving overall health and well-being, and the World Health Reports of 2001[10] and 2002[64] were devoted exclusively to the issues of mental health and health promotion. To enhance the value and visibility of mental health, the WHO states that 'National mental health policies should not be solely concerned with mental illness but recognise the broader issues affecting the mental health of all sectors of society … including the social integration of severely marginalised groups'[65]. Further details on the policy context of mental health promotion are in Annex 5.

5.5 FRAMEWORK FOR MENTAL HEALTH PROMOTION

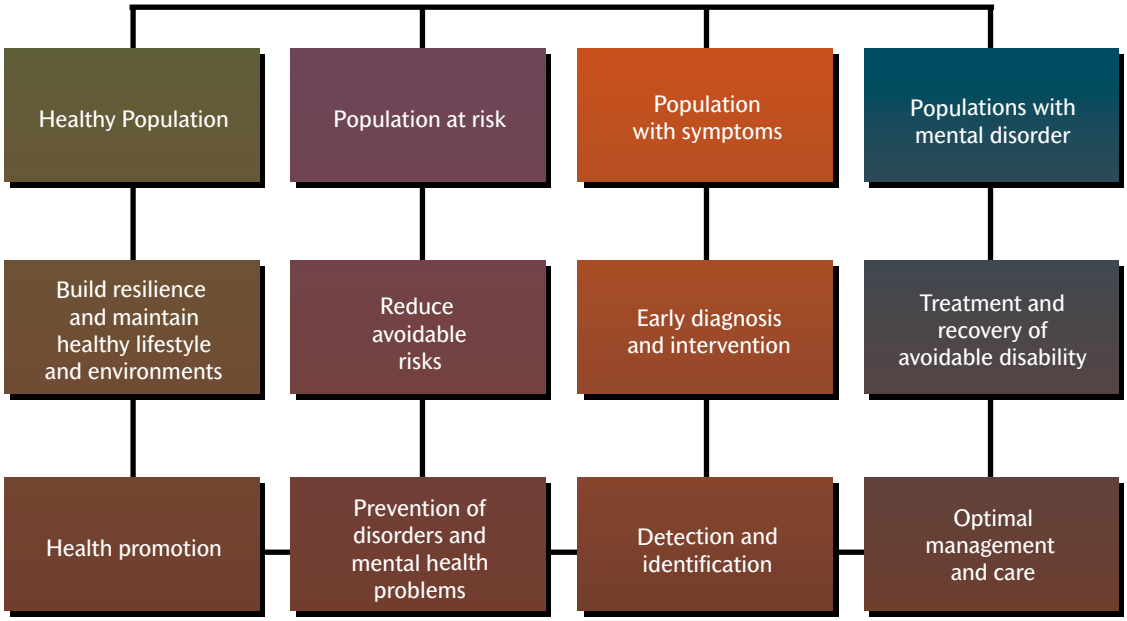
Mental health promotion focuses on improving social, physical and economic environments that determine the mental health of populations and individuals. A population perspective on promoting positive mental health is outlined in Figure 5.1[66].

This framework outlines the opportunities for mental health promotion among different population groups from healthy populations to those with mental disorders. There is a role for mental health promotion across the range of mental health interventions and services, reaching into the wider population in the community. It is essential that the effectiveness of all programmes and initiatives to promote mental health is monitored and assessed by objective, measurable targets or performance indicators.

RECOMMENDATION 5.2: All mental health promotion programmes and initiatives should be evaluated against locally agreed targets and standards.

Figure 5.1 Opportunities for mental health promotion: A population perspective

Adapted from Building capacity to promote mental health of Australians.[66]



The advantage of the population perspective is that interventions and programmes targeted at groups within the population can make a difference to the lives of individuals. This perspective also includes those who may already have developed mental health problems, as well as the healthy population.

The programmes and interventions put in place can be tailored to specific groups and delivered in appropriate settings. For example, building resilience and promoting health for healthy populations, involves taking mental health promotion programmes into schools. Programmes and interventions aimed at reducing risk and enhancing early identification for high-risk groups can be delivered in primary care. Treatment and optimal care for people with mental disorders is delivered in mental health services.

The delivery of such a diverse range of programmes also requires the development of health and social policy that extends beyond the clinical and treatment focus of current mental health service delivery to encompass promotion and prevention perspectives.

In particular, the influence of broader social and economic factors on mental health needs to be addressed. This has special relevance in relation to issues of stress, social and rural isolation, and the impact of a rapidly changing social, economic and political climate[67]. This inter-relatedness of physical and mental health and the influence of broader social and economic factors on both are often categorised as 'cross-cutting issues' (issues that cut across the remit of more than one government department or sector).

5.5.1 CROSS-CUTTING ISSUES

It is likely that mental health promotion programmes have a wider positive impact because material and educational

deprivation are the biggest factors influencing overall health. In the *Strategy Statement on Health and Well-being*[68], it was acknowledged that 'close and continuous inter-sectoral cooperation' is required to achieve health and social gain. This importance of a cross-sectoral approach is further endorsed in the *Annual Report of the Chief Medical Officer (Ireland)*[69]*:*

> Many of the causal factors of health inequalities, such as poverty and unemployment, are outside the direct control of the health services. Inter-sectoral collaboration is required to tackle these problems, and partnership between government and the statutory and voluntary sectors is vital if the cycle of inequality is to be broken. Close cooperation between the Departments of Health and Children; Education and Science; Environment and Local Government; Social Community and Family Affairs; Finance … will be required to address this important issue (p. 31).

The importance of a partnership approach to addressing these cross-cutting issues is well recognised across countries and the term 'joined-up government' is often used to describe it.

RECOMMENDATION 5.3: A framework for inter-departmental cooperation in the development of cross-cutting health and social policy should be put in place. The NAPS framework is a useful example of such an initiative (see Chapter Four).

5.6 PRIORITY ISSUES IN MENTAL HEALTH PROMOTION

Four key issues in relation to the promotion of positive mental health are focussed on in this policy:

1. promoting positive mental health and well-being
2. raising awareness of the importance of mental health
3. enhancing the capacity of mental health services providers and the general community to promote positive mental health
4. suicide prevention.

Actions in these four areas can best be achieved by adopting a lifespan approach to mental health promotion across various settings and supported by a national research, evaluation and monitoring programme. The lifespan approach (already described in Chapter Two) will also facilitate the inter-sectoral, multidisciplinary and inter-agency requirements for successful mental health promotion.

Key life stages have been identified as:

- Early Years (0–4 years)
- School Aged Children (5–12 years)
- Youth
- Adults
- Older People

The mental health promotion needs of each of these groups is covered in the relevant chapters in this policy. While the lifestages model takes a 'cradle to the grave' approach to mental health promotion, it is also intended to address the mental health needs of specific populations. In terms of mental health promotion, the needs of service users and carers are included in Chapter Eleven. The needs of other groups such as travellers, the refugee and asylum-seeking population, and other immigrant populations will be addressed by the provision of comprehensive mental health services that are based on care planning taking **all** the needs of the individual into account. Appropriate programmes need to be developed to promote greater integration of these distinct groups at every stage in the lifespan.

RECOMMENDATION 5.4: Designated health promotion officers should have special responsibility for mental health promotion working in cooperation with local voluntary and community groups and with formal links to mental health services.

5.7 TRAINING IN MENTAL HEALTH PROMOTION SKILLS

The WHO[58] emphasises the importance of capacity building among health professionals to ensure successful prevention practices and effective promotion of positive mental health.

It identifies several training areas as being particularly important, namely in policy-making, programme development and research and recommends that:

> Each country should take initiatives to develop capacity and expertise at national and local levels for evidence-based prevention of mental disorders and promotion of mental health.

Training components for mental disorder prevention and mental health promotion should be embedded in existing training initiatives that target health promotion, public health, primary health care, mental health care and their related disciplines (see Chapter Eighteen).

RECOMMENDATION 5.5: Training and education programmes should be put in place to develop capacity and expertise at national and local levels for evidence-based prevention of mental disorders and promotion of mental health.

5.8 RECOMMENDATIONS

1. Sufficient benefit has been shown from mental health promotion programmes for them to be incorporated into all levels of mental health and health services as appropriate. Programmes should particularly focus on those interventions known to enhance protective factors and decrease risk factors for developing mental health problems.

2. All mental health promotion programmes and initiatives should be evaluated against locally agreed targets and standards.

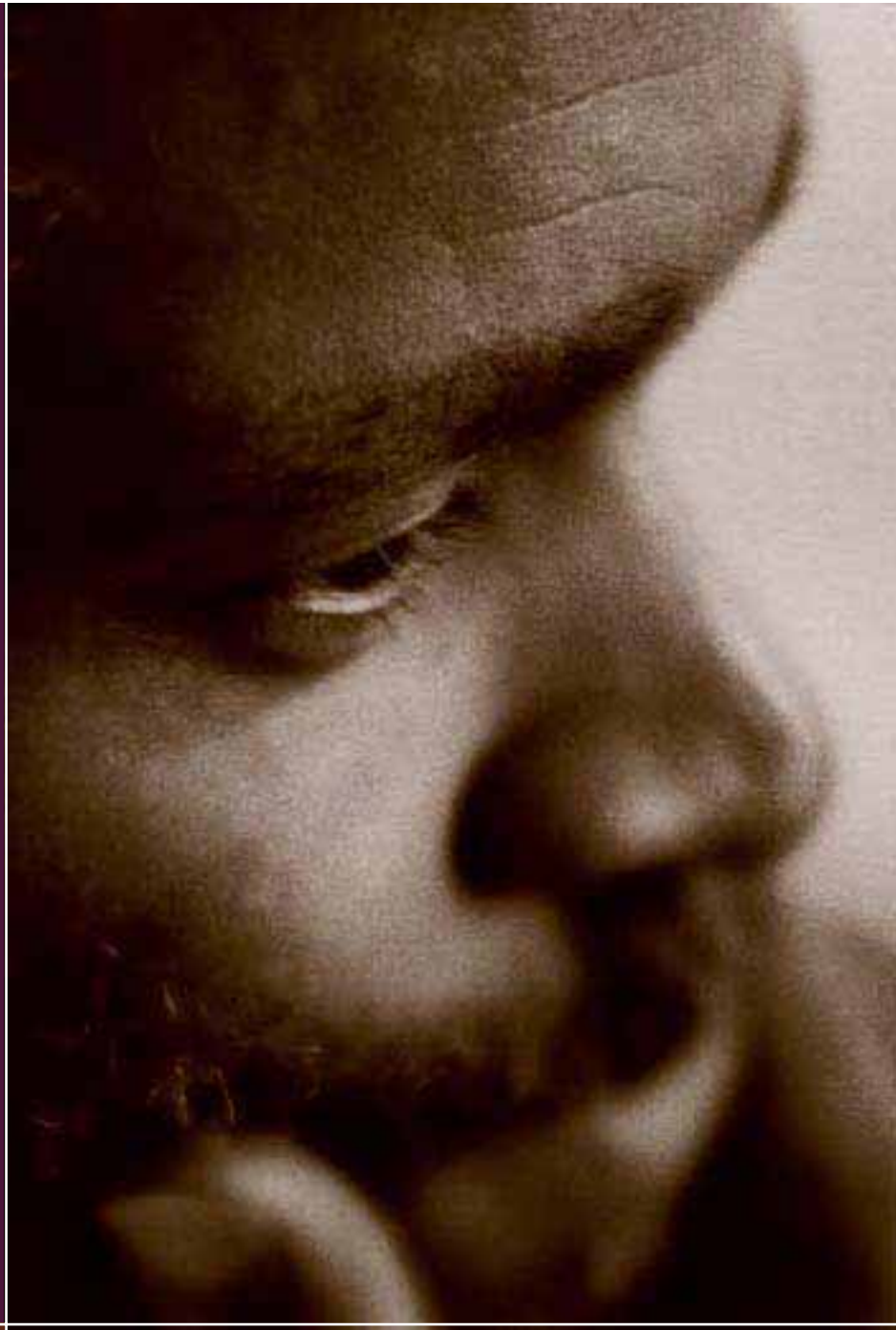
3. A framework for inter-departmental cooperation in the development of cross-cutting health and social policy should be put in place. The NAPS framework is a useful example of such an initiative (see Chapter Four).

4. Designated health promotion officers should have special responsibility for mental health promotion working in cooperation with local voluntary and community groups and with formal links to mental health services.

5. Training and education programmes should be put in place to develop capacity and expertise at national and local levels for evidence-based prevention of mental disorders and promotion of mental health.

Plan

The proposed community-based mental health service will be coordinated and delivered through Community Mental Health Teams (CMHTs), which are designed to serve the needs of particular care groups across the lifespan from childhood to later life.



CHAPTER SIX

Mental health in Ireland: Where we are now

6.1 INTRODUCTION

The history of mental health services in Ireland has been well documented and describes how, for a variety of reasons, Ireland was 'hospital prone' and had a high provision of hospital beds for mental illness[70,71,72,73] (see Annex 6 for more detail).

Two mental health policy documents *Report of the Commission of Inquiry on Mental Illness*[74] and *Planning for the Future*[75] made many recommendations to improve mental health services and were focused especially on the need to reduce the use of in-patient care.

The recommendations of the *Commission of Inquiry* were only partly implemented and while the recommendations of *Planning for the Future* were more widely implemented, there is still considerable room for improvement.

6.2 SOCIAL AND DEMOGRAPHIC CONTEXT

Ireland has undergone considerable social change in the past 20 years. The population has increased by half a million people and there are now close to four million people living in the Republic[76]. The age structure has also changed, with fewer children in the population and more older people. Ireland is now a much wealthier country – the GDP (gross domestic product) has tripled in the last ten years. The high unemployment rates that blighted the 1980s have been dramatically improved. In 1984 around 15% of the population was unemployed compared to 4% in 2004.

Learning

Despite recent economic success, there are still serious problems in Irish society, some of which are 'now starker against the transformed background'[77]. Economic success also brings new challenges. Most notably from a mental health point of view, marked inequalities still exist; relative income poverty is still high by EU standards and has increased.

Family structure has changed, and this presents its own challenges. More people are living alone; 22% of all households in 2002 were one-person households[76]. The number of lone parent families was 114,000 in 2003. The main carers of those with long-term mental illness are usually women – mothers and spouses. There are now

more women in the labour force, and consequently fewer informal carers. Over half of women aged 15–64 now participate in the labour force, compared to around 17% in 1984. While it is not now possible for many families to provide informal care, many mental health services still assume that this type of full-time care is available at home.

The ethnic and cultural structure of Irish society has also changed. In the 2002 census, approximately 6% of the population recorded a birthplace outside Ireland. However, figures on immigration in the years 2003 to 2005 indicate an estimate of closer to 10% of the population[78]. In 2005 for example, there were an estimated 70,000 immigrants, the largest proportion of whom (38%) came from the ten new EU accession states[78].

More important perhaps than the changes described in numbers and percentages above, are those changes that cannot be captured so easily. Qualitative changes in Irish society have been noted, describing a society that is now more rushed, less caring and more materialistic. Where the oddities or 'eccentricities' of some individuals would in the past have been tolerated or incorporated into the community, such individuals are now viewed with indifference or even fear. Society has become more litigious and as a consequence service providers, particularly health service providers, have become highly risk-conscious. This has a great impact on how mental health services are delivered and can create direct conflicts between individual rights and the need for 'safety'.

6.3 CURRENT MENTAL HEALTH SERVICE PROVISION

Most of the activity of mental health services is carried on in the community, in publicly funded mental health services. This means that people with mental health problems are typically seen in outpatient settings, in day hospitals and day centres, and at home. Only a small minority of these individuals are admitted to in-patient care.

Unfortunately the figures we have on mental health services give us much more information on in-patient services than community mental health services. There is also a dearth of information on what happens in mental health services, other than in terms of the number of admissions or attendances at different facilities. We do not know the number of individuals nationally who avail of mental health services, the type of interventions or treatments they receive, or the effectiveness of those treatments.

The lack of a national morbidity survey means we have no information on the number of people with mental health problems in the Irish population. These shortcomings in mental health information are described more fully in Chapter Nineteen. Table 6.1 below presents an overview of key parameters in mental health services in 2004.

6.3.1 THE INDEPENDENT MENTAL HEALTH SECTOR

The term 'independent' is used to describe private mental health services. There are currently 626 beds in private psychiatric hospitals in Ireland, all of which are in Dublin[79]. Eighteen per cent of all psychiatric admissions were to private hospitals in 2003[86].

Many people also see psychiatrists on a private basis although there are no figures available on this. A number of psychologists and psychotherapists operate private practices but there are no figures available on how many individuals avail of these services. Approximately 52% of the population has private medical insurance cover.

6.3.2 THE NON-GOVERNMENTAL ORGANISATION (NGO) SECTOR

Voluntary groups and organisations are formally organised, privately owned, self-governing, non-profit driven and autonomous, and as such are ideally placed to seek improvements in the way mental health services are delivered.

These organisations contribute greatly to the promotion of good mental health in the community and many receive funds from the HSE to help them in their work. Many voluntary organisations have been proactive in the development of community-based mental health services, for example, residential and day support services, rehabilitation services and information and support services.

Because they are based in communities, voluntary groups are active at a local level and their agendas are driven by the priorities and needs of people at the local level, rather than by national strategies and policy directives. This means that they can understand the needs and priorities of their local areas and can respond with innovative ideas, and provide flexibility for the development of these ideas into action.

Voluntary groups and organisations often have a strong advocacy role at local, national and international level. In the past, these groups have taken a lead in highlighting the inadequacies of statutory services and have often been the driving force for change.

6.4 MENTAL HEALTH LEGISLATION AND POLICY

Mental health services are shaped by legislation and policy. The legislation governing mental health services in Ireland has been the *Mental Treatment Act, 1945*[80], and associated amendments and regulations, and to a lesser extent the *Health Act, 1970*[81]. Part Three of the *Mental Health Act, 2001*[82] has been commenced, and this has led to the formation of the Mental Health Commission. This is an independent, statutory body that is charged under the Act with fostering and promoting high standards in the delivery of mental health services and ensuring that the interests of those involuntarily detained are protected.

This part of the *Mental Health Act, 2001*[82] has also led to the appointment of an Inspector of Mental Health Services. This new office replaced that of the Inspector of Mental Hospitals, which operated under the provisions of the *Mental Treatment Act, 1945*[80].

Mental health policy in Ireland has been determined by both the *Report of the Commission of Inquiry on Mental Illness*[74] and *Planning for the Future*[75]. In addition, the *Green Paper on Mental Health*[83] and the *White Paper on Mental Health*[84] contributed to the debate around the development of mental health services and helped shape the *Mental Health Act, 2001*[82].

6.4.1 *PLANNING FOR THE FUTURE* (1984)

A study group was appointed in 1981 to examine the development of psychiatric services. This group concluded that the psychiatric service at that time was still below an acceptable standard and that:

> At present, the psychiatric hospital is the focal point of the psychiatric service in most of the country. Large numbers of patients reside permanently in these hospitals. Many of them have lived there for years in conditions which in many cases are less than adequate because of overcrowding and capital underfunding. In addition, staff and public attitudes have tended to concentrate effort on hospital care as a result of which community facilities are relatively underdeveloped. The hospitals were designed to isolate the mentally ill from society and this isolation still persists. (p. xi, *Planning for the Future*, 1984).

The central recommendations of *Planning for the Future* proposed a new model of mental health care; it was to be comprehensive, with a multidisciplinary approach, provide continuity of care and be effectively coordinated. This new service was to be community-oriented to the extent that care should be provided in an individual's home, with a variety of community-based services, and was to provide support to families. The basic unit of service was to be the sector team, located in the sector, preferably in a day facility. Community psychiatric services were to be organised to facilitate the amalgamation of these services and other community services.

The development of structural aspects of the mental health services reveals considerable progress in the implementation of specific recommendations from *Planning for the Future* (Table 6.1 below). There has been a substantial increase in the provision of community residences and in the provision of day facilities (a three-fold increase in both). The number of general hospital psychiatric units increased from eight in 1984 to 22 in 2004. The number of psychiatric beds has decreased quite dramatically, by approximately 67%. Correspondingly, the number of patients resident in hospital and the rate of admissions to psychiatric hospitals and units have also decreased.

Table 6.1 Key parameters in Irish mental health services: 1984 and 2004. Numbers with rates per 100,000 total population.

	1983/1984*		2004	
	Number	**Rate**	**Number**	**Rate**
Activity				
In-patients in psychiatric hospitals and units at end of year	12,484	362.5	3,556	90.8
Long-stay patients (in hospital for more than 5 years)	7,086	205.8	1,242	31.7
New long-stay patients (in hospital for more than 1 year but less than 5 years)	2,083	60.5	615	15.7
Admissions to psychiatric hospitals and units	28,830	837.3	22,279	568.7
First admissions to psychiatric hospitals and units	8,746	254.0	6,134	156.6
Outpatient clinic attendances	200,321	5,817.5	212,644	5,428.5
Day hospital attendances	--	--	162,233	4,141.6
Day centre attendances	--	--	413,771	10,562.9
Facilities				
Psychiatric beds (number of in-patients for 1984 used as a proxy)	12,484	362.5	4,121	105.2
General Hospital Psychiatric Units	8	--	22	--
Persons in community residences (a proxy for number of places)	942	27.4	3,065	78.2
Day hospital places	--	--	1,022	26.1
Day centre places	--	--	2,486	63.5
Total day places	1,180	34.3	3,508	89.6

**Figures for 1983 or 1984 are used depending on availability.*
*Note: All rates are calculated from the **total** population for the 1981 and 2002 census respectively. Therefore, some rates will differ from the rates in source publications.*
Sources: Activities of Irish Psychiatric Services 2004[86]
Mental Health Commission Annual Report 2004[79]
Community mental health services in Ireland 2004[87]
Planning for the Future[75]

However, all the elements of the radical service model envisaged in *Planning for the Future* are not in place in all parts of the country. It is also questionable whether the spirit of the community-oriented model has been fully implemented, that is, whether the main provision of care has fully moved from in-patient settings to the community.

Very few mental health services have established home care teams for the treatment of acute mental illness in service users' own homes as an alternative to hospital admission. There is evidence that many day hospitals are not providing the same treatments that are available in an acute in-patient setting and are therefore not offering an alternative to acute in-patient care[85].

The 2004 *Report of the Inspector of Mental Health Services*[79], revealed a number of issues that need to be addressed "with some urgency". These issues included:

> The development of new management systems at expanded catchment and national level are essential to allow the necessary development of specialty services and facilities and to ensure proper planning and funding of services nationally. The development of functioning community mental health teams is necessary to allow the provision of community-based care programmes in all specialties, including home-based and assertive outreach care as alternatives to in-patient care. Increased user input at all levels is necessary to ensure that services are always user-focused. Appropriate clinical governance systems are necessary to ensure safe and effective services and minimise individual practice variations. Service audit systems are necessary to allow ongoing service monitoring and evaluation. Modern information systems are required to support all these activities. (p.125).

6.5 KEY ISSUES IN THE ORIENTATION AND FUNCTIONING OF IRISH MENTAL HEALTH SERVICES

The enormous changes brought about in the mental health services in Ireland since 1984 must not be underestimated. No other area of health or social care in Ireland has changed so dramatically in that period.

There have been many barriers to the development of mental health services in Ireland, a lack of resources being an obvious barrier, but it is by no means the only one. Much of the debate around the provision of mental health services tends to focus exclusively on the issue of resources, as if all change is precluded unless there are more resources. However, there are several key issues concerning the orientation and functioning of mental health services that must be addressed if the implementation of the policy expounded in this document is to be effective.

6.6 ORIENTATION

6.6.1 CHANGING PRACTICE

Following *Planning for the Future*, the structures in mental health services changed, but how services were managed and organised did not change substantially, and the thinking around how to treat people did not change very significantly. For example, people were moved from an institution to a residence in the community, but the treatment they received and their daily lives often did not change substantially. Many of these people, though now outside the institutions that might formerly have housed them, remained 'institutionalised' and isolated from the general community.

This new policy focuses on a different approach to people with mental health problems, not as passive recipients of care, but as active participants in care who need to be helped and enabled to recover – not necessarily in the sense of 'being cured' but rather in the sense of regaining

control over their lives and of learning to live with symptoms if they cannot be eliminated.

There is an emphasis on the delivery of mental health services through multidisciplinary community mental health teams (CMHTs). The findings from the consultation process greatly influenced this focus, and the vision and values that underpin this mental health policy reflect these findings (Chapter One).

6.6.2 FAMILY/CARER INVOLVEMENT AND SUPPORT

The lack of progress in involving and supporting families and carers of those with mental health problems is also evidence of a lack of change in mindset. The formation of a therapeutic alliance between the individual service user, their family/carer and the mental health professional is the first step in fully engaging with a person with a mental health problem. This should be a key approach in the new mental health services. Structures and principles for involving service users and carers in mental health services are presented in Chapter Three.

6.6.3 THE COMMUNITY

A key assumption in *Planning for the Future* was that the community would be supportive and welcoming of a policy that meant people with mental health problems would be treated in the community and not removed to a remote institution. It was also assumed that once these people were living in the community they would somehow become integrated and part of the community.

This has happened only to a limited extent, and in a few parts of the country, often when mental health services have made special efforts to involve the local community. The inclusion of people with mental health problems in society needs to be actively tackled and not passively aspired to. Chapter Four discusses the issue of social inclusion in more detail and describes ways in which to achieve it.

6.7 FUNCTIONING

6.7.1 MULTIDISCIPLINARY WORKING

The importance of changing the thinking that underlies the delivery of mental health services is fundamental to effective multidisciplinary working. While multidisciplinary working has been in place in some parts of the country (for example in child and adolescent mental health services and some adult mental health services) it is very underdeveloped in most mental health services[79].

Effective multidisciplinary working is dependent not just on having the requisite mental health professionals in place. It depends on mental health professionals changing how they practice and work together, so that they work as a team. An assumption that this will somehow happen if a variety of mental health professionals is appointed is somewhat naïve.

The experience of multidisciplinary teams in mental health, and in the new primary care teams, is that team formation is an explicit process that needs to be resourced in terms of training, and time and space for the team to develop agreed ways of working and a shared philosophy. Multidisciplinary CMHT working is described in Chapter Nine.

6.7.2 LEADERSHIP

One of the key factors in achieving effective multidisciplinary team working is good leadership. Individuals with strong leadership skills have been successful in bringing about change in mental health services in Ireland and in other countries.

Potential leaders in the mental health area need to receive support, not just with training and education, but by supporting innovation and excellence in all parts of the mental health service.

The partnership approach that is intrinsic in this policy, along with strong leadership, will lead to the transformation of mental health services envisioned in this policy. Management and organisation are discussed in Chapter Sixteen.

6.7.3 DEVELOPMENT OF SPECIALISMS

> There is a serious lack of development of the necessary range of specialist mental health services nationally and no HSE Area has the full complement of services of sufficient quality to provide comprehensive mental health care *(Inspector of Mental Health Services[79]).*

This lack of development is due to a number of reasons. In some instances there is a lack of resources and an insufficient number of multidisciplinary teams in many of the specialist areas. Other specialisms, such as mental health services for those with severe and enduring mental illness (also known as rehabilitation mental health services) have many resources but still remain underdeveloped.

The uneven availability of such services around the country creates an inequitable situation for service users and families. Plans for the development of mental health services across the lifespan are presented in Chapters Ten to Fifteen.

6.7.4 MANAGEMENT

The current management structures of mental health services were identified as seriously deficient by the Inspector of Mental Health Services[79]. It was noted that 'the development of new management systems at expanded catchment and national level are essential to allow the necessary development of specialty services[79]. One of the key functions of local management for this policy, is to translate national policy into local implementation plans.

6.7.5 EDUCATION AND TRAINING

Changes in thinking are achieved through education and training. The vision and physical structures in any mental health policy are not, in themselves, sufficient to bring about substantial change in mental health service delivery; those providing the services need to be enabled to change their practice. Training and education are covered in Chapter Eighteen.

6.7.6 RESOURCES

It would be naïve to believe that the substantial changes described in this policy can be achieved without a significant input of resources. The provision of adequate resources for mental health is a prerequisite for the implementation of this policy. The fact that the proportion of the overall health budget allocated to mental health services has declined in the past twenty years is a cause for concern.

However, it must also be acknowledged that change is not solely concerned with resources. Some services in the country, with lower levels of resources than many other services, have brought about huge changes in how their mental health services are delivered.

It must also be acknowledged that physical structures are inflexible and tie up resources to a proscribed set of functions. For example, a focus on beds and places puts a physical limitation on what a service can do, whereas building up a well-trained CMHT enables a service to focus on meeting the needs of an individual as flexibly as possible.

This ability to achieve change in spite of poor resources must not be seen as support for the low level of funds devoted to mental health. If this policy is to fulfil its vision, the proportion of funds allocated to mental health must reflect the level of disability in the population.

A change in thinking is also required by those responsible for planning and funding mental health services. Ireland needs to invest in the mental health of its population, just as it invests in its education.

That means prioritising early intervention in children and supporting families. The cooperation of other government departments and agencies is needed to ensure people with mental health problems are included in – rather than excluded from – the society they belong to. The financing of mental health services is described in Chapter Seventeen.

6.8 ACHIEVING INTEGRATION

A comprehensive mental health system exists when mental health activities – from community support groups, to voluntary groups, to primary care, to specialist mental health services – work in an integrated, coordinated fashion for the benefit of all people with mental health difficulties.

There is currently no such system in Ireland. The current structure of mental health services, where they are seen as not only separate from other health services, but separate from the community in which they operate, promotes the continuing exclusion and stigmatisation of people with mental health problems.

The framework proposed in this policy is a framework for a mental health system where informal supports and local community groups have a recognised role, where primary care is closely linked to specialist mental health services, and where mental health services across the lifespan are integrated and coordinated. This overall framework has been described in Chapter Two and a detailed framework for mental health services will be described in Chapter Eight.

CHAPTER SEVEN

Mental health in primary care

7.1 INTRODUCTION

When an individual experiences a mental health problem, contact with their general practitioner (GP) is usually their first formal attempt to seek help. This contact can be the key to a timely and successful resolution of their mental health problem, if the problem is identified and treated by the GP or referred on to the local mental health service.

GPs in primary care also have a key role as 'gatekeepers' to the mental health service; for the majority of people, access to a mental health services is via a referral from a GP. Mental health provision in primary care is shown in the framework described in Chapter Two (Figure 2.1).

Integrat

The framework described in this policy recognises the pivotal role of primary care services in addressing the mental health needs of the population. Most mental health treatment and care is delivered in primary care, and it has long been recognised that 90% of mental health problems are dealt with in primary care without referral to a specialist mental health service. The importance of primary care in mental health has been emphasised in the WHO report *Mental Health: New Understanding, New Hope*[10]. The first of the ten recommendations made by this report was that treatment for people with mental disorders should be provided in primary care as this 'enables the largest number of people to get easier and faster access to services …'[10].

7.2 FINDINGS FROM THE CONSULTATION PROCESS

Chief among the concerns expressed during the consultation process was the perceived 'over-reliance on medication' in dealing with mental health problems. This was seen to be the case for not just secondary level mental health services but also for GP provided care. Many submissions stated that 'a comprehensive range of psychological therapies should be provided at primary, secondary and tertiary levels'. Many of the submissions acknowledged the importance of medication for individuals, and recognised the need for 'greater availability of mental health professionals within the

community'. Several submissions noted that 'GPs should have ready access to these professionals'[2,3].

RECOMMENDATION 7.1: All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.

7.3 WHAT IS PRIMARY CARE?

In the strategy on primary care *A New Direction*[88], primary care is defined as follows:

> Primary care is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being. (p.15, *Primary Care Strategy*[88]).

The term 'primary care' is often used synonymously with 'general practice'. While general practice is a key element of primary care, the term primary care encompasses a much broader range of health and social services, delivered by a variety of professionals, such as GPs, public health nurses, social workers, community welfare officers, welfare officers in places of employment, and many others.

There is a wide range of community care services that deliver mental health care at the primary care level in the community. This is particularly the case for children. Child care services at the community care level deploy social workers, psychologists, speech and language therapists, occupational therapists and others who work closely with child and adolescent mental health services.

In addition, the National Educational Psychological Service (NEPS) is a primary care level service for children in school. These services are an important mental health resource in primary care and are described in more detail in Chapter Ten on child and adolescent mental health services. Other primary care services such as student health services need support from and access to mental health services when required.

7.4 THE CURRENT ORGANISATION OF PRIMARY CARE IN IRELAND

Primary care services are delivered by GPs, either working singly or in groups, sometimes with a practice nurse. General practice services are currently provided by independent practitioners. There are approximately 2,250 practising GPs in the state, some of whom practice part-time[89]. They operate from approximately 1,280 different practices throughout the country, with just over half (51%) still single-handed; the remainder are in partnerships or group practices.

There is a difficulty in recruiting GPs to deprived areas where mental health needs are greatest. At the end of 2002, 2,134 GPs held General Medical Services (GMS) contracts. In March 2004, over 1.1 million people were covered by medical cards on the GMS scheme, about 29% of the population. The remainder of the population are 'private patients' and attend their GP on a fee-paying basis. Thus, general practice in Ireland might be described as 'primarily a private sector activity' [89].

There is no centrally collected information on the type of services or treatments given to people with mental health problems in primary care. For example, figures on the availability of psychologists, counsellors or other mental health professionals who work from GP practices are not available. Anecdotal evidence suggests their numbers are very low.

However, there is information available on the drugs prescribed under the General Medical Services (GMS) scheme, which gives some picture of the pattern of psychotropic drug prescribing for the 29% of the population covered by the scheme.

Prescriptions under the classification 'Nervous System', accounted for 20% of expenditure on drugs on the GMS scheme (€130 million), 15% of drug expenditure on the long-term illness scheme (€11 million) and 15% of expenditure on the drugs payment scheme (€49 million), a total of €190 million in 2003[90]. These figures include prescribing by GPs and some prescribing that originates in mental health services. The value gained through this expenditure needs further assessment.

7.4.1 THE POLICY CONTEXT

Primary care services will be undergoing change in their organisation and delivery in the coming years, in accordance with the recommendations of the *Primary Care Strategy*[88]. The development of primary care is seen as a key area, offering great potential to achieve the growth and development in service provision required to implement the overall *Health Strategy*[1].

In the model proposed in the *Primary Care Strategy* it is envisaged that a group of primary care providers will come together to form an inter-disciplinary team, known as the primary care team. This **primary care team** will be composed of GPs, health-care assistants, home helps, nurses or midwives, occupational therapists, physiotherapists, social workers and administrative support and would serve small population groups of approximately 3,000 to 7,000 people.

It is envisaged that a wider network of health and social care professionals, such as chiropodists, community pharmacists, community welfare officers, dentists, dieticians, psychologists, and speech and language therapists will be formed and will work with a number of primary care teams in a **primary care network**.

7.4.2 INTEGRATION OF PRIMARY CARE TEAM WITH SPECIALIST SERVICES

The *Primary Care Strategy* envisages improved integration between primary care teams and specialist services. Referral protocols, direct access to diagnostic facilities, discharge plans, individual care plans, integrated care pathways, and shared care arrangements will allow the primary care teams to provide much of the care currently provided by specialist services.

The *Strategy* proposes that the primary care team will liaise with specialist teams in the community (such as mental health teams) to improve integration of care. The issue of integration between primary care and mental health services and how this might be achieved is discussed in greater detail in section 7.7 of this chapter.

7.5 PREVALENCE OF MENTAL HEALTH PROBLEMS IN PRIMARY CARE SETTINGS

Between GP practices the prevalence of mental health problems can vary widely, depending on factors such as the location of the practice (for example, in an area with a large homeless population, or high socio-economic deprivation or where there are several supported residences for mental health service users), or characteristics of the practice or GPs themselves. Practices with a particular interest in mental health or with on-site counsellors, for example, will attract a higher proportion of individuals with mental health problems.

Mental health problems are indicated in as many as one in four primary care consultations[91], making mental health second only to consultations for respiratory infection [92]. Nine out of ten mental health problems are dealt with in

primary care without referral to a specialist mental health service[93].

7.5.1 IRISH DATA ON PREVALENCE OF MENTAL HEALTH PROBLEMS IN PRIMARY CARE

National figures on the treatment of mental health problems in general practice in Ireland are not available. The most recent figures on this area are from a study carried out by The Irish College of General Practitioners (ICGP) and the South Western Area Health Board (SWAHB) in partnership[94]. All GPs in the SWAHB were included and 64% responded, reporting that 25% of their caseload had 'psychological or mental health issues'. Most GPs (85%) referred less than 5% of these patients to mental health specialists.

A series of studies by the Department of Community Health and General Practice in Trinity College looked at the general health and service use of people living in different parts of Dublin[95,96,97]. The proportion of people consulting their GP because of 'stress' varied from 26% in the Docklands area to 35% in Tallaght and 41% in Finglas.

RECOMMENDATION 7.2: Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.

7.6 THE ROLE OF PRIMARY CARE IN THE TREATMENT AND CARE OF MENTAL DISORDERS

GPs are the first, and in many cases the only, health professionals to be involved in the management of a wide range of mental health problems. The typical mental health problems encountered by GPs are often centred around life events and social circumstances, such as bereavement or marital difficulties.

The GPs in the SWAHB study[94] reported the most common mental health conditions in the individuals they see as anxiety (49%), depression (24%) emotional difficulties (20%) and other disorders such as psychosis and eating disorders (7%). GPs felt that most of the individuals with anxiety disorders, depression and emotional difficulties could be treated in primary care with adequate support.

The type of support GPs wanted was access to counsellors or psychologists, i.e. professionals with the skills needed to deal with the majority of mental health problems encountered in primary care.

7.6.1 TREATMENT IN PRIMARY CARE

GPs are the 'gatekeepers' of the mental health services, i.e. it is the role of GPs to detect and diagnose a mental health problem and either treat the individual themselves in the primary care setting, or refer the individual on to a mental health service.

Currently, the treatment most usually offered to individuals with mental health difficulties in primary care is medication. GPs and service users have expressed a desire for far greater availability of other treatments, such as psychological therapies.

There is good evidence that psychological interventions such as cognitive behaviour therapy and interpersonal therapies are often clinically effective as well as cost effective, and these should be available in the primary care network. There are other psychological interventions which may be useful in primary care settings. An example of one such intervention is given in Annex 7.

7.6.2 PHYSICAL HEALTH CARE

It has been shown that people with severe mental illness have poorer physical health than the general population. They are more likely to smoke; they are more likely to have a substance misuse problem; and they eat a less healthy diet. They are less likely to be employed, more

likely to be socially excluded and their incomes are significantly lower[98,99].

GPs are the key providers of general health care to this group. GPs also have an important role to play in the support of individuals with long-term mental health problems. This role is usually in partnership with the local mental health service. All service users, particularly those resident in long-stay wards, should be registered with a GP to provide for their health-care needs.

RECOMMENDATION 7.3: All mental health service users, including those in long-stay wards, should be registered with a GP.

7.6.3 MENTAL HEALTH PROMOTION AND PREVENTION IN PRIMARY CARE

In terms of mental health promotion and prevention, the development of programmes to impart coping skills, problem-solving skills, help-seeking and resilience is an important means of preventing the development of mental health problems. Graduate workers in primary care mental health are being trained in the UK to provide this type of programme[100]. These programmes could be provided with an enhanced mental health capacity as part of a primary care team.

There is also a role for primary care in the rehabilitation and recovery process for individuals overcoming mental health problems. GPs should be able to access services that are specifically tailored for this group of individuals.

Evidence from GPs suggests that the preventive capacity of GPs would be greatly improved if adequate mental health services for children and adolescents were available. GPs can, and do, identify children who may have a behavioural or mental health problem. However, the specialist, multidisciplinary assessment required by such children is not readily available because of the scarcity of child and adolescent mental health services. This issue is specifically addressed in Chapter Ten.

RECOMMENDATION 7.4: Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing.

7.7 HOW SHOULD PRIMARY CARE AND MENTAL HEALTH SERVICES WORK TOGETHER?

Many of the findings from the study on mental health in primary care[94] related to the need for increased collaboration between GPs and mental health service providers and how best this might be organised. Issues such as the need to improve communication between the parties and the need to ensure continuity of care and coordination of care can be most effectively addressed by establishing a model of shared care that best meets the needs of both the primary care team and mental health service providers.

The network of mental health services proposed in this policy should offer one point of access for GPs who want to refer individuals on to mental health services or are looking for advice and guidance on the management of a specific individual. In the proposed model there should also be a single point of access for a crisis response when needed.

7.7.1 THE CONSULTATION/LIAISON MODEL OF WORKING TOGETHER

One of the key issues in formulating a model for mental health in primary care is to ensure sufficient access to appropriate care for people with possibly short-term mental health difficulties, balanced with the need to ensure that the needs of people with severe and enduring mental health problems are not overlooked[101,102].

There are various ways of working, which differ in the intensity of direct patient contact (see Annex 7 for details). An evidence-based, flexible model of working together is required for the configuration of primary care and mental health services.

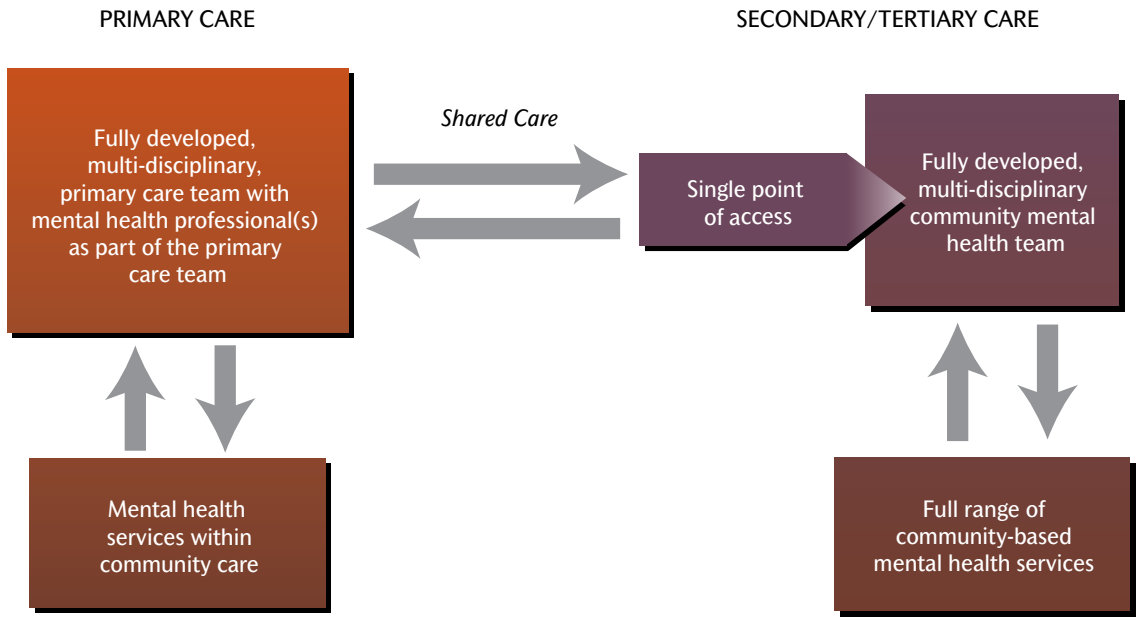
The consultation/liaison model can be easily adapted to different types of primary care delivery (e.g. single-handed and group practices) and different local configurations of mental health services. This type of model can also be used to ensure appropriate provision of out-of-hours cover by both primary care and mental health services.

The consultation/liaison model places great emphasis on developing close links between the primary care team and the mental health team in order to reduce rather than increase referrals of milder mental health problems, selectively encourage referral of serious mental illness and enhance GPs' skills in the detection and management of mental illness. This type of close relationship between primary care and mental health teams was recommended in *Planning for the Future*[75] but has not happened to a significant extent in a formal way. A number of models have been described in the UK which involve different members of the community mental health team providing consultation advice and liaison to the GP/primary care team [103,104,105].

7.8 PROPOSED MODEL FOR SHARED MENTAL HEALTH CARE

Drawing on the lessons that can be gained from the literature, along with what is proposed in the *Primary Care Strategy*[88], the following model of mental health in primary care is proposed (Figure 7.1), along with some basic principles of operation.

Figure 7.1: Model for shared mental health care



The consultation/liaison model is recommended, along with the presence of a mental health professional as part of the primary care team or network. This mental health professional is not a member of the CMHT but is a primary care mental health professional.

RECOMMENDATION 7.5: It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.

RECOMMENDATION 7.6: Mental health professionals should be available in the primary care setting, either within community care, the primary care team or the primary care network.

This model can be adapted to the needs of the GPs and the population they serve. For example, a single-handed GP may not be in a position to employ a mental health professional, but a number of single-handed GPs may come together to employ one.

The model allows for the appropriate provision of mental health care at primary care level, along with access to advice, routine and crisis referral to the local CMHT, with a single point of access for referral.

In areas where the *Primary Care Strategy* has not yet been implemented, the HSE should provide primary care mental health professionals. It may also be possible to create links with the mental health professionals in community care services in order to provide this primary care level mental health input. This currently happens to a great extent with services for children but should be extended to cover adults. This type of working is described as the 'primary care network' in the *Primary Care Strategy*.

RECOMMENDATION 7.7: Local multidisciplinary CMHTs should provide a single point of access for primary care for advice, routine and crisis referral to all mental health services (community and hospital based).

In order for such a model to work, a range of policies and protocols need to be agreed between the primary care team and the CMHT, for example to clarify appropriate referrals and facilitate such referrals. Particular attention needs to be paid to discharge policies.

RECOMMENDATION 7.8: Protocols and policies should be agreed locally by primary care teams and community mental health teams – particularly around discharge planning. There should be continuous communication and feedback between primary care and the CMHT.

Issues or structures which slow down the discharge of patients from a CMHT should be tackled. Action can be taken at an organisational level to create incentives for GPs to have a greater role in the care and treatment of people with mental health problems and to tackle disincentives for the use of primary care.

RECOMMENDATION 7.9: A wide range of incentive schemes should be introduced to ensure mental health treatment and care can be provided in primary care.

7.9 PHYSICAL INFRASTRUCTURE

The physical infrastructure required to provide a comprehensive primary care and mental health service is vital.

In the first instance, the availability of a modern, well-maintained premises gives a message to both staff and service users that they are important and deserve care in an appropriate setting. Secondly, it is essential that there is adequate space for each of the team members to carry out their functions. Thirdly, it has been found that purpose-built, 'multi-function', health centres allow much greater integration between the services located there, and create a natural communication network between the services located under one roof.

While location in one building may facilitate communication and other aspects of team working, it may be necessary to have members of the primary care team in different locations, particularly in sparsely populated areas.

RECOMMENDATION 7.10: Physical infrastructure that meets modern quality standards should provide sufficient space to enable primary care and CMHTs to provide high quality care.

7.10 MANAGEMENT AND ORGANISATION

There are other structural and organisational issues that can facilitate better cooperation between primary care and mental health services. For example, having coterminous boundaries for mental health services and primary care services is a simple measure that should improve cooperation.

Regular meetings between GPs in the mental health catchment area and the management team of the mental health services are an essential part of maintaining an effective relationship between the two elements. Further details of the management arrangements for mental health services are in Chapter Sixteen.

7.11 TRAINING AND EDUCATION NEEDS

Most GPs in Ireland do not have specific training in mental health. In the sample of GPs questioned in the SWAHB survey[94], 68% indicated they had no specific training in mental health; the remaining 32% had training consisting of between three and nine months' clinical placement and/or during their hospital rotation.

This raises the issue of the appropriateness of the mental health training received by GPs. Much of this training occurs in specialist mental health services; in psychiatric in-patient units and community-based mental health services. This type of psychiatric placement means that GPs often do not experience the type of mental health and social problems they will experience in primary care settings[106].

Seventy per cent of the GPs in the SWAHB study indicated that they were interested in further training in the area of mental health and the ICGP is formulating a new training programme to address this need. The lack of training in mental health also has implications for the provision of out-of-hours cover.

A general principle behind any new training initiative should be the creation of collaborative training programmes at undergraduate and postgraduate level for doctors and other mental health professionals. This would help to foster an understanding of the different roles and skills of the disciplines and the importance of multidisciplinary working.

This has been echoed in the *Progress Report of the National Primary Care Steering Group*[106], which made a series of recommendations and suggestions concerning training for the professionals involved in primary care. It is also important that service users are involved in the mental health training of GPs.

There is a need to build 'mental health capacity' in the proposed primary care teams and this gives rise to a number of training and education needs:

1. training in mental health for GP trainees
2. continuing medical education (CME) training for GPs
3. training for mental health professionals on primary care teams
4. training in mental health for all members of primary care team

7.11.1 TRAINING IN MENTAL HEALTH FOR GPS AND CME TRAINING FOR GPS

GPs have expressed their need for additional training in the areas such as interviewing techniques, counselling skills, specific therapies such as cognitive behaviour therapy (CBT)[94]. GPs should also have training in the mental health needs of people with an intellectual disability. The ICGP is currently revising its existing training modules to incorporate mental health education and awareness.

A mental health educational programme with different modules covering skills and a knowledge base is also to be developed. There are various channels for training GPs on mental health. This could include accredited short courses on specific mental health skills or mental disorders, distance-learning modules and training modules such as audiotapes, videos and CD-ROM and e-learning. The ICGP plans to develop a stand-alone 'mental health in primary care' distance learning course in the near future.

7.11.2 TRAINING FOR MENTAL HEALTH PROFESSIONALS ON PRIMARY CARE TEAMS

All mental health professionals on primary care teams need to have appropriate qualifications and training from recognised bodies. Because of the lack of regulation in the area of counselling, special attention needs to be paid to the qualifications and accreditation of counsellors.

Agreement needs to be reached on what qualifications can be recognised and what bodies are accepted for accrediting purposes. The issue of accreditation of counsellors is important and substantial and deserves separate consideration by an independent group and is discussed further in Chapter Eighteen.

7.11.3 TRAINING IN MENTAL HEALTH FOR ALL MEMBERS OF PRIMARY CARE TEAM

All members of the primary care team need to have an awareness and understanding of mental health issues, and training should be provided to ensure this.

RECOMMENDATION 7.11: The education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy (i.e. community-based mental health services). Service users should be involved in the provision of education on mental health.

7.12 RECOMMENDATIONS

1. All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.

2. Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.

3. All mental health service users, including those in long-stay wards, should be registered with a GP.

4. Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing.

5. It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.

6. Mental health professionals should be available in the primary care setting, either within community care, the primary care team or the primary care network.

7. Local multidisciplinary CMHTs should provide a single point of access for primary care for advice, routine and crisis referral to all mental health services (community and hospital based).

8. Protocols and policies should be agreed locally by primary care teams and community mental health teams - particularly around discharge planning. There should be continuous communication and feedback between primary care and CMHT.

9. A wide range of incentive schemes should be introduced to ensure mental health treatment and care can be provided in primary care.

10. Physical infrastructure that meets modern quality standards should provide sufficient space to enable primary care and CMHTs to provide high quality care.

11. The education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy (i.e. community-based mental health services). Service users should be involved in the provision of education on mental health.

CHAPTER EIGHT

Framework for mental health service delivery

8.1 THE FRAMEWORK FOR MENTAL HEALTH SERVICE DELIVERY

Mental health services are part of the complete mental health system described in Chapter Two. In order to implement the full range of specialist mental health services recommended in this policy document, substantial changes in the organisation and structure of mental health services are required.

A framework to ensure coordinated mental health service delivery for the population is described in this chapter. Details of the proposed management and organisation structures for mental health services are provided in Chapter Sixteen.

Larger catchment areas are necessary to ensure the full range of mental health services can be provided to a defined population. The Inspector of Mental Health Services has noted that small catchment size has 'impeded the development of specialist services requiring larger populations and has led to a defensive fragmentation of care delivery between mental health specialties in different care programmes.[79] (p 121).

Larger catchments allow for the delivery and integration of this wide range of mental health specialties, located together in community mental health centres, and gives more scope for choice to service users while maintaining the advantage of remaining within the service user's local area.

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This policy proposes a change in the size of the catchment areas used to administer mental health services. Most catchment areas are currently around 100,000 in population. The new catchment areas should have a population of 200,000 to 400,000, depending on local circumstances. The average mental health catchment area should be around 300,000 in population and this is the number that has been used to configure and cost the mental health services in this policy.

Based on these numbers, there will be a total of 12 or 13 **Mental Health Catchment Areas** in the country. Each Mental Health Catchment Area should contain within it the full range of mental health services, with the exception of those services that require provision on a regional or national basis.

8.2 THE FORMATION OF MENTAL HEALTH CATCHMENT AREAS

There should be flexibility regarding catchment area size and composition, taking population structure and distribution, geographical factors and deprivation into account. The population range of 200,000 to 400,000 should ensure a viable population size to enable the provision of the range of specialisms, while ensuring accessibility for service users.

Catchment areas of this size will cover two or three local health offices, depending on local population and dispersal. It is essential that local health office catchment areas should not be split across different Mental Health Catchment Areas. Boundaries of mental health catchment areas and one or more local health offices must be coterminous.

The final decision on the number of teams as described below will depend on local needs. A strict team-to-population ratio has deliberately not been set so that the emphasis will be on local population structures and needs. Preference should be given to providing additional personnel to teams where there is more need but not enough to justify a full team, rather than splitting teams.

For example, if there are 10,000 older people in one area and 12,000 in another, more personnel should be given to the team with the greater population, rather than an attempt to create a full team on a one-third or one-half basis.

Services should be organised so that they are located in areas of deprivation, which will ensure easier access, and that local deprivation is taken into account in the provision and staffing of services. Taking the above example, two areas with a population of 10,000 and 12,000 respectively may have the same personnel provision if the area with the smaller population is more deprived than that with the larger.

The mental health services within each Mental Health Catchment Area are presented in Figure 8.1. Service is provided through multidisciplinary community mental health teams (CMHTs) and the functioning of these teams is described in Chapter Nine. Age ranges for services are provided for guidance only as the decision on which team provides a service to an individual should at all times be determined by the needs of that individual.

8.2.1 SECTORS

A sector is the population unit looked after by a community mental health team (CMHT). Previously, sectors were approximately 25,000 in population size, although there was large variation nationally. Sectors in the new structure will range from 50,000 to 300,000 depending on the specific mental health services. Some services are also provided on the basis of the HSE regions, which have a population of approximately 1,000,000.

ity-based

Figure 8.1: Framework for catchment area mental health services 300,000 population approximately

8.3 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Within each Mental Health Catchment Area of 300,000 there should be six multidisciplinary community mental health teams (CMHTs) to provide mental health services to children and adolescents. Two teams should cover approximately 100,000 population. Child and adolescent mental health services should provide mental health services for everybody aged under 18 years in the catchment area. An additional CMHT should be provided to provide paediatric liaison mental health services for 300,000 population. Forensic and substance misuse mental health services for children and adolescents are described in the relevant sections below. A detailed description of child and adolescent mental health services is provided in Chapter Ten.

Child and adolescent mental health services

- two multidisciplinary CMHTs per 100,000 population
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care as appropriate for children and adolescents aged 0–18 years and covering the day hospital in each catchment area
- one additional multidisciplinary team in each 300,000 catchment area to provide paediatric liaison mental health services
- one day hospital per 300,000
- 100 in-patient beds nationally for all aged 0-18 years, in five units of 20 beds each

8.4 ADULT MENTAL HEALTH SERVICES

The central structure within the adult mental health service should be a specialised CMHT. Each CMHT should serve everybody aged 18–64 years in a population of approximately 50,000. Home-based treatment should be the main method of treatment delivery and all elements of the adult mental health service, such as access to in-patient admission, should be provided as appropriate through the CMHT.

There should be a single point of contact for access to all parts of the adult mental health services for primary care and all referring agents. By providing a comprehensive and community-oriented continuum of care, the need for acute in-patient beds should be reduced.

There should be flexibility within the design of these services. For example, within rural areas it may be appropriate to have a different service configuration. Services should also be provided for those who are difficult to manage (DMP). Adult mental health services are described in detail in Chapter Eleven.

Adult mental health services

- one multidisciplinary CMHT per 50,000 population, with two consultant psychiatrists per team
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care; home-based care; crisis house; day hospital; early intervention etc.
- one acute in-patient unit per 300,000 population with 35 beds*
- one crisis house per 300,000 with ten places
- four intensive care rehabilitation units (ICRU) to be provided – one in each of the four HSE regions, with 30 beds. Each ICRU to be staffed by a multidisciplinary team with additional nursing staff
- two high-support intensive care residences of ten places each in each HSE region (a total of eight residences with 80 places nationally)
- two Early Intervention Services be provided on a pilot basis

**see details of in-patient provision in section 8.13*

8.5 RECOVERY AND REHABILITATION MENTAL HEALTH SERVICES FOR SEVERE AND ENDURING MENTAL ILLNESS

Individuals with severe and enduring mental illness are recognised as an especially vulnerable group of adults, in need of intensive treatment and care in order for the individual to regain their selfhood and their place in society. Mental health services for this group should be provided by multidisciplinary CMHTs, with one team per 100,000 population. These teams should provide intensive treatment and rehabilitation, and should have a number of members delivering assertive outreach care. In-patient beds and other parts of mental health services in the catchment area should be accessed during acute episodes if required. Recovery and rehabilitation mental health services are described in detail in Chapter Twelve.

Recovery and rehabilitation mental health services for severe and enduring mental illness

- one multidisciplinary CMHT per 100,000 population
- based in, and operating from, community mental health centres
- providing intensive multidisciplinary assessment, treatment and care; assertive outreach, etc.
- three community residential units of ten places each to be provided per 100,000 population
- one to two day centres per 300,000 providing a total of 30 places
- one service user-provided support centre/social club per 100,000

8.6 MENTAL HEALTH SERVICES FOR OLDER PEOPLE

The mental health needs of older people are recognised as requiring specific skills for assessment, treatment and care. Within each catchment area, mental health services for older people should be provided by three multidisciplinary CMHTs, each serving approximately 100,000 population. All individuals over 65 years can access the mental health services for older people. The needs of the individual will determine which team is best suited to meet those needs (i.e. between adult, older people and the team for severe and enduring mental illness). Mental health services for older people are covered in Chapter Thirteen.

Mental health services for older people

- one multidisciplinary CMHT per 100,000 total population
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care, with an emphasis on home assessment and treatment if possible, and on maintaining the older person in their community
- eight in-patient beds in the general acute in-patient unit
- one day hospital per 300,000 population with 25 places specifically for mental health services for older people, with a possibility of additional sessional or mobile day hospitals in rural areas
- one unit with 30 beds per 300,000 population for continuing care/challenging behaviour

**see details of in-patient provision in section 8.13*

8.7 MENTAL HEALTH SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY

The mental health needs of individuals with intellectual disability should be provided for on a catchment area basis by multidisciplinary CMHTs. Two teams per 300,000 should serve adults with intellectual disability with one team per 300,000 for children with intellectual disability. Provision of forensic services for this group is described in section 8.8. Intellectual disability mental health services are described in Chapter Fourteen.

Intellectual disability mental health services

- two multidisciplinary CMHTs for adults with intellectual disability per 300,000 population
- one multidisciplinary CMHT for children and adolescents with intellectual disability per 300,000 population
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care, with an emphasis on home assessment and treatment if possible, either in the individual's family home or at a residence provided by an intellectual disability service
- five acute beds in the acute in-patient unit*
- one day hospital per 300,000 with ten places
- ten rehabilitation beds in intellectual disability residential centres which have approved centre status

**see details of in-patient provision in section 8.13*

8.8 FORENSIC MENTAL HEALTH SERVICES

There should be one community forensic mental health team per HSE region, in addition to the teams already in the Central Mental Hospital. These teams should provide court diversion services and liaison and support for local gardaí and other mental health services in the region. Provision is also made for a forensic service for children and adolescents and for a forensic service for those with an intellectual disability. Forensic teams should also work closely with personnel in the Intensive Care Rehabilitation Units. Forensic mental health services are covered in Chapter Fifteen.

Forensic mental health services

- one multidisciplinary CMHT per HSE region
- based in, and operating from, community mental health centres
- providing court diversion services and liaison and support for local gardaí and for other mental health services in the region
- two multidisciplinary teams for children and adolescents nationally – one to be based in a ten-bed secure unit for children and adolescents and one to be a community based resource
- one national intellectual disability forensic mental health team and national unit to provide secure care to those with intellectual disability

8.9 MENTAL HEALTH SERVICES FOR THE HOMELESS

A central principle for all mental health services described here is that mental health services should be provided for an individual by the CMHT in the catchment area in which they normally reside. If people become homeless, this CMHT is still responsible for their mental health care. However, this can present difficulties, particularly in the cities, as many people drift into the city areas though prior service contact may have been elsewhere in the country, or abroad. For this reason, and because the largest proportion of homeless are in Dublin, two multidisciplinary, community-based teams are proposed for the Dublin area. Mental health services for this group are described in Chapter Fifteen.

Mental health services for the homeless

- two multidisciplinary CMHTs for Dublin, one for North Dublin and one for South Dublin.
- based in, and operating from, community mental health centres
- providing assessment, treatment and care on an assertive outreach basis
- one crisis house of ten beds for those not requiring admission to acute psychiatric beds
- the use of acute psychiatric beds if required, from the overall complement for the Dublin area
- two day centres and one day hospital should also be provided for these teams

8.10 SUBSTANCE MISUSE MENTAL HEALTH SERVICES

One multidisciplinary CMHT should be available in each 300,000 catchment area to provide a substance misuse mental health service for all adults in the catchment with mental illness co-morbid with a complex or severe substance misuse problem. Chapter Fifteen has details of these mental health services.

Substance misuse mental health services

- one multidisciplinary CMHT per catchment area of 300,000
- these teams to work closely with the forensic CMHT, the adult CMHT and substance misuse services in the community to ensure appropriate referral and provision for individuals with co-morbid substance misuse and mental illness
- two consultants already work with adolescents with substance misuse and co-morbid mental health problems. These consultants should have full multidisciplinary teams. Two additional teams should be provided to ensure provision of one team per 1 million HSE region to serve this group.

8.11 MENTAL HEALTH SERVICES FOR PERSONS WITH EATING DISORDERS

Mental health services for this group are very poorly developed in Ireland. For adults with eating disorders, it is proposed that a specialist multidisciplinary team should be available for those people who cannot be treated by the general adult CMHT. There should be one of these teams in each HSE region. These teams should have access to six beds in the regional acute in-patient unit. Children and adolescents with eating disorders should be treated by their local child and adolescent CMHT. A national tertiary referral centre with a multidisciplinary team should be developed for specialist care of this group. Mental health services for adults, and for children and adolescents, with eating disorders are described in Chapter Fifteen.

Mental health services for people with eating disorders

- one multidisciplinary CMHT per HSE region for adults (a total of four nationally)
- these teams to work closely with the general adult CMHTs and primary care to provide advice and support for cases being treated at these levels of the mental health system
- six beds in the regional in-patient unit should be available to these teams
- a national tertiary referral centre for children and adolescents with a full multidisciplinary team should be developed

8.12 LIAISON MENTAL HEALTH SERVICES

Liaison mental health services should be provided by one multidisciplinary team per Regional hospital – which equates to roughly one team per catchment area or 13 teams nationally. Two multidisciplinary teams should provide a national resource for neuropsychiatry services. In addition, one perinatal mental health resource should be provided in a national maternity hospital, with a national remit. These mental health services are described in Chapter Fifteen.

Liaison mental health services

- one multidisciplinary liaison team per Regional hospital (roughly one per 300,000 – 13 nationally)
- two multidisciplinary teams providing a national neuropsychiatry service
- one national neuropsychiatric unit with six to ten beds
- one perinatal mental health resource to be provided in a national maternity hospital

8.13 IN-PATIENT CARE

There should be 50 acute in-patient beds per Mental Health Catchment Area, provided in the Regional Hospital. In some areas, these beds may be provided as two units with 25 beds each. The breakdown of these beds is shown below. Flexible use of acute beds is desirable and rigid demarcations are not to be encouraged. However, given the special needs of those in mental health services for older people and those with intellectual disability, it is preferable that 'sub-units' be provided within the overall psychiatric unit to suit the specific requirements of these groups. Similarly, given the therapeutic requirements of adults with eating disorders, it is preferable that these beds be located in one regional unit (i.e. six beds per one million population).Provision of beds for other groups and functions is also summarised, having been listed already in the details for each service.

In-patient care

- one acute in-patient unit per catchment area of 300,000 population with 50 beds to be used as follows:
  - 35 beds for general adult mental health services, including six close observation beds
  - eight beds for mental health services of older people (sub-unit)
  - five beds for mental health services for people with intellectual disability (sub-unit)
  - two beds for people with eating disorders (may be amalgamated in one unit per region of six beds)
- this acute in-patient unit should be located in the 'Major' or 'Regional' hospital, while taking into account the location of existing units (can be provided in two units of 25 beds each)
- one crisis house per 300,000 with ten places
- four intensive care rehabilitation units (ICRU) – one in each of the four HSE regions, with 30 beds each
- two high support intensive care residences of ten places each, in each HSE region (a total of eight residences with 80 places nationally)
- one unit with 30 beds per 300,000 population for continuing care/challenging behaviour for mental health services for older people
- ten rehabilitation beds in intellectual disability residential centres which have approved centre status
- 100 in-patient beds nationally for 0–18 year olds, in five units of 20 beds each
- ten-bed national secure unit for children and adolescents
- ten-bed national secure unit for those with intellectual disability

CHAPTER NINE

The Community Mental Health Team (CMHT)

9.1 INTRODUCTION

The proposed community-based mental health service will be coordinated and delivered through Community Mental Health Teams (CMHTs), which are designed to serve the needs of particular care groups across the lifespan from childhood to later life.

Within this multidisciplinary team, skilled professionals combine their unique expertise to provide integrated care to service users in the context of their local community.

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Working, planning and training becomes a joint activity and involves service users in the development and evaluation of services.

The rationale for cooperative teamwork is that it increases the clinical capacity and quality of care available to service users, through including a variety of professional perspectives in case formulation, care planning and service delivery[107].

The CMHT coordinates a range of interventions for individuals in a variety of locations, including home care treatment, day hospital, outpatient facilities and in-patient units, and interacts and liaises with specialist catchment or regional services to coordinate the care of individuals who require special consideration.

Each team should agree flexible protocols for its clinical and operational practice, adapted to the needs and social context of its sector population. Standards for service provision should be set by the teams, health managers and service users, to ensure consistency and equity.

CMHTs have a number of core functions. They are there to:

- provide support and advice to primary care providers on the management of mental health problems in the community, and to facilitate appropriate referrals
- provide prompt assessment and treatment of complex mental health disorders
- provide a range of interventions for service users with specific disorders, drawing on evidence-based and best-practice interventions. They also ensure and coordinate any additional specialist care required
- gain a detailed understanding of the mental health needs and priorities of the local population and establish a database of local resources available to users

- assist users and carers in accessing relevant agencies and community supports, so that they can achieve and sustain maximum re-integration in the community.

9.2 COMPOSITION OF THE CMHT

The needs of different groups of service users should determine the precise mix of skills required within their local CMHT. Teams should include input from psychiatry, nursing, social work, clinical psychology, occupational therapy, and clinicians with specific expertise – for example addiction counsellors, psychotherapists, creative/recreational therapists, speech and language therapists - and should also have adequate administrative support. To fulfil its many different functions, a CMHT may also require the addition of mental health support workers – people with health and social care skills pertinent to the practical needs of service users. Mental health support workers should be drawn from people with appropriate practical training and experience of mental health problems (see Chapter Eighteen).

The precise number of mental health professionals in each of these categories may vary according to the particular requirements of the sector population. Specific clinicians will often combine a number of skills and fulfil a number of roles within the CMHT. For example, a community nurse may develop expertise in a particular therapeutic approach and function in a number of different ways within each team. A social worker may be trained in systemic family therapy training, and bring this specialised skill to the sector as part of their role within the CMHT. What is important is that there is adequate capacity in each team to meet the needs of its sector population.

Adequate administrative support staffing is essential to enable the CMHT to deal with the paperwork associated with clinical activity, and to assist in record keeping, service auditing and data storage and to ensure that clinicians spend as much time as possible on clinical work.

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RECOMMENDATION 9.1: To provide an effective community-based service, CMHTs should offer multidisciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families. Each multidisciplinary team should include the core skills of psychiatry, nursing, social work, clinical psychology, occupational therapy. The composition and skill mix of each CMHT should be appropriate to the needs and social circumstances of its sector population.

9.3 GOVERNANCE OF THE CMHT

The guidelines for CMHTs apply equally to all the teams proposed in this policy. The aim of the CMHT is to provide comprehensive multidisciplinary interventions to address the range of needs of the service user. The key administrative and clinical functions required to ensure good governance of CMHTs are as follows:

1. **Clinical leadership** – a lead clinician will articulate the collective vision of the team and ensure clinical probity. In keeping with current legislation and contractual arrangements this role would be the remit of the consultant psychiatrist or psychiatrists attached to the team. Where there are two consultants appointed to a CMHT, agreement should be reached locally as to how this clinical leadership role is provided within the team. For example, this may be on a geographical or particular interest basis. In addition to the clinical leadership role, clinical accountability for all disciplines must be explicit within the team.

2. **Team coordination** – this clinical and administrative function should be managed by a team coordinator. This individual should be an intrinsic part of the team. Any of the CMHT members can fill this position, provided they have the organisational and interpersonal skills required to coordinate the activities of the team. The team coordinator's functions should include the administration and triage of referrals in consultation with the consultants and other team members, managing the waiting lists, organisation of team meetings, and liaising with GPs and primary care professionals, local community agencies, self-help and other community resources. It is recommended that this individual be an experienced mental health professional, at least equivalent to a Clinical Nurse Manager 3 grade (CNM3) or assistant director of nursing grade, as appropriate.

3. **Practice management** – Administrative functions of the team such as budgeting, auditing, data collection and evaluation, IT and systems management should be carried out by a practice manager. This individual should be appointed from within the team or from the mental health service management system. Financial management skills should be a key requirement for this post. It is recommended that this individual be a clerical officer grade six or seven (CO6 or CO7).

In addition, it is the responsibility of these three individuals to liaise with the overall management structure for the catchment area and represent the needs of their particular sector team in overall service planning and development.

RECOMMENDATION 9.2: The cornerstone of mental health service delivery should be an enhanced multidisciplinary Community Mental Health Team (CMHT), which incorporates a shared governance model, and delivers best-practice community-based care to serve the needs of children, adults and older people.

9.4 LOCATION OF CMHTS

CMHTs should base their operations in a community mental health centre. These centres should be located close to other relevant community agencies, and have adequate space and facilities to accommodate the full clinical requirements of the CMHT. Ideally, three or four different CMHTs should share the same accommodation. These community mental health centres should also offer an ethos which is attractive and valued by service users.

9.5 OPERATIONAL PRINCIPLES OF THE CMHT

The following key functions and general operational guidelines are included here as they relate to the activities of generic CMHTs. These should necessarily be adapted to the particular circumstances of individual specialist teams and their sector populations.

9.6 KEY FUNCTIONS AND GENERAL OPERATIONAL GUIDELINES

Function	Operation
Liaising with primary care services	Provide support and advice to primary care services regarding management of the large proportion of mental health problems they treat. These consultations may take place in respect of a particular service user, or may occur through a member of the CMHT who is assigned to liaise with primary care providers.
Processing new referrals	All referrals to the CMHT should be through a single point of entry, clearly identified to primary care services. This function may be assigned to the team coordinator, who will bring each new referral to the regular scheduled CMHT meetings for discussion. In managing new referrals, consideration should be given to making the best use of the resources and specific skills of the team members to avoid prolonged delays for service users in accessing treatment.
Setting up care plans	The needs of each service user should be discussed jointly by the team, in consultation with users and carers, in order to construct a comprehensive care plan. Care plans should be written and agreed between all parties, and include a time frame, goals and aims of the user, the strategies and resources to achieve these outcomes, and clear criteria for assessing outcome and user satisfaction.
Assigning a key worker	Where care of an individual is assigned to more than one of the team members, a 'key worker' – a team member who will be known and accessible to the service user and through whom clinical services can be personalised and coordinated – should be identified. The role of key worker can be assigned to any discipline within the team, subject to discussion and agreement.
Supporting carers	The burden experienced by individuals who provide regular and substantive care to people with severe disorders should be recorded and monitored as part of the overall care plan.
Managing future crises	As part of the formal care plan, it is recommended that the team, in collaboration with the service user, evolve agreed protocols for management of any future mental health crises that may arise.
Involving service users and carers	A person-centred, recovery-oriented service requires the active participation of service users at each level of service delivery and this should be an intrinsic aspect of CMHT development. The involvement of advocates and carers needs to be facilitated as a matter of priority, as their commitment and involvement with the service user plays a key role in their recovery.
A 'child-friendly' approach	The safety and well-being of children whose needs may be compromised by parental illness needs to be carefully monitored. The team should discuss with the user how a child's unmet needs can be considered. In the event of a high-risk situation developing, the child's needs must take priority.
Regular team meetings	Regular scheduled meetings of the CMHT are critical to care coordination and team development. The full team routinely discusses assessments, care plans and reviews service capacity. Team meetings serve as a forum for discussing referrals to other specialised services – e.g. early intervention, rehabilitation, forensic services – and for planning and ensuring continuity of care across different teams/programmes.
Case notes	There should be a single written record for each service user, where entries are made each time a team member has contact with them or with significant others in the course of their recovery.

Linking with community resources	A critical function of the team is to maintain integration of the user in their community life. Factors which promote/inhibit a service user's capacity to sustain themselves in the community will form part of the care plan. An assigned member of the CMHT will act as an advocate for the user in negotiating practical difficulties with key individuals and agencies where employment or accommodation has been jeopardised by their mental health problems. Teams should keep a resource file of local provisions and opportunities available to service users.
Linking with other health services	All CMHTs should have formal links with other health services in their area, particularly with relevant departments in general hospitals. CMHTs should have direct access to medical and radiological services, as part of the comprehensive assessment of specific presentations. This is especially the case for those services which have few links to the general hospital, such as child and adolescent mental health services.
Ongoing contact with primary care	Contact with primary care services should be maintained to inform GPs, or other referral agencies, of the user's progress in recovery and their discharge from secondary or tertiary services back to the community.
Addressing the user's practical needs	Mental health workers have a role to play in offering direct practical help to service users, particularly those with severe and enduring illness. Help with obtaining benefits, and with budgeting, shopping and child minding may be appropriate in fostering independence and effective integration in their local communities.
Hours of operation	A fundamental component of the CMHT is to clarify arrangements for provision of a 24-hour, multidisciplinary crisis response capacity.

RECOMMENDATION 9.3: Links between CMHTs, primary care services, voluntary groups and local community resources relevant to the service user's recovery should be established and formalised.

RECOMMENDATION 9.4: All CMHTs should have direct access to medical and radiological services as part of the comprehensive assessment of specific presentations.

9.7 ACCOUNTABILITY OF THE CMHT

CMHTs should be accountable to service users and carers and develop specific interventions in line with the priority needs of its sector population. The various activities of the team should be evaluated in terms of service user satisfaction and in terms of performance indicators that are agreed nationally for mental health services.

RECOMMENDATION 9.5: Evaluation of the activities of the CMHT in terms of meaningful performance indicators should take place on an annual basis and incorporate service user feedback.

9.8 FACTORS THAT FACILITATE OR INHIBIT EFFECTIVE FUNCTIONING OF CMHTS

Working in CMHTs can be experienced as difficult for a number of reasons. Members can find themselves torn between allegiance to their independent professional roles and to functioning collaboratively with others to realise team goals. Research has suggested that balancing generic versus professional roles, providing clear mechanisms for conflict resolution and providing resources to nurture and develop the CMHT, may be critical factors in promoting effective team functioning[108]. These factors should be taken into account when teams are being set up and sufficient time and training given to ensure the effective functioning of the CMHT.

RECOMMENDATION 9.6: Research should be undertaken to establish how many services currently have effective CMHTs and to identify the factors that facilitate and impede effective team functioning and the resources required to support the effective functioning of CMHTs.

9.9 RECOMMENDATIONS

1. To provide an effective community-based service, CMHTs should offer multidisciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families. Each multidisciplinary team should include the core skills of psychiatry, nursing, social work, clinical psychology, occupational therapy. The composition and skill mix of each CMHT should be appropriate to the needs and social circumstances of its sector population.
2. The cornerstone of mental health service delivery should be an enhanced multidisciplinary Community Mental Health Team (CMHT), which incorporates a shared governance model, and delivers best-practice community-based care to serve the needs of children, adults and older adults.
3. Links between CMHTs, primary care services, voluntary groups and local community resources relevant to the service user's recovery should be established and formalised.
4. All CMHTs should have direct access to medical and radiological services as part of the comprehensive assessment of specific presentations.
5. Evaluation of the activities of the CMHT in terms of meaningful performance indicators should take place on an annual basis and incorporate service user feedback.
6. Research should be undertaken to establish how many services currently have effective CMHTs and to identify the factors that facilitate and impede effective team functioning and the resources required to support the effective functioning of CMHTs.

CHAPTER 10

Child and adolescent mental health services

10.1 INTRODUCTION

Children aged up to 18 years comprise a quarter of the population of Ireland. To grow and develop as healthy individuals they need safety and security within their primary relationships, opportunities to play and learn, and the positive self-esteem that comes from knowing they are valued and cherished by families and friends.

The vast majority of children do not develop mental health problems but at any point in time approximately 2% of children will require specialist mental health expertise[109]. These children experience distressing emotional, behavioural or relationship problems that can hinder learning and social development. Significant mental health risk factors in childhood include loss, separation, trauma, child abuse, and family breakdown.

This chapter details how positive mental health in children can be promoted generally in our society, and how specialist mental health services can be delivered efficiently to children who need them.

10.2 BEST PRACTICE IN CHILD AND ADOLESCENT SERVICES

The importance of children's mental health is well recognised and Ireland is party to international commitments to provide health services for children, e.g. Article 24 of the United Nations Convention on the Rights of the Child (ratified by Ireland in 1992), which specifies that 'the State shall recognise the rights of a child to the enjoyment of the highest attainable standard of health and the facilities for the treatment and rehabilitation of health, shall strive to ensure that no child is deprived of his or her right of access to such health care services'.

Develop

In Ireland, the *National Children's Strategy*[110], reiterated the principle that 'children will be supported to enjoy the optimum physical, mental and emotional well-being'.

Several reports have influenced the development of child and adolescent mental health services, for example the *Report on the Child and Adolescent Psychiatry Services in the Eastern Health Board*[111], and the *Development Plan for Child and Adolescent Psychiatric Services in Ireland*[112]. Two reports from a working group appointed by the Department of Health and Children addressed the need

for increased in-patient beds and for improved resources to care for 16–18 year olds who can fall between child or adult services, and may not receive care appropriate to their particular needs[113,114].

RECOMMENDATION 10.1: The need to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents is endorsed in this policy.

RECOMMENDATION 10.2: Child and adolescent mental health services should provide mental health services to all aged 0-18 years. Transitional arrangements to facilitate the expansion of current service provision should be planned by the proposed National Mental Health Service Directorate and the local CMHTs.

10.3 CURRENT SERVICE PROVISION IN IRELAND

When *Planning for the Future* was adopted as policy in 1984, there were only 18 Child Guidance Teams and three in-patient units in the country; based in Dublin, Galway and Cork. Following the implementation of the recommendations in *Planning for the Future*, child and adolescent mental health services have since been established in every HSE area, with 39 expanded child CMHTs offering a wide range of therapeutic approaches including CBT, brief therapy and systemic family therapy.

The role of psychopharmacology has been developed in line with the greater appreciation of biological influences on behaviour; and post-graduate training courses and research opportunities have increased the available expertise in this country.

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Adolescents want accessible, user-friendly services, specific to their needs. Young people say they are least likely to approach adults or professionals when they have problems and are more likely to depend on their peers. There are currently no systems in place to routinely seek the views of children and adolescents who attend services.

RECOMMENDATION 10.3: It is recommended that service users and their families and carers be offered opportunities to give feedback on their experience and to influence developments within these services.

Current service provision also includes dedicated in-patient facilities, paediatric liaison services, specialist services for children who have experienced sexual abuse and a National Education Psychological Service (NEPS), under the aegis of the Department of Education and Science.

The mental health needs of children and adolescents come within the scope of the Disability Act, 2005[115] and the Education for Persons with Special Educational Needs Act, 2004[114]. The type of multidisciplinary assessment, treatment and care envisaged in this policy framework is in keeping with the requirements of these legislative provisions.

10.4 GAPS IN CURRENT SERVICE PROVISION

In spite of the improvements in services for children and adolescents, a number of deficiencies exist which require attention as a matter of priority:

- Child community mental health teams (CMHTs) and services are well below the norms recommended by the *Working Group on Child and Adolescent Psychiatric Services*[113]. There is also an inequitable variation in the distribution of child services across the country.
- Dedicated adolescent mental health services are virtually non-existent on a national basis.
- Paediatric liaison services are not available in the majority of major hospitals outside of the three national children's hospitals based in Dublin.
- Mental health services for autism and autistic spectrum disorders are not always accessible.
- There are insufficient in-patient and day hospital facilities.
- There are no dedicated child and adolescent forensic teams.

10.5 FRAMEWORK FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Responding to children's mental health needs can be conceptualised at different levels, ranging from early intervention and health promotion programmes, to primary and community care services and specialist mental health services for the treatment of complex disorders.

10.6 HEALTH PROMOTION/EARLY INTERVENTION

There is considerable evidence to show that early identification of behavioural difficulties and early implementation of family support programmes promote better mental health outcomes for children at risk[117]. This report recommends that programmes addressing risk and protective factors early in life should be targeted at child populations at risk, e.g. being in a family with low income and education levels. There are numerous examples of best practice in this area including the *Community Mothers Programme* [118], and *Life Start Scheme Programmes*[119], which have proven benefits for children in disadvantaged areas.

For children aged between 5 and 12, the school setting provides an ideal setting for the promotion of positive mental health. There is strong evidence for a health-promoting schools approach to mental health promotion which enrols the whole school environment including curriculum, school ethos, physical environment, links with parents and community, in supporting the positive mental health of school users[120].

The capacity-building and personal development elements of the Social Personal and Health Education curriculum (SPHE) represent important mental health promotion opportunities for school-age children. In recent years, particular emphasis has been placed on bullying prevention as a key element of mental health promotion activity within the schools setting. Bullying policies are being developed across the primary school sector as part of the school policy planning process and several programmes have been evaluated[121].

Adolescence is a key stage of psychological development when children require an understanding of the life challenges they face and need to develop basic skills to cope with difficult emotions. It is a time of increased risk of poor mental health with anxiety, depression, psychosis, eating disorders, and substance misuse becoming more prevalent, as well as an increasing risk of deliberate self-harm and suicidal behaviour. For those children in school settings it is proposed that the SPHE be extended to include the senior cycle. The *Mental Health Matters* programme, developed by Mental Health Ireland, provides a useful resource for secondary schools, both in

conjunction with the wider SPHE curriculum and also as a stand-alone teaching unit.

For young people who have left school early, it is recommended that education and training programmes be offered to them in line with best international practice. Provision of these programmes should be the responsibility of the Department of Education and Science.

RECOMMENDATION 10.4: Programmes addressing mental health promotion and primary prevention early in life should be targeted at child populations at risk.

RECOMMENDATION 10.5: For those children in school settings it is recommended that the SPHE be extended to include the senior cycle and that evidence-based mental health promotion programmes be implemented in primary and secondary schools.

RECOMMENDATION 10.6: Provision of programmes for adolescents who leave school prematurely should be the responsibility of the Department of Education and Science.

10.7 PRIMARY CARE/COMMUNITY CARE SERVICES

GPs are usually the first point of contact for families who seek help for various problems. They are ideally placed 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.

Community care services that operate under the Childcare Act, 1991[122] provide assessment, monitoring and support services for children who are at risk of mental health difficulties or in need of care and protection.

Community care also includes the following services:

- community care psychology services
- social work services
- speech and language therapists
- community paediatric occupational therapists
- public health nurses
- public health doctors and area medical officers
- specialist early intervention services for children with developmental delay
- child abuse validation and post-abuse counselling services.

Clear links need to developed between mental health services and primary care/community resources, to coordinate appropriate service provision for children and adolescents at risk for mental health problems.

10.8 SPECIALIST CHILD AND ADOLESCENT CMHTS

Child and adolescent mental health services should be provided by multidisciplinary CMHTs. Two teams should be provided for each sector of approximately 100,000 population. These teams should serve all children and adolescents in the sector population, providing multidisciplinary assessment and a comprehensive range of interventions in a variety of settings such as home, outpatient and day hospital settings as appropriate. The teams should also cover the child and adolescent day hospital in the catchment area (see section 10.10 on physical resources). One additional team per catchment area of 300,000 population should also be provided, to provide liaison cover to paediatric, general hospitals and maternity units in their area.

The child and adolescent CMHTs should be available evenly across the country, have clearly defined care pathways in each sector, and establish cooperative links with primary and community care resources. Each CMHT should adopt a recovery-oriented model of care and involve users and carers at every level of service planning and delivery.

RECOMMENDATION 10.7 Two child and adolescent CMHTs should be appointed to each sector (population: 100,000). One child and adolescent CMHT should also be provided in each catchment area (300,000 population) to provide liaison cover.

RECOMMENDATION 10.8 These child and adolescent CMHTs should develop clear links with primary and community care services and identify and prioritise the mental health needs of children in each catchment area.

10.9 HUMAN RESOURCES REQUIRED

Two child and adolescent CMHTs should be established for each sector of 100,000 population. Individual teams should comprise the following:

- one consultant psychiatrist
- one doctor in training
- two psychiatric nurses
- two clinical psychologists
- two social workers
- one occupational therapist
- one speech and language therapist
- one child care worker
- two administrative staff.

The composition of each CMHT should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions. A range of therapeutic expertise should be available within each team, including play therapy, family therapy and structured therapeutic programmes (individual and group) according to the needs of service users.

Governance should be in accordance with the guidelines described for multidisciplinary CMHTs in Chapter Nine. Each team should have a clearly identified clinical leader, team coordinator and practice manager.

10.10 PHYSICAL RESOURCES REQUIRED

Each team should be based in a community mental health centre. These centres should have sufficient scope to accommodate outpatient and day hospital services.

One day hospital should be provided in each mental health catchment area (300,000 population approximately). The child and adolescent mental health teams in each catchment area can decide locally how the day hospital should be covered so that the most equitable and efficient use can be made of this resource.

A small percentage of children with mental health disorders will require in-patient admission. The present provision of 20 in-patient beds for children is seriously deficient.

It is recommended that the current agreed proposal to supply an additional four 20-bed units in major hospital centres be completed as a matter of urgency. This provision will result in 100 in-patient beds for children and adolescents nationally. This provision should be evaluated after five years to assess how it is meeting the needs of the population. In-patient facilities should provide large, spacious rooms for activities and possibly even classroom facilities, so children can continue their school curriculum work during their stay.

Because of the wide span of age group and the variety of disorders which would require this type of treatment, careful consideration should be given to the design of these units, their layout and the categorisation according to age groups and developmental level of the children they serve. A person-centred approach to service provision requires that these facilities should be user-friendly and sensitive to the needs of children and adolescents.

RECOMMENDATION 10.9: Urgent attention should be given to the completion of the planned four 20-bed units in Cork, Limerick, Galway and Dublin, and multidisciplinary teams should be provided for these units.

10.11 LINKS WITH MEDICINE, PAEDIATRICS, GENERAL MEDICINE AND OBSTETRICS

CMHTs require access to medical facilities for investigation of possible organic causes of mental disorders. Requirements may include genetic screening, health screening prior to treatment (for example with pharmacological treatments), monitoring of physical health while on medication (for example, immediate access to ECG testing facilities) and possible paediatric consultation. Medical paediatric consultations are frequently required to clarify the physical health status of some children with mental disorders. CMHTs should have the facility to refer directly for blood tests, ECG, CT scan, MRI imaging and other tests in cases where they are indicated.

10.12 CHILDREN REQUIRING SPECIAL CONSIDERATION

A number of children who come to the attention of the mental health services have particular needs which require special consideration.

- **Children with autism**
  The needs of children with autism are diverse and require significant inputs from the educational system, in addition to health (see Annex 10). Their main needs are in the area of language and communication programmes, social skills and self-care training programmes, specific education interventions, vocational advice and training, family support, access to respite care, support and education for siblings. The role of child and adolescent CMHTs in the area of autism can be defined as consultation on difficult diagnoses and specialist episodic treatment of acute mental disorders. A proportion of these children may attend the CMHT for children and adolescents with intellectual disability, as their needs dictate.

RECOMMENDATION 10.10: Early intervention and assessment services for children with autism should include comprehensive multidisciplinary and paediatric assessment and mental health consultation with the local community mental health team, where necessary.

- **Children of parents with mental health problems**
  Children whose parents have complex recurrent mental health problems are at risk of developing mental health problems themselves and require sensitive consideration. A skilful needs and risk assessment of children in high-risk situations should be adopted by mental health services as a minimum standard. This should involve cooperation and consultation between child and adolescent CMHTs and adult CMHTs. The emphasis at all times should be on supporting the child and the family and ensuring that the needs of the child are met.

- **Children in care**
  There are approximately 4,500 children in care in Ireland at present. Of these 81% are in foster care, 13% are in children's residential centres and a small proportion are in high-support and secure units. Their needs are many and varied and often can be traced back to disrupted attachments in very early life, exposure to trauma, abuse, violence, deprivation, neglect and serious domestic disruption. It is vital that children in care receive the maximum support required for their needs and that the foster parents and the staff of residential group homes who care for them are supported in every way possible. The primary support for these children should be provided by the psychological services in community care. Where children in care require specialist mental health care, this should be provided by the local child and adolescent CMHT.

- **Children within the forensic system**
  The specialty of forensic child and adolescent mental health concerns itself with the assessment of children who for various reasons come in contact with the courts and legal system. The needs of this group of children are addressed in Chapter Fifteen, (section 15.1.8) on forensic mental health services.

- **Suicide and deliberate self-harm (DSH)**
  All children presenting with DSH should receive assessment and treatment where appropriate by the child and adolescent CMHT.

- **Substance misuse in children and adolescents**
  Community substance misuse services should provide counselling to children and adolescents with substance misuse problems and no mental health difficulties. Children and adolescents who are misusing substances and have a co-morbid mental health problem should have access to teams with special expertise in this area. Chapter Fifteen, (section 15.3.4) deals with the needs of this group of children.

10.13 RECOMMENDATIONS

1. The need to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents is endorsed in this policy.

2. Child and adolescent mental health services should provide mental health services to all aged 0-18 years. Transitional arrangements to facilitate the expansion of current service provision should be planned by the proposed National Mental Health Service Directorate and the local CMHTs.

3. It is recommended that service users and their families and carers be offered opportunities to give feedback on their experience and to influence developments within these services.

4. Programmes addressing mental health promotion and primary prevention early in life should be targeted at child populations at risk.

5. For those children in school settings it is recommended that the SPHE be extended to include the senior cycle and that evidence-based mental health promotion programmes be implemented in primary and secondary schools.

6. Provision of programmes for adolescents who leave school prematurely should be the responsibility of the Department of Education and Science.

7. Two child and adolescent CMHTs should be appointed to each sector (population: 100,000). One child and adolescent CMHT should also be provided in each catchment area (300,000 population) to provide liaison cover.

8. These child and adolescent CMHTs should develop clear links with primary and community care services and identify and prioritise the mental health needs of children in each catchment area.

9. Urgent attention should be given to the completion of the planned four 20-bed units in Cork, Limerick, Galway and Dublin, and multidisciplinary teams should be provided for these units.

10. Early intervention and assessment services for children with autism should include comprehensive multidisciplinary and paediatric assessment and mental health consultation with the local community mental health team, where necessary.

CHAPTER ELEVEN

General adult mental health services

11.1 INTRODUCTION

Adults within the 18–65 year age group, two thirds of the Irish population, present the greatest challenge to mental health service provision because of the range and prevalence of mental health problems they experience.

While it is to be expected that most adults will encounter mild to moderate psychological difficulties at some stage in their lives, it is estimated that almost one in four adults experience psychological difficulties that would benefit from expert intervention[10].

In Ireland, the majority of these people are treated by primary care agencies in the community, including GPs, student health services, voluntary organisations and private practitioners. GPs report a wide range in the prevalence of mental health problems among the people they see[94]. They refer about 10% of adults who meet criteria for complex mental disorders to specialist mental health services.

While there is a good deal of data on the activity of parts of the mental health services (e.g. in-patient services), there is a general lack of data on the number of people attending the services, their characteristics, needs and outcomes. There were 22,229 in-patient psychiatric admissions in 2004, a rate of 735 per 100,000 of the population aged 16 and older[86]. The most recent census of the in-patient population reported 3,556 residents, a hospitalisation rate of 117 per 100,000 population over 16 years[79].

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11.2 CURRENT SERVICE PROVISION IN IRELAND

Planning for the Future[75] provided the strategic framework that enabled the adult mental health services to evolve from an institutional to a community-based service model and approach.

A range of structures, facilities and multidisciplinary clinical services, including acute in-patient and outpatient treatment alternatives, were introduced and delivered within defined geographical areas organised at catchment and sector area levels.

The service model advocated holistic treatments and multidisciplinary approaches that were to become the

focus of acute mental health care and rehabilitation in the community.

The service was intended to engage patients within the context of their own lives, families and communities. However, the operational system of mental health services has continued to be predominantly hospital-based.

11.3 SHORTCOMINGS IN EXISTING SERVICE PROVISION

The present adult mental health service provision demonstrates the following shortcomings:

- While the concept of multidisciplinary teams is an aspiration shared by most service providers, in practice it remains a reality only among a minority of services[79]. Individual professionals work independently with service users who are referred to them. As a result, there are limited opportunities to engage in a multidisciplinary assessment of a person's needs and to construct an integrated care plan. Service planning and delivery has tended to be fragmented and dictated by the particular ideology of discreet professional groups.
- The social context of mental illness has often been overlooked with the result that very little practical

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- Adult mental health services are insufficiently community orientated and delivered.
- There is a serious dearth of suitable community-based facilities for the delivery of high quality care. This applies to community mental health centres, day hospital accommodation and community residences.
- The lack of specialised mental health services (such as mental health services for older people and for people with intellectual disability) has affected all services, but has specifically inhibited the development of general adult mental health services, whose resources have been stretched to cover a wide variety of individuals with specialist needs.

help has been offered to individuals in terms of managing and negotiating their needs 'back in the community'. One consequence of this shortcoming in services has been a high rate of relapse and readmission. Over 70% of all psychiatric admissions are readmissions[86].

- Outpatient services have tended to be determined by the resources available, rather than providing an integrated model of care that addressed the broad needs of the service user, including the biological, psychological and social aspects of presenting disorders.

- Comorbid difficulties and emotional needs arising from the experience of serious mental disorders have not always been given due regard in the care of service users. The emotional aspect of mental disorder and the disruption it can cause a person's social and occupational role and function requires consideration as part of any comprehensive care plan. The consultation process with service users revealed a major scarcity of psychological therapies to assist them in dealing with the subjective experience of mental illness and re-establishing healthy supportive relationships with significant people in their lives.

- Current service provision lacks a positive focus on the capacity of individuals to recover and lead lives that are personally and socially meaningful to them. A suitable understanding of what a truly 'recovery-oriented' policy of care means, needs to be clarified and operationalised so that both service providers and service users can feel more optimistic and confident that treatment strategies can achieve significant and lasting change.

11.4 FRAMEWORK FOR SERVICE PROVISION

This new policy proposes a service that will function as a key element in promoting positive mental health broadly in society, and offer specialist expertise to people with complex mental health disorders. It describes a person-centred, community-based, recovery-oriented model for adult mental health care, which is coordinated through CMHTs.

This model is informed by the values and principles outlined in Chapter One which should be reflected in every aspect of service delivery. The service provided should listen to people's needs and views and take them into account, and it should be available to its users when they need it.

While the intention is that these principles will be embraced throughout national mental health services, this policy framework does not presume that 'one size fits all'. It recognises that the values and actions recommended will require adaptation to the particular circumstances and culture of local sector services.

The mental health needs of adults come within the scope of the Disability Act, 2005[115]. The type of multidisciplinary assessment, treatment and care envisaged in this policy framework is in keeping with the requirements of this Act.

Fig 2.1 in Chapter Two presents a framework for adult mental health care that incorporates health promotion, natural supports and community resources available to an individual, primary care, and general adult mental health services.

11.5 HEALTH PROMOTION

Mental health promotion programmes and initiatives can be delivered effectively to the adult population in a variety of settings. It is important that these programmes set clear objectives and targets and evaluate their effectiveness.

Settings where health promotion is relevant include the community, workplace and educational institutions:

- **community settings:** A large body of evidence identifies the community as a key setting for health promotion activities. The WHO[123] emphasises the importance of a person-centred approach to community development where the focus is on developing the social, economic, environmental, and cultural well-being of communities, in particular its marginalised members.

- **workplace settings:** Workplace health promotion has been highly successful across Europe and has been found to reduce the incidence of work-related ill health and to support health-related practices in the workforce[123].

- **third-level educational settings:** Ireland has one of the highest levels of participation in third-level education within the EU. The importance of promoting positive mental health among this large third-level student population cannot be underestimated, with recent research showing a high percentage of students experiencing mental health difficulties including depression, anxiety, loneliness, substance misuse and suicidal behaviour[124]. It is recommended that a Health Promoting College Network be developed and implemented.

- **in-patient settings:** Acute in-patient units should be part of the Health Promoting Hospitals Initiative. Through the Irish Health Promoting Hospitals Network, this initiative aims to create hospital environments conducive to health, including mental health.

RECOMMENDATION 11.1: Education and promotion of positive mental health should be encouraged within the general community. These initiatives should have clearly specified goals and objectives and should be evaluated regularly.

RECOMMENDATION 11.2: A Health Promoting College Network should be developed and implemented.

11.6 PRIMARY CARE

The *National Health Strategy*[1] recognises the importance of primary care in 'keeping people well' and sees the promotion of health (including mental health) as a key element of primary care services. The prevalence of well-defined psychological problems has been estimated to be about 24% among those who consult with primary care providers[93,94]. The resources and training needs of personnel in these settings need to be appreciated and resourced to improve the recognition and intervention skills with this large subgroup of service users (see also Chapter Seven). Part of the function of the CMHT should be to provide support and consultation to primary care providers in managing or referring individuals with mental health problems, to clarify pathways to care when referral is indicated, particularly for urgent referral, and to facilitate continuity of care when an individual is discharged back to community living.

RECOMMENDATION 11.3: CMHTs should provide support and consultation to primary care providers in the management and referral of individuals with mental health problems.

11.7 GENERAL ADULT COMMUNITY MENTAL HEALTH SERVICES

General adult mental health services should provide mental health care in local sectors of approximately 50,000 population, coordinated through CMHTs. These teams should combine a diverse range of expertise and coordinate care through a number of treatment modalities and service structures.

11.7.1 COMPOSITION OF THE GENERAL ADULT CMHT

CMHTs function best when they are comprised of dedicated staff, whose main responsibility is working within that team, where there is an adequate skill mix relative to the needs of service users, and a single management structure that is self-governing. Within each catchment area of 300,000 population there should be six general adult CMHTs serving circa 50,000 population. These CMHTs should comprise the following range of professionals:

- two consultant psychiatrists
- two doctors in training
- two psychologists
- two psychiatric social workers
- six to eight psychiatric nurses
- two or three occupational therapists

- one or two addiction counsellors/psychotherapists
- two or three mental health support workers
- administrative support staff

The provision of two consultant psychiatrists is recommended to provide choice for the service user and to encourage the development of clinical specialisation within the CMHT. It is important that these teams contain the appropriate mix of competencies to provide comprehensive care to service users.

The needs of service users should determine the development of the specific skills required within the team. It may be appropriate to include psychotherapists, counsellors and other creative and recreational therapists within the composition of the CMHT and this should be considered when statutory registration for counsellors and psychotherapists has been established.

Adequate administrative support staff is essential to enable the CMHT to deal with the paper work associated with clinical work, and to assist in record keeping, service auditing and data storage.

Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

RECOMMENDATION 11.4: The proposed general adult mental health service should be delivered through the core entity of one Community Mental Health Team (CMHT) for sector populations of approximately 50,000. Each team should have two consultant psychiatrists.

RECOMMENDATION 11.5: It is recommended that a shared governance model, incorporating clinical team leader, team coordinator and practice manager be established to ensure the provision of best-practice integrated care, and evaluation of services provided.

11.7.2 PHYSICAL RESOURCES REQUIRED

- **outpatient clinics**

  There is a strong clinical consensus in many countries that outpatient clinics, based in community mental health centres or hospitals, offer a relatively efficient way to assess and intervene with a wide range of mental health difficulties, provided that these clinics are easily accessible. Initial appointments and follow-up timed appointments should be provided within the community mental health centre, as they offer a more attractive option for service users. In addition, assessment and treatment planning in the context of the community mental health facility make it easier to draw on the full range of expertise in the CMHT and to avoid protracted delays where users require specialised input from a member of the team. These clinics should be for consultation only and should not be vehicles for the prescribing of medication to repeat attendees. They should be suitably located and be well-designed, well-built and well-maintained.

- **Community Mental Health Centres**

  CMHTs should base their operations in a Community Mental Health Centre. These centres should be located close to other relevant community agencies, and have adequate space and facilities to accommodate the full clinical requirements of the CMHT. They should also present an ethos that is attractive and valued by service users.

- **day hospitals**

  The Community Mental Health Centre should include a day hospital. Day hospitals offer an alternative to in-patient admission for a proportion of service users. Social and psychological therapy programmes are offered in addition to medication for people with acute mental disorders whose needs can be met in a day hospital setting. There is good evidence that acute day hospital facilities are suitable for a quarter to a third of service users who would otherwise be admitted to hospital[125,126]. It is important that the service user's needs be considered and incorporated

in the development of day hospitals. The danger is that many seemingly desirable generic activities and therapy programmes may be offered as a matter of course without the collaboration of service users, whose actual needs should shape the particular range of activities on offer.

- **crisis houses**
  A crisis house is used for crisis intervention and for acute respite purposes. A crisis period should be brief; usually between 24 and 72 hours. Where it is possible to offer and deliver crisis intervention in the community this should be the preferred treatment option; for example, when the source of the crisis is in the family home a bed in a crisis house may be appropriate. A crisis house is not an intensive treatment option but rather a place of refuge, of understanding, and of support for individuals in crisis. The facility is not restrictive and offers each user an opportunity to deal with issues surrounding their lives by accessing appropriate interventions such as counselling, family therapy, psychology, social work or other available holistic options as required. Service users are encouraged to move on following the resolution of their crisis, with an option for appropriate support and follow-up contact should that be required. Evaluation of crisis houses has found that they are acceptable to service users and that they may offer an alternative to in-patient care for a proportion of those who would otherwise be admitted to hospital[127,128].

- **acute in-patient units**
  The provision of a high-quality acute in-patient unit based in a general hospital is an important element of a community-based mental health service. Its purpose is to provide a range of therapeutic interventions and clinical care options for service users experiencing severe and acute psychological distress, e.g. psychosis, severe depression. Admission is offered when it is established that the individual's acute care needs cannot be treated appropriately at home, or in an alternative, less restrictive, setting. Within the proposed policy framework, 50 beds will be provided for each mental health catchment area of 300,000 population. These beds may be located in a single unit, or may be divided across two units in the catchment area to facilitate easy access for service users and their carers. This provision of in-patient beds proposes a reduction of the number of beds available under current arrangements, but transition to this reduced bed capacity can only occur with the increased provision of community-based alternatives.

In-patient admissions should be coordinated and customised for each service user by the CMHT. For the duration of their in-patient stay, multidisciplinary care plans should be evolved and agreed with each service user.

The specific operational arrangements and management for in-patient units need to be determined within the context of each catchment area service, with clear pathways in and out of the unit being agreed with local CMHTs. Clear policies on visiting, leave from the unit, patient advocacy and the availability of resources for those with special needs – non-English speaking, the hard of hearing, etc – should be available to all service users. These operational systems and protocols should be designed in line with standards established by the Mental Health Commission[4].

One finding from the consultation process was that admission to in-patient units can be a time of immense disorientation and distress for service users and families. The need for great sensitivity on the part of the staff involved needs to be taken on board. Assessment during admission should consider not only the service user's acute mental health needs, but also their physical health status, dietary requirements and critical factors in their family or social system that have contributed to their current crisis. Service users need to have the opportunity to give feedback to staff on their experience of being resident in the unit [3,4,79].

RECOMMENDATION 11.6: CMHTs should be located in Community Mental Health Centres with consideration for easy access for service users. High quality day hospitals and acute in-patient care facilities should also be provided.

11.8 COMMUNITY-BASED INTERVENTION PROGRAMMES

The general adult CMHT should conduct assessments and provide a range of best-practice interventions for adults with complex mental health problems. It will incorporate a number of treatment modalities to deliver services to local sectors including home-based treatment, crisis intervention, outpatient and day hospital programmes, acute in-patient care and risk assessment.

Service provision in each of these modalities should be discussed and agreed between members of each CMHT and documented explicitly as part of the CMHT service protocol. In each of these modalities, members of the CMHT will operate in partnership with service users and their carers, and develop integrated recovery-oriented care plans.

In keeping with the use of the biopsychosocial model throughout mental health service provision, a comprehensive range of treatment options and interventions should be available to the service user, customised to their individual needs, and employing biological, psychological and social interventions in a coordinated and integrated manner. (See Annex 11 for a discussion of psychological and social therapies).

RECOMMENDATION 11.7: CMHTs should evolve a clear care plan with each service user and, where appropriate, this should be discussed with carers.

RECOMMENDATION 11.8: Each team should include a range of psychological therapy expertise to offer individual and group psychotherapies in line with best practice.

RECOMMENDATION 11.9: Service users and providers should collaborate to draw up clear guidelines on the psychological needs of users and the range of community resources and supports available to them locally.

In general there are now four main community-based intervention programmes employed in the effective delivery of community-based care:

- home-based care
- crisis intervention
- early intervention
- assertive outreach

11.8.1 HOME-BASED CARE

Home-based care is a treatment modality that responds to acute and severe mental health crises by engaging with the service user in their home setting. This treatment modality is provided through a group of professionals drawn from the general adult CMHT who can respond promptly to crises that occur in the lives of new or existing service users. A provisional care plan to address immediate needs is drawn up and agreed with service user and carer.

The introduction of home-care treatment in a number of Western countries has been found to be greatly appreciated by service users and carers and to dramatically impact on the need for hospital admission[129,130]. Every effort should be made to provide treatment solutions other than admission to hospital, which should be employed only as a last resort. Short-term living options, which may be available through respite provision in high-density urban settings, or through relatives or voluntary organisations, may also be considered as a way to provide short-term relief in a crisis, where appropriate.

Given the specialist expertise involved in the provision of home-based treatment, a number of dedicated

members of the CMHT should form a core sub-team and be responsible for this aspect of the service. Different expertise from within the CMHT can be co-opted to the home-based service, depending on the particular needs of service users. This home-based treatment team should report regularly to weekly CMHT meetings and function as a triage and gatekeeper element.

Referrals should be directed to the home-based treatment team via the CMHT. The home-based treatment team assumes responsibility for the care of the individual in crisis and this may involve liaising with other agencies or settings where the crisis occurs, for example Garda stations, third-level educational institutions, and work settings.

Individuals being seen by the home-based treatment team should be reviewed regularly with the full CMHT to ensure coordination of care within the specialist mental health services. Regular discussion within the CMHT should also afford opportunities to review clinical formulation and care plans and consider what additional expertise from within the CMHT or the wider catchment area may be appropriate.

RECOMMENDATION 11.10: Home-based treatment teams should be identified within each CMHT and provide prompt services to known and new service users as appropriate. This sub-team should have a gate-keeping role in respect of all hospital admissions.

11.8.2 CRISIS INTERVENTION

With the provision of a full range of CMHTs and programmes for adults with mental illness, and the closer contact envisaged between service users and their carers, the likelihood of unforeseen and unexpected crises arising should be reduced. However, each adult CMHT will need to agree protocols for ensuring a prompt response to crises that develop within their particular sector. This should be available on a 24/7 basis and should include the capacity to respond in a multidisciplinary way to a specific individual's crisis.

It is proposed that there should be a 'crisis house' within each catchment area, offering brief accommodation to service users who need a safe place to recover their bearings and work with the CMHT to evolve a care plan that will address the key factors that have precipitated their crisis.

RECOMMENDATION 11.11: Arrangements should be evolved and agreed within each CMHT for the provision of 24/7 multidisciplinary crisis intervention. Each catchment area should have the facility of a crisis house to offer temporary low support accommodation if appropriate.

11.8.3 EARLY INTERVENTION

In recent years, there has been an increasing emphasis on prompt identification and intervention with initial or early episodes of psychosis[131,132]. Emerging evidence indicates that there is a clear relationship between the length of time it takes to respond to an individual's first experience of psychosis – the 'duration of untreated psychosis' (DUP) – and long-term outcome for that service user[133,134]. This finding has promoted a movement in many Western countries to establish specialist Early Intervention Services (EIS).

EIS consist of specialist multidisciplinary teams dedicated to the care of people with a first episode of psychosis. They differ from standard care in two distinct ways – they focus on early detection of established cases of psychosis and they offer specialised and intensive interventions.

Most EIS are based on populations of 350,000 and care for people in the first three to five years after a first episode. They are recovery-focused and employ innovative and youth-oriented approaches to engage young adults and their families. They provide services predominantly in local community facilities, in environments that are least restrictive, intrusive and stigmatising. Vocational support is also vital to enable young people make a non-stigmatised and seamless transition back toward their goals.

There is some evidence to show that EIS reduce the duration of untreated psychosis, reduce the severity of symptoms, reduce suicidal behaviour, reduce the rate of relapse and subsequent hospitalisations and are highly thought of by both those who use such services and their families[135,136]. From a health economic perspective EIS involvement has been shown to be cost effective[137]. A pilot EIS project in South Dublin and Wicklow is currently underway and may provide a stronger evidence base and a specific protocol for the implementation of early intervention teams in an Irish urban context. It is recommended that this study be replicated in a second catchment area with different socio-demographic characteristics with a view to establishing the efficacy of EIS for the Irish mental health care service.

RECOMMENDATION 11.12: In addition to the existing Early Intervention Services (EIS) pilot project currently underway in the HSE, a second EIS pilot project should be undertaken with a population characterised by a different socio-demographic profile, with a view to establishing the efficacy of EIS for the Irish mental health service.

11.8.4 ASSERTIVE OUTREACH

Assertive outreach, the fourth of the community-based intervention programmes, is employed predominantly in the community rehabilitation of people with enduring illness that has caused substantial impairment and disability. It is dealt with in detail in Chapter Twelve.

11.9 DIFFICULT TO MANAGE BEHAVIOURS

Difficult to Manage Behaviours (DMBs) can pose the most serious challenges to services and represent serious risk to the service user and to others. Difficult to manage behavioural disturbances require intensive multidisciplinary intervention to produce any significant change.

Service users who present with DMBs are broadly divisible into two clinical types - those with acute short-lived disturbance, typically the consequence of psychotic illness, and those with more enduring mental health problems and associated challenging behaviour. The former require close observation for a relatively short period during the acute phase of illness. The second group requires longer-term care and rehabilitation in purpose-built accommodation. In addition, outpatients with mental health problems in the context of a borderline personality disorder can pose significant challenges to CMHTs and require explicit treatment protocols in line with current best practice (see Chapter Fifteen, section 15.8).

11.9.1. THE CURRENT EXTENT OF ACUTE DMB AND CLOSE OBSERVATION PROVISION

There is no reliable information available on the extent of acute disturbance requiring care in close observation sub-units, although data exists on the use of seclusion and one-to-one nursing observation in Irish psychiatric services in 2003 and this offers a measurement of such disturbance: 682 patients were secluded and 934 patients received special one-to-one nursing[44]. Close observation facilities exist at some Irish acute general hospital units. Some are separate, self-contained sub-units of the main unit with from three to nine beds and perhaps including a seclusion room. A few units provide self-contained dining, day and garden facilities. In others, there is safe room and observation station provision. The units which have close observation sub-units report that virtually all acute short-lived disturbance can be treated in that setting and that for a catchment of 100,000 two beds are adequate. On this basis, the most desirable response to the acute disturbance issue nationally is for a maximum of 80 beds in acute units.

11.9.2 WHAT IS REQUIRED FOR ACUTE DMB?

This policy has recommended that there be one acute in-patient unit of 50 beds each per catchment area of 300,000 population. Each of these 50-bedded units should have a close observation area containing 6 bedrooms, flexibly used as to gender, and one seclusion room. This sub-unit should be flexibly designed so that it can be integrated or separated from the main unit, and when not required for DMB is available for routine usage. Where possible this unit should have a separate external entry for severely disturbed admissions. It will not require a dining provision but it is essential that there be adequate space for patient management and comfort with foyer and lounge arrangements together with adequate bathroom facilities. This should be available in all general hospital units; and has been provided in the newer units.

RECOMMENDATION 11.13: Each 50 bed acute psychiatric unit should include a close observation unit of six beds.

11.9.3 THE CURRENT EXTENT OF ENDURING ILLNESS DMB AND INTENSIVE CARE PROVISION

There has been no survey of the prevalence of enduring illness DMB in Irish mental health services. In the past, these individuals were dealt with by keeping many wards in psychiatric hospitals locked, with many patients needlessly confined. Some wards were identified as 'refractory' and specially designated for the care of individuals with DMB.

With the passage of time and increasing openness in psychiatric in-patient settings, the locked ward became the exception. In certain hospitals however, locked wards continued to be used exclusively for DMB. Current locked ward provision has been used to crudely estimate the need for this group (see Annex 11 for a description of DMB services nationally).

11.9.4 WHAT IS REQUIRED FOR ENDURING ILLNESS DMB?

The issue of care for people with DMB was considered by a *Working Group on the Care of the Disturbed Mentally Ill* appointed by the Department of Health in the 1990s. This Working Group issued a discussion document to the then Health Boards. The Health Boards recommended the development of intensive care units in each Health Board area. However, best estimates now suggest that a regional requirement, rather than a catchment area one, is more appropriate.

It is recommended that four of these intensive care rehabilitation units be provided nationally, one in each HSE region containing 30 beds (a total of 120 nationally). These 30 beds should be in two sub-units of 15 beds each. Intensive care rehabilitation units (ICRUs) should be staffed by a multidisciplinary team with appropriate experience and training, particularly in the area of rehabilitation and recovery. The use of the term 'intensive care rehabilitation' stresses the central importance of rehabilitation and recovery interventions for this group.

The use of the ICRUs should feature as part of a network of regional services and should function smoothly and efficiently in that context. This will require organisational structures and functions and policies that are clearly understood and agreed. Thus the movement and transfer arrangements between the acute unit, close observation area, ICRU and community-based facilities must be smooth and flow easily. In the context of the Criminal Law Insanity Bill there should be good working relations between forensic services and the ICRU. There must also be joint clinical management between catchment area CMHTs and the ICRU team.

RECOMMENDATION 11.14: Each of the four HSE regions should provide a 30-bed ICRU unit – with two sub-units of 15 beds each – to a total of 120 places nationally, staffed with multidisciplinary teams with appropriate training.

In association with ICRUs, and as part of continuing rehabilitation, there is a need for community residences of especially high support. These facilities should be specially designed to function as high support intensive care residences. They should be provided on a regional basis with two in each region of ten places and operating in close association with the ICRUs. This will provide a national complement of 80 places.

RECOMMENDATION 11.15: Each of the four HSE regions should provide two high support intensive care residences of ten places each.

11.9.5 GOVERNANCE OF INTENSIVE CARE REHABILITATION UNITS

The operation of ICRUs should be to the highest ethical and professional standards. Operational policies and principles should be developed in consultation with service users and should be clearly understood, subscribed to, and adhered to by all team members throughout the entire service. Arrangements should be agreed locally to nominate a designated clinical director for these units to fulfil the terms of the Mental Health Act, 2001[82].

ICRUs must have:

- clearly defined admission and discharge criteria
- an agreed referral process
- clear and unambiguous operational policies and procedures
- full documentation of the previous three requirements, presented to all staff as part of the induction process and readily accessible at all times
- an appropriate physical environment
- cohesive multidisciplinary team functioning
- close liaison with general adult mental health services
- appropriate risk management procedures
- staff trained and conversant with a variety of techniques essential to good ICRU function and operation, such as prediction and prevention of disturbed or violent behaviour, de-escalation, physical interventions, seclusion, rapid tranquillisation, resuscitation and defibrillation.

11.10 RISK ASSESSMENT

The development of clinical risk-management and risk-assessment approaches within mental health settings is essential. Reducing exposure to litigation and financial risk addresses just one narrow aspect of the risk-management agenda. The recording and analysis of adverse events in clinical risk management must be seen in a wider context of service user safety, staff safety, quality service delivery and clinical governance.

11.11 RECOMMENDATIONS

1. Education and promotion of positive mental health should be encouraged within the general community. These initiatives should have clearly specified goals and objectives and should be evaluated regularly.

2. A Health Promoting College Network should be developed and implemented.

3. CMHTs should provide support and consultation to primary care providers in the management and referral of individuals with mental health problems.

4. The proposed general adult mental health service should be delivered through the core entity of one Community Mental Health Team (CMHT) for sector populations of approximately 50,000. Each team should have two consultant psychiatrists.

5. It is recommended that a shared governance model, incorporating clinical team leader, team coordinator and practice manager be established to ensure the provision of best-practice integrated care, and evaluation of services provided.

6. CMHTs should be located in Community Mental Health Centres with consideration for easy access for service users. High quality day hospitals and acute in-patient care facilities should also be provided.

7. CMHTs should evolve a clear care plan with each service user and, where appropriate, this should be discussed with carers.

8. Each team should include a range of psychological therapy expertise to offer individual and group psychotherapies in line with best practice.

9. Service users and providers should collaborate to draw up clear guidelines on the psychological needs of users and the range of community resources and supports available to them locally.

10. Home-based treatment teams should be identified within each CMHT and provide prompt services to known and new service users as appropriate. This sub-team should have a gate-keeping role in respect of all hospital admissions.

11. Arrangements should be evolved and agreed within each CMHT for the provision of 24/7 multidisciplinary crisis intervention. Each catchment area should have the facility of a crisis house to offer temporary low support accommodation if appropriate.

12. In addition to the existing Early Intervention Services (EIS) pilot project currently underway in the HSE, a second EIS pilot project should be undertaken with a population characterised by a different socio-demographic profile, with a view to establishing the efficacy of EIS for the Irish mental health service.

13. Each 50 bed acute psychiatric unit should include a close observation unit of six beds.

14. Each of the four HSE regions should provide a 30-bed ICRU unit – with two sub-units of 15 beds each – to a total of 120 places nationally, staffed with multidisciplinary teams with appropriate training.

15. Each of the four HSE regions should provide two high support intensive care residences of 10 places each.

CHAPTER TWELVE

Rehabilitation and recovery mental health services for people with severe and enduring mental illness

12.1 INTRODUCTION

People with severe and enduring mental illness can experience a range of problems that result in their lives becoming restricted and impoverished.

This group of service users is perhaps the most vulnerable in the mental health service, and ultimately, the quality of the service overall can be measured by the quality of care provided to this group. Many of the problems associated with this care group in the past reflected limitations in

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Difficulties may arise as a direct or indirect result of the disorder; persistent symptoms can cause distress for the individual and for those around them, and medication may create disabling side-effects, while non-compliance can lead to dis-engagement from therapeutic programmes and likely relapse.

Other problems can arise in a service context, where the skills and resources required to promote meaningful recovery are unavailable. In the absence of comprehensive recovery-oriented care, problems experienced by service users include loss of self-confidence and sense of purpose in life, institutionalisation, unemployment, social isolation and housing difficulties.

professional appreciation of their emotional and practical needs, and also a limited appreciation of their potential to grow and develop as individuals through and beyond the experience of severe illness.

Rehabilitation and recovery CMHTs provide specialised services for people disadvantaged by a range of problems that can develop with severe mental illness, and which cannot be adequately met by the general adult CMHTs.

'Rehabilitation' in this context describes a facilitative process that enables disadvantaged individuals to access as independent a life as possible in social, cultural and economic terms.

Underpinning the work of the rehabilitation team is a strong commitment to the principle of recovery. 'Recovery' used here reflects the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.

Commitment to the recovery principle in rehabilitation mental health is so critical that specialised services dedicated to this group will be referred to in this policy as 'rehabilitation and recovery mental health services'.

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In this chapter, a service model is described which sets out a comprehensive framework appropriate to the needs of this group of service users.

RECOMMENDATION 12.1: A strong commitment to the principle of 'Recovery' should underpin the work of the rehabilitation CMHT - the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.

12.2 CURRENT SERVICE PROVISION IN IRELAND

The programme of ward closure accelerated following the publication of *Planning for the Future*[75] and the number of in-patients in mental hospitals continued to decrease from a total of 19,801 in 1963 to 3,556 in-patients in mental hospitals at the end of 2004[79]. A significant rise in community-based facilities paralleled this decline in bed usage, giving rise to over 3,100 community residential places under the care of the mental health services in 2004[87].

Significant numbers of long-stay service users, particularly the elderly and people with intellectual disability, were 'discharged' through de-designation, a process which re-categorised the facility in which they were living as no longer being part of a mental hospital.

This programme had a limited vision of rehabilitation; which equated it with re-settlement and maintenance. As a result, these service users were no longer considered to have mental health problems and were not subject to the protections of the Mental Treatment Act, 1945[80]. However, many did still have significant problems in living their daily lives. The discharge to community residential facilities, which were often little more than replacement long-stay wards – in their size and in the absence of active rehabilitation programmes – was preceded by a variable degree of rehabilitation.

The lack of appropriate services for this group of service users has had major consequences for mental health services and for the individuals themselves. In addition to the distress of illness, they are at high risk of ending up homeless, becoming involved in petty crime, being inappropriately imprisoned, or being in a state of social isolation and dereliction.

Of particular relevance to people with severe and enduring mental illness is the risk of repeated involuntary detentions. Frequently they are referred to the mental health services and re-admitted for acute care, despite clear evidence of the failure of a predominantly

medication-based, bed-based service to meet their needs. They may be discharged after repeated admissions with their core needs unaddressed. These difficulties have resulted in criticisms being levelled at community-based services for the failure to facilitate this group in re-integrating with their own communities.

Many of this group experience substantial distress resulting from persistent symptoms, institutionalisation and loss of selfhood and require individualised, specialised interventions. With appropriate recovery-oriented programmes, many could reach a level of functioning sufficient to live and enjoy a more independent life in the community.

12.3 DESCRIPTION OF THIS SERVICE USER GROUP

The service users for which the rehabilitation and recovery services are designed fall into four main groups:

- **long-stay in-patients:** people who have been continuously in mental hospitals for prolonged periods of a year or more.
- **discharged long-stay service users:** people who were previously discharged from long-stay wards and who now live in staffed community residences or supported housing in the community.
- **new long-stay service users:** people who, in recent times, have passed from acute to long-term care. Some have been retained in hospital for long periods because of the nature and severity of their illness. Some are long-stay on acute units, though in some services they are transferred to long-stay wards.
- **new service users with severe and complex mental health problems:** people who have presented with severe illness since the deinstitutionalisation programme began. They may never have been in a long-stay ward, but some will have had multiple admissions to acute wards. If living with relatives, the effects of their disorder may place considerable burden on their carers. Some may never have been admitted to hospital and are particularly at risk of becoming homeless or spending time in prison.

12.4 ESTIMATE OF THE NUMBER OF PEOPLE WITH SEVERE MENTAL ILLNESS

There was a total of 3,556 in-patients in hospital at the end of 2004[79]. Of this group, 1,242 were in hospital for longer than five years, a rate of 41.0 per 100,000 population over 16 years. Six hundred and thirty of these were aged 19-64 years (51%), 558 (45%) were over 65 years. In addition to these long-stay service users, 615 in-patients were categorised as 'new long stay' (in hospital for more than one but less than five years). Three hundred and twenty six of this new long-stay group were under 65, and 282 were over 65 years[79].

12.5 GAPS IN EXISTING SERVICES

Shortcomings in the existing services for people with severe and enduring mental illness include the following:

- At present, there are only five specialist rehabilitation teams in the country. No team has the full range and number of staff required and only two of these rehabilitation CMHTs have sufficient staffing to provide a service to the four core client groups.
- Current service provision doesn't address the broad needs of service users for social as well as clinical recovery. There is a need for a well-developed and shared philosophy of recovery-oriented care and of structured, person-centred, recovery-oriented programmes for service users with severe and enduring mental illness.
- The family and friends of those who have severe mental illness carry a significant burden of care. This frequently goes unrecognised and unacknowledged by service providers. Services need to provide families and carers with support, information, and easily accessible help when needed.

- Many of the current vocational training programmes which are a key component of rehabilitation and recovery, do not meet the needs of service users for moving into mainstream employment.
- There is a serious lack of adequate housing and accommodation options for enabling service users to move through the different stages of recovery and progress towards the goal of independent community-based living.
- There is a lack of advocacy and peer support for this group of service users within the mental health system.

12.6 FRAMEWORK FOR SERVICE PROVISION

Given the number of people requiring specialist rehabilitation services, the geographic spread of people requiring such services and the size of the required team, specialist services for people with severe and enduring mental illness are best structured on the basis of one team per 100,000 of the general population.

It is recommended that three multidisciplinary teams be provided in a mental health catchment area of 300,000 (one per 100,000). A minimum of 39 teams are needed nationally. Indications are that there are adequate numbers of staff already in the system to form the core of these teams.

Re-allocation of existing staff to rehabilitation and recovery teams must ensure that the required training is provided to equip them with an understanding of the philosophy and the specialist skills embodied in this recovery-oriented service model. All teams are likely to require new appointments in clinical psychology, social work and occupational therapy and other professionals who can bring a recovery perspective and a mix of skills to this service.

RECOMMENDATION 12.2: Some 39 rehabilitation and recovery CMHTs should be established nationally, with assigned sector populations of 100,000. Assertive outreach teams providing community-based interventions should be the principal modality through which these teams work.

12.7 CORE STAFFING OF A REHABILITATION ADULT MENTAL HEALTH SERVICE

There is an established knowledge base and range of specialised measures which are essential if service users are to be adequately assessed and their needs appropriately addressed.

By definition, these people have disabilities which persist in the long term and this, in addition to the associated social supports they require, makes it essential that a range of specialised resources are made available. Dedicated CMHTs are required to coordinate and optimise the use of these resources.

The composition of these teams should include the following:

- one consultant psychiatrist
- 10-15 psychiatric nurses for Assertive Outreach Nursing Team (maximum case load of 12 service users to one nurse)
- mental health support workers – based on numbers of service users who require such support, who can provide peer support and advocacy
- two occupational therapists
- two social workers
- two clinical psychologists
- cognitive behaviour therapist/psychotherapist
- addiction counsellor
- additional staff:
  – domestic skills trainer
  – creative/recreational therapists

- administrative support
- staff associated with day centres and community residences.

Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

12.8 PRINCIPLES FOR THE WORKING OF REHABILITATION TEAMS

Given the nature and complexity of the problems experienced by this care group, specialist rehabilitation mental health services must operate on a different time-scale to acute services.

Setbacks are an inevitable part of the recovery process. Since the core principle of rehabilitation and recovery is to facilitate individuals so that they may reach their maximum level of independence, rehabilitation mental health services must be strongly person-centred, with the needs of the individual service user always at the centre of the working of the team.

There are a number of key principles underpinning the functioning of a rehabilitation and recovery mental health team:

- **assertive outreach:** the central principle is the provision of individualised, focused and proactive care to service users to minimise the risk of disengagement and to maximise involvement in the recovery process. Service users with severe mental illness do not do well in a demand-led health service. As a result, the concept of 'assertive outreach' care has developed. A subgroup within the team, usually psychiatric nurses, should be the main providers of assertive outreach care. Each member of the assertive outreach team will be the key contact for a number of their service users. It is recommended that the optimum number of service users per key contact is 10–12, but this may vary depending on the level of input each service user needs.
- **person-centred:** the use of person-centred, realistic, recovery-orientation should be evident in detailed individual assessment and carefully formulated care plans. Detailed and intensive follow-through of these care plans is critical to the success of this service.
- **practical:** rehabilitation and recovery team members have a role to play in offering direct practical help to the service user, particularly those with severe illness. Help with obtaining benefits, budgeting, shopping and child minding may be appropriate in fostering independence and effective integration in their local communities. In meeting the objective of returning people to valued life experiences, care should be taken to offer this help in a way that empowers the user, rather than encouraging passive dependency.
- **key worker designation:** the allocation of a key worker to each service user and their carers, so that every service user and carer has direct and easy access to a known team member. The role of the key worker is to establish a close relationship with the service user, to take responsibility for actively remaining in contact with them and to take the initiative in making contact if they fail to do so. The key worker coordinates the care input from all other team members and provides feedback to the team on progress. The key worker also provides a link between the service user's informal carers and the team. Any member of the rehabilitation team may be a key worker.
- **liaison with other agencies:** close liaison with other agencies, both statutory and voluntary, is required to access maximum support for service users. These agencies include: housing agencies, employment training agencies, employment support agencies, all relevant voluntary support groups and self-help groups, health services and statutory support services

(general practitioners, public health nurses, home helps, community occupational therapists, etc).

12.9 FACILITIES FOR RECOVERY AND REHABILITATION CMHTS

The following physical resources should be provided for rehabilitation and recovery CMHTs:

Team Headquarters: a community facility large enough to provide a working base for all team members. Such a headquarters should ideally be placed in a community mental health centre and may be shared with other specialist teams, such as general adult community mental health teams.

Day Centre: a facility that provides individualised programmes for service users who are unable to avail of community-based employment or recreational activities. One to two centres per catchment area, depending on population density will likely be required, offering a total of 30 places.

Service user run centres and peer-provided services: These services are particularly relevant to the users of rehabilitation and recovery mental health services. They offer opportunities for peer support and re-integration and independence in the community. It is recommended that these services be linked to and supported by the CMHT. These support centres offer flexible, broad-based support to all service users both on a drop-in basis and on a planned basis.

Access to acute in-patient care: the rehabilitation team should have direct access to in-patient care in the catchment in-patient unit if required.

RECOMMENDATION 12.3: The physical infrastructure required to deliver a comprehensive service should be provided in each sector. Rehabilitation and recovery CMHTs should have responsibility for those physical resources appropriate to the needs of their service users, such as community residences.

12.10 ACCOMMODATION NEEDS OF PEOPLE WITH SEVERE MENTAL ILLNESS

The majority of new service users with severe mental illness will not require community residential facilities, but will need varying degrees of support to live in individualised, independent accommodation.

The statutory responsibility to provide this housing is not within the remit of the mental health services or the HSE. Close cooperation with relevant housing authorities is required to ensure this obligation towards people with severe and enduring illness is honoured. Tenancy agreements need to be developed and agreed between service users and specific housing authorities. The standard and quality of these facilities should be closely monitored and recorded by the CMHT.

The need for 24-hour-staffed residences will decrease once the cohort of former long stay hospital service users has been catered for. In the long term, there will a requirement of approximately 30 places in large urban areas, with fewer required in areas with low deprivation levels. These residences should have a maximum of ten places to foster a non-institutional environment. Some may be designated to provide social respite care.

Due regard should be given to the sensitivities of core residents of a facility, if certain rooms are used for short-term respite care. Nursing staff in these residences should be predominantly involved in therapeutic activities with residents, rather than with domestic or administrative activities.

A flexible policy needs to be adopted by rehabilitation and recovery teams as service users progress through different housing arrangements in the course of their recovery. Staff also need to be flexible and recovery-oriented, encouraging movement through the system of available housing options.

As the general adult CMHTs develop, the need for the current accommodation resources in mental health

services (such as high, medium and low support community residences and group homes) should diminish. These should then become part of the resource available to the rehabilitation team. A local plan for the transitional arrangements to achieve this should be drawn up by the catchment area management team.

RECOMMENDATION 12.4: 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 best enable service users to move from high support to low support and independent accommodation need to be considered.

RECOMMENDATION 12.5: Rehabilitation and recovery mental health services should develop local connections through linking with local statutory and voluntary service providers and support networks for people with a mental illness is required to support community integration.

RECOMMENDATION 12.6: All current staff within the mental health system who are appointed to rehabilitation and recovery services should receive training in recovery-oriented competencies and principles.

12.11 RELATIONSHIP WITH CATCHMENT AREA SPECIALIST MENTAL HEALTH TEAMS

Protocols for appropriate working relationships with other specialist teams are essential. These protocols should address liaison, referral, discharge and use of shared facilities. While the majority of referrals will come from the general adult mental health services there will need to be a particularly effective relationship with forensic services, addiction services and mental health services for the homeless.

A relatively small number of people with severe mental illness will present with problems of seriously disturbed behaviour and may have had contact with the criminal justice system and the forensic mental health services. Others may never have been charged with a crime, although considered a particular risk to others.

These individuals require specialist care in a secure environment and require joint input from the rehabilitation and recovery mental health services and the forensic mental health services. A national network of high-support intensive care residences, providing in the region of 80 beds nationally, is required for this group of service users. These units should have joint inputs from rehabilitation teams and forensic teams.

Service users with severe mental illness who abuse alcohol and other drugs will frequently have had contact with addiction services, general adult services, forensic services and rehabilitation services. The service most suitable to care for such people will depend on individual circumstances and shared care will be necessary in many cases.

Many individuals with mental health problems who are homeless have severe mental illnesses. While first contact with the mental health services may be through a mental health service for the homeless, a proportion will benefit from transfer to a rehabilitation service.

12.12 TRAINING AND EMPLOYMENT CONSIDERATIONS

In the past number of years, with the introduction of rehabilitation training and vocational training for service users, there have been many positive developments in the quality and standard of programme delivery, in particular in the area of rehabilitation training. People with mental health difficulties can now access programmes which acknowledge their need for a more rounded approach in programme design and delivery. However, significant difficulties exist in accessing employment at the end of such programmes.

People with mental health difficulties are still the least likely of all the disability groups to gain employment in the open labour market. This is partly a result of the social and personal barriers unique to people with residual difficulties arising from severe mental illness. Social barriers may result from the poor understanding of severe mental illness. Personal barriers to achieving and sustaining open employment can result from functional difficulties associated with severe and long-standing mental health problems: fear of failure, lack of self-confidence, limited attention span, maintaining stamina throughout the work day and managing time pressure and deadlines.

A primary consideration of the rehabilitation service should be the development of person-centred systematic programmes to help users address and overcome these difficulties. Vocational training and employment are not the responsibility of the mental health services, but there is a need for rehabilitation and recovery services to liaise with the agencies that do have statutory responsibility in this regard, and ensure that whatever arrangements are offered, are in the best interest of the service user.

In addition, there is a need for training providers to develop training and employment support services to facilitate recovery and re-employment. Providers are aware of this under the *Qualifications (Education and Training) Act 1999*[138], which stipulates that the learner and their needs are at the centre of the training programme.

There is also a need for joint working between the rehabilitation team and the institutions responsible for these individuals. Models of good practice that have been demonstrated by agencies working in the area of vocational and rehabilitative training and work services need to be supported and developed.

There is a need to reverse the trend which saw many service users attending multiple training courses without being equipped to proceed to real employment, and also to do away with some training and workshop facilities that do not meet required standards. Some employment support schemes do not meet the needs of those with severe mental illness and this problem requires priority consideration. The 'place and train' models of individual placement and support (IPS) programmes have shown increased rates of 'real' employment compared with traditional vocational approaches[48,49]. In these programmes service users are placed in real jobs and then offered direct personal training and support to help them succeed in their work.

RECOMMENDATION 12.7: The development of formal coordination structures between health services and employment agencies should be a priority if the delivery of seamless services is to be facilitated.

RECOMMENDATION 12.8: To facilitate the service user in re-establishing meaningful employment, development of accessible mainstream training support services and coordination between the rehabilitation services and training and vocational agencies is required.

12.13 GUARDIANSHIP LEGISLATION

In addition to the problems posed by severe and enduring illness, some service users may develop an increasing sense of learned helplessness when it comes to managing critical aspects of their everyday affairs.

Some may be unable to make informed decisions regarding some aspects of their life, e.g. money management, choice of residence, and consent to medication and other interventions. The recent consultative paper from the Law Reform Commission recognises this and makes proposals for a new type of individualised, flexible guardianship[139]. This will be of benefit to these service users, allowing them to remain as independent as possible while receiving necessary protection.

12.14 EVALUATION OF REHABILITATION AND RECOVERY SERVICES

Evaluation of these services should consider improvements in quality of life for service users and the level to which each has achieved a meaningful level of recovery, in terms of the agreed aims and objectives stated in their care plan.

In addition, evidence of increased social support networks, reduced admissions, and re-integration into the community should also be monitored and evaluated objectively.

Measures must incorporate feedback from service users and their carers. This information should be considered by the full rehabilitation and recovery CMHT and directly inform service improvement and development.

RECOMMENDATION 12.9: Evaluation of services to the severe and enduring service user group should incorporate quality-of-life measures and assess the benefit and value of these services directly to service users and their families.

12.15 RECOMMENDATIONS

1. A strong commitment to the principle of 'Recovery' should underpin the work of the rehabilitation CMHT - the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.

2. Some 39 rehabilitation and recovery CMHTs should be established nationally, with assigned sector populations of 100,000. Assertive outreach teams providing community-based interventions should be the principal modality through which these teams work.

3. The physical infrastructure required to deliver a comprehensive service should be provided in each sector. Rehabilitation and recovery CMHTs should have responsibility for those physical resources appropriate to the needs of their service users, such as community residences.

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

5. Rehabilitation and recovery mental health services should develop local connections through linking with local statutory and voluntary service providers and support networks for people with a mental illness is required to support community integration.

6. All current staff within the mental health system who are appointed to rehabilitation and recovery services should receive training in recovery-oriented competencies and principles.

7. The development of formal coordination structures between health services and employment agencies should be a priority if the delivery of seamless services is to be facilitated.

8. To facilitate the service user in re-establishing meaningful employment, development of accessible mainstream training support services and coordination between the rehabilitation services and training and vocational agencies is required.

9. Evaluation of services to the severe and enduring service user group should incorporate quality-of-life measures and assess the benefit and value of these services directly to service users and their families.

CHAPTER THIRTEEN

Mental health services for older people

13.1 INTRODUCTION

As life-expectancy in Ireland grows, it is increasingly important to consider the particular mental health needs of people in later life and to provide a comprehensive range of services appropriate to their needs. While all users of mental health services are entitled to knowledge of their right to services, and access to delivery of those services, this is crucial in the case of older people.

Home-

Service providers addressing the needs of older people must subscribe to their inherent worth, respect their dignity and care for them on the basis of equity, fairness and accessibility. A prime consideration is that mental health services for older people (MHSOP) should be person-centred and promote self-determination.

Dedicated MHSOP teams, attuned to the special needs of older people with mental health problems, are a recent development in Ireland. Previously, older people with mental health problems were dealt with by the generic adult mental health services. This resulted in a service that was not attuned to the special needs of older people with mental illness; they were being cared for by professionals who had neither the special training nor expertise needed to meet their unique requirements.

The critical principle in service provision for older people, including those living in the community, is that – regardless of their mental health history – they should have access to the services most appropriate to their needs. In principle, anybody aged 65 years or over with primary mental health disorders, or with secondary behavioural and affective problems arising from dementia, should be cared for by a MHSOP team.

People with a previous history of mental health problems, including those with severe and enduring mental illness, may already have an established relationship with their local general adult mental health service. On turning 65 years old, they should be afforded the option of choosing to continue this relationship, but they should also be afforded the option, to which they are entitled, of transferring their care to their local MHSOP team. The final decision should be based on which team can best meet the particular needs of the individual.

The preference of the majority of older people with mental health difficulties is that whatever care they require be offered to them in the context of their own home. This has implications for carers and family members who may be living with them and whose contribution should be appreciated. The role of carers in the older person's life should be considered in every aspect of service provision. It is essential that carers be given support and education regarding the complex and challenging mental health problems experienced by those in their care.

While the importance of quality health services for older people cannot be over-emphasised, it is equally important not to over-medicalise the process of ageing and limit society's thinking about ageing to issues of disease, treatment and frailty.

These difficult realities can be part of the experience of ageing but so also can the capacity for growth and change in later life and the vital contributions that older people can and do make within their communities.

As the numbers of people entering later life increase substantially in coming years, it is likely that the voice of the older adult will be far less muted and will demand a quality of life that far exceeds current restricted myths

based

RECOMMENDATION 13.1: Any person, aged 65 years or over, with primary mental health disorders or with secondary behavioural and affective problems arising from experience of dementia, has the right to be cared for by mental health services for older people (MHSOP).

13.2 MENTAL HEALTH AND AGEING

People of advancing years are faced with a number of stresses and challenges resulting from loss of close attachments, changes to their vocational and social roles, and depletion of their general health and physical capacities.

about ageing. Nevertheless, there are conditions that develop among some older people that require MHSOP.

Three main conditions come within the remit of this specialist service:

- functional disorders, of which depression is the most prominent
- organic brain disorders (dementia in particular)
- other disorders such as anxiety, substance abuse - mainly of alcohol - and to a lesser extent psychosis (schizophrenia-like disorders) arising for the first time in later life.

For a more detailed account of the prevalence of these disorders in Irish samples of older adults, see Annex 13.

13.3 THE IMPACT OF DEMOGRAPHIC CHANGE

Dementia and depression increase in the population as the numbers of adults over 65 increases. Predicted demographic changes in Ireland will have considerable impact on the numbers of older persons requiring MHSOP.

Table 13.1 sets out the population numbers projected in three later-life age groups and the percentage of the total population that they represent. The implications for the increased numbers of people with depression and dementia, based on prevalence estimates of 11% depressive syndrome and 5% for dementia, are also presented.

The table highlights the predicted doubling of the number of people over 65 years in the next 20 years and signals the need for expanded mental health services to respond to the growing need for specialist care among older adults[140].

13.4 CURRENT MENTAL HEALTH SERVICE PROVISION FOR OLDER PEOPLE

While the number of catchment areas with MHSOP teams continues to increase there are still many without any specialised mental health service. Currently there are 20 consultants supported by teams of varying degrees of completeness.

Most services cater for a population of older persons in excess of the recommended norm of 10,000[141]. There are staffing shortfalls at senior nursing level and inadequate numbers of occupational therapists, social workers and clinical psychologists.

In terms of physical resources, there are 62 acute designated assessment and treatment beds, some in specially designated locations within acute general hospital units; others available for MHSOP on request from the general psychiatric beds rather than being specifically designated. There are seven day hospitals providing somewhat less than 100 places and 469 continuing care beds.

Table 13.1: Population projections for selected years and age groups. Estimated depressive syndrome and dementia numbers.

	2001		2016		2026		2036	
	Number	% of population	Number	% of population	Number	% of population	Number	% of population
65 and over	430,000	11.1	629,000	13.3	866,000	16.0	1,114,000	19.7
75 and over	187,000	4.9	254,000	5.2	382,000	7.1	551,000	9.5
85 and over	40,000	1.1	64,000	1.1	91,000	1.6	159,000	2.7
	Number		Number		Number		Number	
Depression Syndrome	47,300		69,190		95,260		122,540	
Dementia	21,500		31,450		43,300		55,750	

Source: Population and Labour force Projections[140]

13.5 GAPS IN EXISTING SPECIALIST SERVICE PROVISION

There are major gaps in current MHSOP provision which include the following:

- absence of MHSOP in many catchment areas
- incomplete multidisciplinary representation in almost all existing MHSOP teams
- lack of specialised assessment and treatment in most acute admission settings
- inadequate accommodation in continuing care facilities under mental health legislation.
- lack of dedicated day hospital facilities in almost all services
- lack of emphasis on recovery and positive coping skills in existing service provision

13.6 FRAMEWORK FOR SERVICE PROVISION

Care for older persons extends over a continuum of services from health promotion, primary care, and home care, through acute general hospital care, specialist day care, acute psychiatric in-patient care, specialised mental health services continuing care, and non-specialist continuing care in hospital settings and nursing home care.

The proposed framework for service provision stresses the need to consider the interdependence of physical and mental health care in older persons. It is vital that there should be an extensive but interlocking range of care options that function in a harmonious, integrated fashion rather than on an all-or-nothing basis.

Too often there is a limited range of alternatives that operate in a disjointed and poorly articulated fashion. It is recommended that there should be an extensive and integrated range of care options available to older people, with clearly established links between them, including public health nursing and primary care services.

13.7 HEALTH PROMOTION

A policy for the promotion of psychological well-being among the older population must recognise that members of this group have varying mental health resources and needs related to their unique life circumstances and developmental histories.

The literature on ageing tends to over-emphasise the medical difficulties and cognitive decline that can be a feature of later life. It is important to preserve a respect for the potential in older people to grow and flourish in later life and to counter negative myths of ageing that can become self-fulfilling prophesies.

A database of Irish initiatives for healthy ageing has been developed under the National Healthy Ageing Programme[142]. In addition, a recent report by the National Council on Ageing and Older People identified key healthy ageing initiatives[143]. These projects all follow best practice guidelines and have shown positive benefits for participants when evaluated.

Social support is a key resource for older people. Self help, support networks and volunteering have been identified as protective factors against poor mental health as well as helping people recover from stressful life events like bereavement[144]. The evidence suggests that these interventions are most successful when linked closely with other community development initiatives. It is recommended that evidence-based beneficial and effective programmes for older adults should be implemented.

As far as the stroke-related organic conditions of vascular origin and Alzheimer's dementia are concerned, the health promotion message is the same as that for preventing cardiovascular disease generally. Early diagnosis and intervention have a legitimate track-record for improving outcome by at least prolonging quality

of life and delaying rates of decline and admission to continuing care.

For this to come about it is important that general practitioners and primary care teams be alert to the possibility of early cognitive impairment in older persons and screen for it in a general if not specific manner. Mechanisms such as memory clinics and other programmes are recognised as having a substantial role to play in deferring progression.

RECOMMENDATION 13.2: Mental health promotion among older adults should preserve a respect for the potential in older people to grow and flourish in later life and to counter negative myths of ageing that can become self-fulfilling prophesies.

RECOMMENDATION 13.3: Health promotion programmes and initiatives found to be beneficial to older adults should be implemented.

13.8 PRIMARY CARE

Primary care services should be a critical component in preserving and promoting good physical and mental health in older adults; regular contact with these services offers the possibility of identifying problems arising from social isolation, unsatisfactory living conditions and physical health problems.

Given the fact that most mental health problems in older persons will first present in this setting, it is important that the awareness level of primary care personnel is honed by education – through formal and informal means – to detect and intervene appropriately. Liaison and consultation from CMHTs for older people must be readily available to primary care for this purpose.

The issue of palliative care in dementia is of singular importance. Prescribing for this group of older people requires considerable expertise, which should be available to the GP through consultation and liaison with MHSOP.

Consultation should also be available to nursing homes and other residential premises that cater for a substantial proportion of people with uncomplicated dementia and for many individuals showing evidence of moderate to severe cognitive decline. The availability of such expertise can greatly increase the range of patients nursing homes can cope with, and thus make available to MHSOP some of the places now vacant in nursing homes.

RECOMMENDATION 13.4: Primary health care teams should play a major role in assessment and screening for mental illness in older people and should work in a coordinated and integrated manner with the specialist teams to provide high quality care, particularly care that is home-based.

13.9 SPECIALIST COMMUNITY MENTAL HEALTH SERVICES FOR OLDER ADULTS

MHSOP should operate through specialised CMHTs, with one team per 100,000 population. A total of 39 teams should constitute the MHSOP nationally and each team should include the following personnel:

- one consultant psychiatrist (with specialist expertise in later life psychiatry)
- one doctor in training
- one senior nurse manager
- three psychiatric nurses
- one clinical psychologist
- one social worker
- one occupational therapist
- two mental health support workers/care assistants
- support staff: administrative/secretarial assistance to support the activities of the MHSOP team.

MHSOP should have access to input from physiotherapists and creative and recreational therapists when required by service users.

Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

Domiciliary assessment and intervention should be the primary care modality for the MHSOP. Care in the home and in the community, as the preferred option of older persons should be acknowledged.

These multidisciplinary teams should process referrals from primary care, develop person-centred care plans for older people in the context of their own homes, and coordinate input from other required services and ensure continuity of care. MHSOP should involve service users and carers as partners in all aspects of service provision.

Participation as a principle of service delivery is of critical importance in MHSOP. The concept of participation implies that older adults and their families should be involved in care programme planning – whether the disorder is functional or organic – and in dealing with matters such as enduring power of attorney and advance directives. For both patients and carers, needs should determine both service response and the nature of the care plan, to ensure that the most relevant service and expertise is provided.

RECOMMENDATION 13.5: A total of 39 MHSOP multidisciplinary teams should be established nationally, one per 100,000 population, providing domiciliary and community-based care.

RECOMMENDATION 13.6: Priority should be given to establishing comprehensive specialist MHSOP where none currently exist.

13.10 PHYSICAL RESOURCES REQUIRED

13.10.1 COMMUNITY-BASED TEAM HEADQUARTERS

The MHSOP team should be based in and operate from a community mental health centre. The headquarters may also function as a multi-purpose centre for information and support for the general public, health and social professionals, and carers. It should provide accommodation for meetings, including those of carer groups, and may also provide for a variety of other functions dependent on need and the availability or lack of other community-based resources.

RECOMMENDATION 13.7: Physical resources essential to service delivery, acute beds and continuing care, service headquarters, community-based and day facilities should be provided for MHSOP within each sector.

13.10.2 ACUTE ASSESSMENT AND TREATMENT UNITS

These should be located in a general hospital psychiatric unit, as a separate section of that unit. Each dedicated facility should be entirely self-sufficient with its own facilities, such as day room, garden, courtyard space, etc. It is recommended that there should be eight acute assessment and treatment beds in each regional acute psychiatric unit for MHSOP.

RECOMMENDATION 13.8: There should be eight acute assessment and treatment beds in each regional acute psychiatric unit for MHSOP.

13.10.3 DAY HOSPITALS

Day hospitals are concerned with medical care in the broad sense, in contrast to day centres, which are largely concerned with social care. Day hospitals for MHSOP should be integrated within the campus of a general hospital. The location of the day hospital there is

recommended so as to facilitate easy access to diagnostic and other services, given the high level of physical/mental health co-morbidity in older people.

It is recommended that one day hospital of 25 places be provided in each mental health catchment area of approximately 300,000. The role of day hospitals in substituting for acute hospital care, for delaying admission to continuing care, and in providing carer respite capacity, should receive evaluation in the Irish context.

In addition to a central day hospital in or adjacent to the catchment general hospital, there is a requirement for peripheral ancillary day hospital provision in association with local community hospitals.

It is not feasible to have people from remote areas attending distant services on a daily basis as may be necessary for extensive diagnostic evaluation or for treatment purposes. It is recommended that proximity to a general or community/district hospital with basic investigative equipment, such as X-ray and phlebotomy facilities, is important to make basic diagnostic procedures possible and to have medical and surgical expertise available on a consultative basis.

It is recommended that a travelling day hospital should be considered, allowing specialist mental health professionals to visit once or twice a week for consultation and advice. Adequate transport for service users is essential to maximise the potential of day hospitals and day centres.

RECOMMENDATION 13.9: There should be one central day hospital per mental health catchment area (300,000 population) providing 25 places, and a number of travelling day hospitals in each mental health catchment area.

13.10.4 DAY CENTRES

Day centres for older people do not come within the remit of mental health services but it is recognised that an inadequate supply of day centres can lead to the misuse of scarce day hospital places. Thirty-one day centres nationwide are currently provided by the Alzheimer's Association. Both paid personnel and volunteers staff them. They are funded through the HSE and by the Alzheimer's Association. A variety of other voluntary organisations also provide day centres. As with day hospitals, the functioning of day centres needs audit and evaluation concerning the needs they meet, the clientele they serve, and their overall contribution to the continuum of service provision for older people.

RECOMMENDATION 13.10: There should be an appropriate provision of day centres in each mental health catchment area, but their provision should not be the responsibility of the MHSOP.

RECOMMENDATION 13.11: There should be appropriate recognition and linkage with voluntary agencies in the field.

13.10.5 OUTPATIENT AND MEMORY CLINICS

Outpatient clinics may have a more limited role in MHSOP than in other areas of mental health services because of the limited mobility and co-morbid physical disabilities of some older people.

It may be the case that the outpatient function can best be performed in the premises of the team headquarters or by community domiciliary teams. Much will depend on pragmatism, in terms of what is locally available. The availability of memory clinics for diagnostic and treatment purposes will similarly be determined by practical realities.

13.10.6 COMMUNITY-BASED RESPITE CARE

There is currently a severe lack of appropriate residential options for older people with mental health problems. Many do not require 24-hour nursing care and are inappropriately placed in mental hospitals and nursing homes because there is a lack of alternative options.

Current arrangements need to be adapted to allow for more flexible and imaginative use of existing resources. Short term residential respite care can be of immense value to carers and can assist the older person to remain at home. Other options that could be made available are sheltered accommodation, with varying degrees of supervision. Night sitting, care attendants, personal assistants and visits from the home care team should be available to people living at home or in sheltered accommodation.

RECOMMENDATION 13.12: Carers and families should receive appropriate recognition and support including education, respite, and crisis response when required.

13.10.7 NURSING HOMES

Older people with mental health problems should have access to nursing homes on the same basis as the rest of the population. The precise need for medium term, longer term or respite care is unclear in the absence of appropriate data on prevalence, outcome and survival, as well as the differing regional availability of nursing home care.

RECOMMENDATION 13.13: Older people with mental health problems should have access to nursing homes on the same basis as the rest of the population.

13.10.8 CONTINUING CARE PROVISION

There is a need for continuing care for older people with mental disorders and/or challenging behaviour. Best estimates suggest around 30 places per 300,000 population are required. These premises should be designated for care under mental health legislative provision, and become approved centres, so that patients may be detained involuntarily should that be necessary. People in these units will then have the protections of the Mental Health Act, 2001[82] and the centres will also be subject to annual inspection.

RECOMMENDATION 13.14: There should be 30 continuing care places for older people with mental disorders in each mental health catchment area.

13.11 RECOMMENDATIONS

1. Any person, aged 65 years or over, with primary mental health disorders or with secondary behavioural and affective problems arising from experience of dementia, has the right to be cared for by mental health services for older people (MHSOP).

2. Mental health promotion among older adults should preserve a respect for the potential in older people to grow and flourish in later life and to counter negative myths of ageing that can become self-fulfilling prophesies.

3. Health promotion programmes and initiatives found to be beneficial to older adults should be implemented.

4. Primary health care teams should play a major role in assessment and screening for mental illness in older people and should work in a coordinated and integrated manner with the specialist teams to provide high quality care, particularly care that is home-based.

5. A total of 39 MHSOP multidisciplinary teams should be established nationally, one per 100,000 population, providing domiciliary and community-based care.

6. Priority should be given to establishing comprehensive specialist MHSOP where none currently exist.

7. Physical resources essential to service delivery, acute beds and continuing care, service headquarters, community-based and day facilities should be provided for MHSOP within each sector.

8. There should be eight acute assessment and treatment beds in each regional acute psychiatric unit for MHSOP.

9. There should be one central day hospital per mental health catchment area (300,000 population) providing 25 places, and a number of travelling day hospitals in each mental health catchment area.

10. There should be an appropriate provision of day centres in each mental health catchment area, but their provision should not be the responsibility of the MHSOP.

11. There should be appropriate recognition and linkage with voluntary agencies in the field.

12. Carers and families should receive appropriate recognition and support including education, respite, and crisis response when required.

13. Older people with mental health problems should have access to nursing homes on the same basis as the rest of the population.

14. There should be 30 continuing care places for older people with mental disorders, in each mental health catchment area.

CHAPTER FOURTEEN

Mental health services for people with intellectual disability

14.1 INTRODUCTION

It is only in the last 20 years that there has been widespread acceptance of the fact that people with intellectual disability can also have a mental health problem*. Services have been slow to respond to this need. Individuals with an intellectual disability are more vulnerable to environmental factors that influence mental health, as they are less able to adapt and respond to features of their environment and to changes in it, and services need to be sensitive to this vulnerability.

inclusion, access and community-based services[145,146]. The specific resonance for people with intellectual disability is that the rights of an individual with an intellectual disability are the same as those of any other member of society.

A service that is based on these principles should be respectful of, and sensitive to, the unique needs of each individual. At an operational level, the use of clinical governance and continuous monitoring of standards

Person-

14.2 BEST PRACTICE IN THE PROVISION OF MENTAL HEALTH SERVICES FOR PEOPLE WITH INTELLECTUAL DISABILITY

The service principles are the same as those for all the mental health services proposed in this policy: citizenship, should ensure that a high quality service is delivered. This combination of explicit principles and operational governance ensures that all the rights of the individual are protected and should help ensure that this vulnerable group are provided with services appropriate to their needs.

* See terminology section for definition of mental health problem. In this policy the ICD-10 Classification of Mental Disorders (WHO) definition of intellectual disability is used and is paraphrased here:

> *Intellectual disability is the presence of a significantly reduced ability to understand new or complex information and to learn new skills, with a reduced ability to cope independently, which starts before adulthood and has a lasting effect on development. However, the presence of low intelligence (IQ below 70) is not, of itself, a sufficient reason for deciding whether an individual requires health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need.*

The terms 'mild', 'moderate', 'severe' and 'profound' are used to describe different levels of intellectual disability. These terms correspond to different IQ levels.

RECOMMENDATION 14.1: The process of service delivery of mental health services to people with intellectual disability should be similar to that for every other citizen.

14.3 THE NUMBER OF PEOPLE WITH INTELLECTUAL DISABILITY IN IRELAND

In 2004 the National Intellectual Disability Database (NIDD) recorded 25,416 individuals with an intellectual disability in Ireland[147]. However, not everybody with a mild intellectual disability is included in the database. Comparing estimates from elsewhere on the prevalence of mild intellectual disability in the population, the NIDD probably has about a third of the people with mild intellectual disability in Ireland in the database. As approximately one third of those with mild intellectual disability should be served by the mental health of intellectual disability (MHID) team[148], the NIDD figures give a useful estimate of need.

14.3.1 THE PREVALENCE OF MENTAL ILLNESS AMONG THOSE WITH INTELLECTUAL DISABILITY

There are many wide and varying estimates of the prevalence of mental illness in individuals with intellectual disability. These wide variations are due to differing inclusion and exclusion criteria, and depend on whether challenging behaviours† are included or not. A recent review of research studies estimated that 50% of people with severe and profound learning disabilities will have a mental health problem at some point in their lives, as will 20–25% of those with mild and moderate intellectual disabilities[149].

centred

Evidence from studies on challenging behaviour suggests that over 3,000 people with intellectual disability in Ireland exhibit challenging behaviour (approximately 12% of those on the NIDD)[147]. There is a relatively small number of individuals with intellectual disability who present with both a mental illness and challenging behaviour. This may

† Challenging behaviour is a term used to describe severe problem behaviour in individuals with an intellectual disability. Challenging behaviour is not a diagnosis, however; it can occur along with a mental health problem, and may be an expression of an underlying mental health problem. It may also be due to environmental conditions. A commonly accepted definition of challenging behaviour is that of Emerson (2001)[150]:

> 'Severely challenging behaviour refers to culturally abnormal behaviour(s) of such intensity and frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities.'

The term problem behaviours is now being used in the DC-LD (*Diagnostic criteria for psychiatric disorders for use with adults with learning disability,* Royal College of Psychiatrists, 2004). These behaviours include verbal or physical aggression, destructive behaviour, self-harming behaviours, sexually inappropriate behaviours and others. Estimates of challenging behaviour from prevalence rates vary widely, and there is a lack of clarity in this area. There are several standardised rating scales for describing challenging behaviour. It is essential that a recognised rating scale is used when describing challenging behaviour and that such a rating scale be agreed nationally so that need can be assessed and measured with greater clarity.

be as many as 1,600 nationally[145]. This represents a group with severe, intractable and enduring problems; they place a huge demand on resources and their needs have to be planned for very carefully.

RECOMMENDATION 14.2: Detailed information on the mental health of people with intellectual disability should be collected by the NIDD. This should be based on a standardised measure. Data should also be gathered by mental health services for those with intellectual disability as part of national mental health information gathering.

RECOMMENDATION 14.3: A national prevalence study of mental health problems including challenging behaviour in the Irish population with intellectual disability should be carried out to assist in service planning.

14.4 CURRENT SERVICE PROVISION

Most of the mental health services for people with intellectual disability are provided by the voluntary and non-statutory sector (e.g. by religious orders, parents associations, etc.).

The voluntary sector has largely determined the shape of intellectual disability services. Service-level agreements are negotiated between the HSE and voluntary agencies to provide care to those with intellectual disability. Multidisciplinary teams in intellectual disability services provide person-centred care that is focused very much on the social, vocational, educational and residential needs of the individual but in general they do not deal with specialist mental health needs.

For people in residential care, mental health care is supported by a relatively small number of psychiatrists with a special interest in the psychiatry of intellectual disability. Most of these psychiatrists work in voluntary agencies that do not have multidisciplinary MHID teams, nor do they have access to the range of facilities required for comprehensive mental health assessment, treatment and care.

14.5 GAPS IN CURRENT SERVICE PROVISION

The National Disability Authority[145] review of mental health services for people with intellectual disability noted that despite improvements and advancements in service provision for this group, their needs 'have yet to be met satisfactorily. This is in spite of a number of reports in recent years that have catalogued the frustrations of … patients and carers in attempting to gain access to appropriate mental health services.' (p.48).

Similarly, while acknowledging improvements in the quality of life for people with intellectual disabilities, a report by the Irish College of Psychiatrists[146] notes that 'mental health/psychiatric services for people with intellectual disabilities have not kept pace with …developments – they remain under-resourced and grossly underdeveloped in many Health Board areas in Ireland. Some counties have no psychiatric service at all for people with intellectual disabilities.' (p.7).

There are still people with intellectual disability and mental health problems who do not receive any service, particularly those with a mild intellectual disability. While there is ring-fenced funding for intellectual disability services, the funding for mental health services within this is not clearly identified.

There are also a number of structural barriers that hinder access to mental health services for people with intellectual disability. For example, voluntary bodies do not operate within defined catchment areas and are not funded to provide a mental health service to all those with an intellectual disability who might need such a service. Therefore, individuals with intellectual disability and a mental health problem do not have the right of access to a mental health service that others in the population have. The catchment area policy for voluntary services is changing in agreement with health boards and more recently the HSE, which has assumed a lead funder role. General adult, and child and adolescent mental health services do not routinely provide a service to people with an intellectual

disability. Because of these barriers some people have no access to mental health services.

Significant funds have been expended by health boards in recent years on inappropriate short-term placements for individuals with intellectual disability and severe mental health problems, or by 'exporting the problem' to providers outside of the State. Approximately 35 people with intellectual disability and mental health/psychiatric disorder are currently on 'out-of-state placements', which puts a great burden on the individuals and families concerned. The cost of these placements to the health services is substantial.

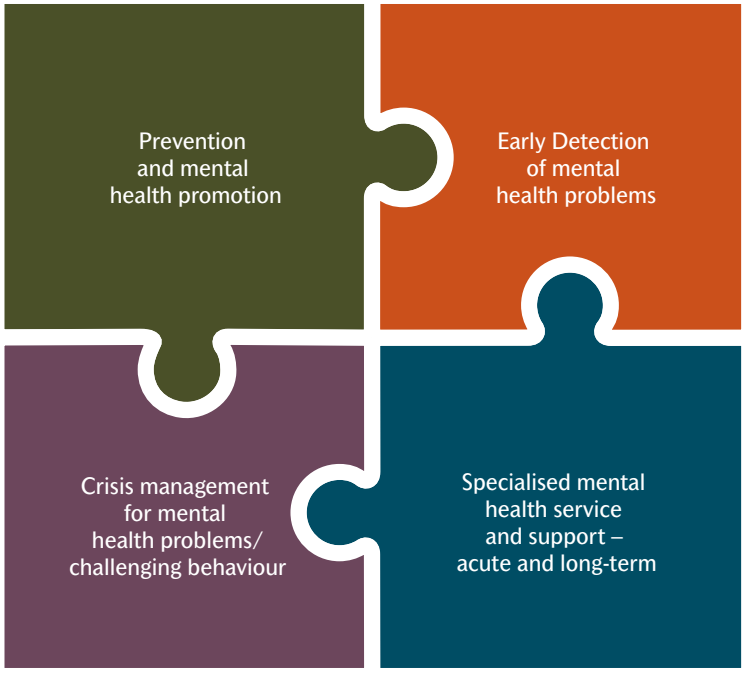
14.6 FRAMEWORK TO MEET THE MENTAL HEALTH NEEDS OF PEOPLE WITH INTELLECTUAL DISABILITY

Within the population of people with intellectual disability there is a range of mental health needs, from those with no mental health problems (the majority), through those with mild mental health difficulties, to those with moderate to severe mental illness (a smaller but significant proportion of those with intellectual disability). A continuum of services is required to address these needs.

Generic adult and child and adolescent mental health services should deal with the majority of people with mild intellectual disability and mental health needs. There is also a significant number of people with mild intellectual disability and challenging behaviour or mental disorder whose needs are best met in the intellectual disability services. Any decision on the service required for an individual with intellectual disability should be based on the needs and the clinical presentation of the individual concerned, and where their needs can best be met.

The service model conceptualised by Mansell[151] describes four inter-related sub-systems that can operate within the same service system or across different service systems (Figure 14.1). Each sub-system serves a different function and within each there are specific interventions or procedures that a service needs to provide to ensure effective responses to the behaviour and needs of individuals. These functions are described in detail below.

Figure 14.1: Key service elements for the mental health needs of individuals with intellectual disability[151].



14.6.1 MENTAL HEALTH PROMOTION

The first function, mental health promotion and prevention, should be available in generic intellectual disability services with support from an MHID team and other services such as the local health promotion unit. While mental health promotion is not routinely available in many intellectual disability services a range of mental health promotion activities is carried out by psychologists and others in some intellectual disability services[152].

The model outlined in Chapter Five on mental health promotion is also applicable for individuals with intellectual disability. In this model the emphasis is on a lifespan approach, providing mental health promotion and preventive interventions and programmes from infancy to old age in settings that are appropriate and relevant. Thus, programmes for infants are provided in the home setting, for young children in the school and home setting and for adults in the work setting, and so on.

Many of these interventions and programmes are immediately applicable to those with intellectual disability (e.g. the Community Mothers Programme[117,118] for infants and young children) while others may need to be adapted, for example the school programmes. Those who are not accessing intellectual disability services should have the same access to mental health promotion programmes as their peers.

RECOMMENDATION 14.4: The promotion and maintenance of mental well-being should be an integral part of service provision within intellectual disability services.

14.6.2 EARLY DETECTION AND INTERVENTION AND PRIMARY CARE

The second function, early detection, should be provided by the generic intellectual disability services, in conjunction with primary care, specifically the GP. It is essential that all individuals with intellectual disability have routine access to a GP, whether they live at home or in a residential setting. The GP, in consultation with the generic intellectual disability team, is the route of referral to the mental health service.

For persons with intellectual disability and mental health problems living in the community with family carers, or in their own accommodation, access to mental health services is particularly difficult owing to the lack of catchment area based services. This has resulted in persons reaching crisis before action is taken to address their mental health problems.

RECOMMENDATION 14.5: All people with an intellectual disability should be registered with a GP and both intellectual disability services and MHID teams should liaise with GPs regarding mental health care.

14.6.3 CRISIS MANAGEMENT FOR MENTAL HEALTH PROBLEMS

One of the first steps to address the mental health needs of people with intellectual disability is to increase the capacity of the intellectual disability services that are already in place. The most recent reports on mental health services for people with intellectual disability[145,146] noted a number of specific requirements to make generic intellectual disability services more responsive to the needs of those with mental health problems and/or challenging behaviour in the areas of prevention, early detection and **crisis management**, namely:

- appropriate staffing levels
- appropriate staff training
- defined policies and procedures
- environmental considerations
- clinical governance.

Many of the recommendations and suggestions are in the category of 'good practice' and would benefit all service users. Strengthening the generic intellectual disability services that are already in place should provide

a sound basis for implementing specific programmes to meet the needs of individuals under three of the four functions described in Figure 14.1, and to work more effectively with the mental health team which operates under function four. However, a multidisciplinary mental health of intellectual disability team is needed to provide function four – the provision of specialised mental health services, both acute and long-term – and to advise and consult with the generic intellectual disability team on mental health promotion and prevention, early detection, and crisis management in particular.

14.6.4 CMHTS FOR PEOPLE WITH INTELLECTUAL DISABILITY

MHID teams should be available to provide treatment and care to those with an intellectual disability and a mental health problem. These teams, and the psychiatrists working within them, should be part of the mental health services for a defined catchment area, along with other teams providing mental health services to adults, children and adolescents and other specialist mental health teams.

It is recommended that two teams should be provided in each catchment area of approximately 300,000 population to serve adults with intellectual disability and mental health problems and that one team per catchment area be provided for children with intellectual disability and mental health problems.

The needs of the individual should be the determining feature of the mental health services required. These particular needs should be taken into account in how these mental health services function. A core principle of the mental health of intellectual disability is that treatment and care be community-based, so in-patient and other settings away from the individual's residence should be used only when necessary.

One of the main roles of the mental health of intellectual disability teams should be providing consultation and liaison to intellectual disability services with the aim of building local capacity and ensuring that appropriate referrals are made to the mental health team.

Function three in the framework – e.g. crisis management – should be available in the generic intellectual disability services, in conjunction with a specialist multidisciplinary MHID team when necessary.

Currently many intellectual disability teams are doing excellent work in this area. In the absence of MHID teams available to intellectual disability services, the staff in the intellectual disability services, particularly the nurses, are the people who deal with crises and challenging behaviour on an everyday basis.

The availability of MHID teams should greatly enhance the service provided in several ways; by providing assistance in early identification of problems, and providing advice and liaison on ongoing problems, both of which would help to prevent situations coming to a crisis point. The MHID teams should also provide training and support to family carers and staff on generic teams implementing specific programmes, and provide counselling and support to families and staff when required.

RECOMMENDATION 14.6: Mental health services for people with intellectual disability should be provided by a specialist mental health of intellectual disability (MHID) team that is catchment area-based. These services should be distinct and separate from, but closely linked to, the multidisciplinary teams in intellectual disability services who provide a health and social care service for people with intellectual disability.

RECOMMENDATION 14.7: The multidisciplinary MHID teams should be provided on the basis of two per 300,000 population for adults with intellectual disability.

RECOMMENDATION 14.8: One MHID team per 300,000 population should be provided for children and adolescents with intellectual disability.

14.7 HUMAN RESOURCES REQUIRED

The training, skills and experience of all members of the multidisciplinary MHID team are crucial. All team members should have dual training or equivalent, and experience in mental health problems in people with intellectual disability.

The following mental health professionals should comprise the core multidisciplinary team to deliver mental health services to adults with intellectual disability and a mental health problem and/or challenging behaviour:

- one consultant psychiatrist
- one doctor in training
- two psychologists
- two clinical nurse specialists (CNS) and registered nurses with specialist training
- two social workers
- one occupational therapist
- administration support staff

Composition of each MHID team should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions. A range of therapeutic expertise should be available within each team according to the needs of service users. Other mental health professionals and other health professionals (e.g. creative therapists, speech and language therapists) should be brought in as required to address these needs.

Governance should be in accordance with the guidelines described for multidisciplinary teams in Chapter Nine. Each team should have a clearly identified clinical leader, team coordinator and practice manager.

14.8 PHYSICAL RESOURCES REQUIRED

For adults with intellectual disability and mental health problems, a range of services should provide a spectrum of provision that can flexibly support, and provide for, the needs of the individual.

This spectrum of services should be community-based and should be provided at home (either the family home or a residence in the intellectual disability service), in outpatient settings, in day hospital settings, and in in-patient settings when required. It should also be kept in mind that recovery in individuals with intellectual disability can be a slow process, and is particularly sensitive to building relationships and maintaining constancy in the environment.

To provide this flexible spectrum of care, five acute in-patient beds will be needed and a number of day hospital places (one day hospital with ten places per 300,000), covered by the MHID team. These acute beds should be provided in a specially designed unit that is part of, but separate from the regional acute in-patient unit.

In addition, a number of rehabilitation and continuing care beds should be provided on a regional basis, for those with severe, intractable problems. Ten rehabilitation beds for these individuals should be delineated in approved centres under the Mental Health Act, 2001[82] and provided within the current intellectual disability residential centres. Admission and discharge policies should be prepared for all in-patient settings. Respite places are also a key provision for this group.

RECOMMENDATION 14.9: A spectrum of facilities should be in place to provide a flexible continuum of care based on need. This should include day hospital places, respite places, and acute, assessment and rehabilitation beds/places. A range of interventions and therapies should be available within these settings.

14.8.1 CHILDREN AND ADOLESCENTS

A similarly flexible spectrum of services based on need will be required for children and adolescents with intellectual disability and mental health problems. Community-based treatment should be the model of service provision, with domiciliary, day hospital and outpatient treatment, as clinically appropriate.

There is a particular need for respite services, family support and 'foster' services for children and adolescents, to provide time-out opportunities for families and children.

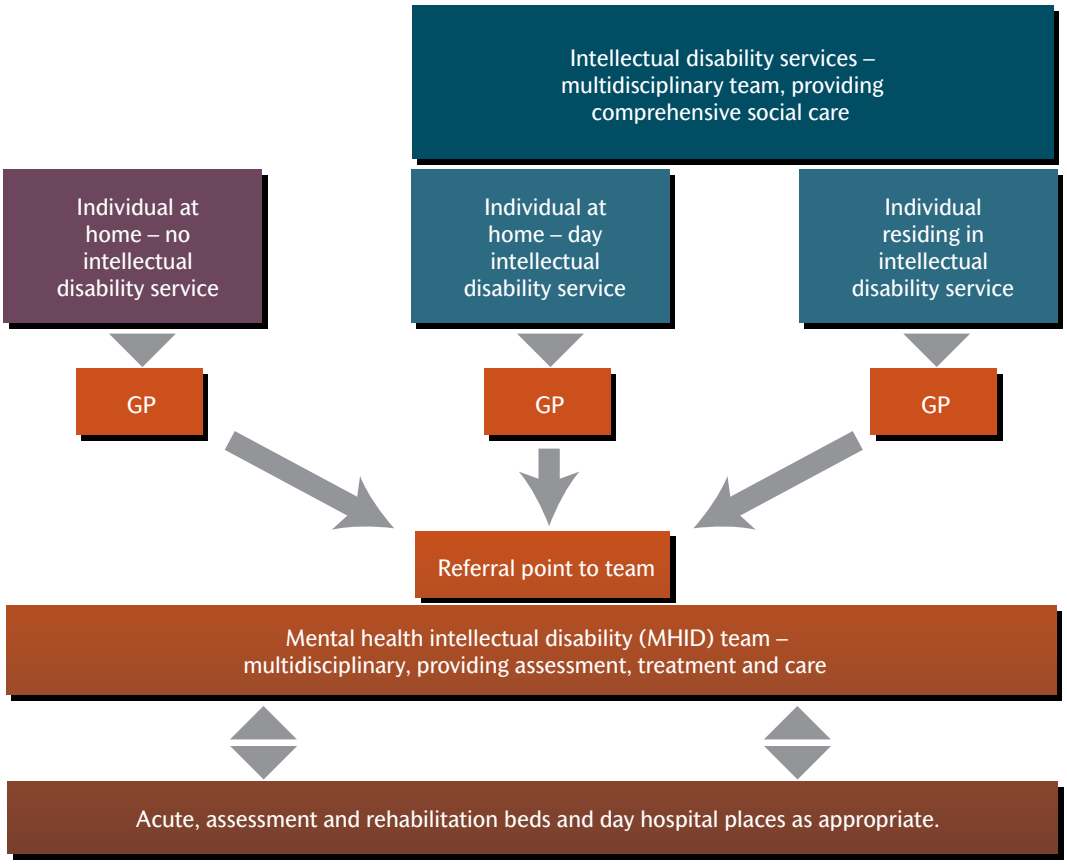
The core team composition should be the same as that for adults, and other disciplines should be brought in as required. There is less published guidance on bed/places requirements for children and adolescents. These should be organised locally, based on need.

14.9 LINKS WITH OTHER SERVICES

The MHID teams should work in the same way as other mental health teams. There should be a single point of entry for referral to the MHID team (see Figure 14.2). This is essential to coordinate a scarce resource. Referral policies should be drawn up in consultation with all concerned. These referral policies should reflect the needs of individuals with intellectual disability living at home with their family, GPs, the generic intellectual disability service providers, the MHID team and other mental health teams such as adult and child and adolescent mental health teams.

RECOMMENDATION 14.10: In order to ensure close integration, referral policies should reflect the needs of individuals with intellectual disability living at home with their family, GPs, the generic intellectual disability service providers, the MHID team and other mental health teams such as adult and child and adolescent mental health teams.

Figure 14.2: Interface between mental health of intellectual disability (MHID) team and other services



14.10 NEEDS OF SPECIFIC GROUPS

14.10.1 THE MENTAL HEALTH NEEDS OF PEOPLE WITH MILD INTELLECTUAL DISABILITY

People with mild intellectual disability comprise the largest group of all those with intellectual disability. Approximately one third of people with mild intellectual disability and mental health problems need the type of specialist mental health service provided by a multidisciplinary MHID team[148]. The remaining two thirds of those with mild intellectual disability and mental health problems should be served by generic mental health teams in adult or child and adolescent mental health services as appropriate.

14.10.2 THE MENTAL HEALTH NEEDS OF PEOPLE WITH AUTISM AND INTELLECTUAL DISABILITY

Services for this group should be provided in an intellectual disability mental health service or child and adolescent or adult mental health service depending on their level of disability.

14.10.3 THE MENTAL HEALTH NEEDS OF THE FORENSIC POPULATION WITH INTELLECTUAL DISABILITY

Criminal offending in people with intellectual disability is often under-reported and is complicated by issues pertaining to competence and *mens rea* (criminal intent). Despite this, a significant proportion of those accommodated within the Irish prison system may have an intellectual disability. There is currently no forensic intellectual disability service in Ireland.

In order to provide mental health services to this small group of individuals it is recommended that a national forensic unit be provided for specialist residential care for low mild, and moderate range of intellectual disability. This unit should have ten beds and be staffed by a multidisciplinary MHID team. This team should also provide specialist advice and consultation to intellectual disability mental health services and other mental health services as required. As with all other mental health services described in this policy, close links should be made with the regional forensic services (Chapter Fifteen) for local advice and liaison. It is recommended that a needs assessment on those who are currently on 'out of state' placements paid for by the HSE should be carried out to determine what their needs are and whether they might be accommodated in Ireland.

RECOMMENDATION 14.11: A national forensic unit should be provided for specialist residential care for low mild, and moderate range of intellectual disability. This unit should have ten beds and be staffed by a multidisciplinary MHID team.

14.10.4 MENTAL HEALTH NEEDS OF OLDER PEOPLE WITH INTELLECTUAL DISABILITY

Older people with intellectual disability are more vulnerable to physical, psychological and social changes. Physical illnesses are common, dementia increases with age and mental disorders have a higher prevalence. For example, people with Down's syndrome have an increased prevalence of dementia, with 15–40% developing dementia from age 35 years onwards. In addition, retirement and bereavement are common life events at this age and bring social change with them. For the person with intellectual disability, a move to residential care, and a change in day service provision may complicate these events. The NIDD has identified ageing as a key issue for the population with intellectual disability over the next ten years[147].

It is proposed that the needs of the older person with an intellectual disability and a mental health problem be met by either the MHID team in liaison with the older person's team or the older person's team in liaison with the MHID team, as appropriate to the needs of the individual. Staff on the MHID team should receive training as required to provide additional skills in assessing and treating older people with intellectual disability and psychiatric disorder.

14.11 LEGISLATIVE PROTECTIONS AND CONSENT

Concerns have been expressed about the legal protections afforded people with intellectual disability. The NDA report[145] concluded that 'the vast majority of individuals with intellectual disability who reside in community accommodation, and who also may be receiving medication or other psychiatric treatment to which they have not had the capacity to consent, are "de facto detained" and are not subjected to any formal independent monitoring' (p.34). Under the Mental Health Act, 2001[82] centres providing mental health in-patient treatment and care will be required to register as approved centres and will be regularly inspected.

14.11.1 ISSUES OF CAPACITY, CONSENT, SECLUSION AND RESTRAINT

NAMHI (The National Association of the Mentally Handicapped in Ireland, the national voluntary organisation working to promote the rights of people with an intellectual disability in Ireland) has expressed concerns about the issue of consent particularly, and their discussion document makes proposals on legal capacity and decision making[153]. The recent Law Reform Commission consultation paper *Vulnerable Adults and the Law: Capacity*[139] recommends the enactment of capacity legislation, and says that this law should place an emphasis on capacity rather than lack of capacity and should be enabling rather than restrictive in nature. In addition, the Law Reform Commission recommends that a functional approach should be taken to the issue of legal capacity, i.e. consideration of capacity in relation to a particular decision at a particular point in time. A more detailed discussion of these issues is in Annex 14.

When the Mental Health Act, 2001[82] is fully enacted, any individual subject to detention, seclusion or restraint in an approved centre will be protected by this Act. Approved centres are also subject to annual inspections by the Inspector of Mental Health Services. Individuals subject to detention, seclusion and restraint in intellectual disability services which are not approved centres will not be protected by the Mental Health Act, 2001. This situation in relation to consent and detention is highly unsatisfactory and is under consideration by the Law Reform Commission and urgently requires a legislative solution.

14.12 RECOMMENDATIONS

1. The process of service delivery of mental health services to people with intellectual disability should be similar to that for every other citizen.

2. Detailed information on the mental health of people with intellectual disability should be collected by the NIDD. This should be based on a standardised measure. Data should also be gathered by mental health services for those with intellectual disability as part of national mental health information gathering.

3. A national prevalence study of mental health problems including challenging behaviour in the Irish population with intellectual disability should be carried out to assist in service planning.

4. The promotion and maintenance of mental well-being should be an integral part of service provision within intellectual disability services.

5. All people with an intellectual disability should be registered with a GP and both intellectual disability services and MHID teams should liaise with GPs regarding mental health care.

6. Mental health services for people with intellectual disability should be provided by a specialist mental health of intellectual disability (MHID) team that is catchment area-based. These services should be distinct and separate from, but closely linked to, the multidisciplinary teams in intellectual disability services who provide a health and social care service for people with intellectual disability.

7. The multidisciplinary MHID teams should be provided on the basis of two per 300,000 population for adults with intellectual disability.

8. One MHID team per 300,000 population should be provided for children and adolescents with intellectual disability.

9. A spectrum of facilities should be in place to provide a flexible continuum of care based on need. This should include day hospital places, respite places, and acute, assessment and rehabilitation beds/places. A range of interventions and therapies should be available within these settings.

10. In order to ensure close integration, referral policies should reflect the needs of individuals with intellectual disability living at home with their family, GPs, the generic intellectual disability service providers, the MHID team and other mental health teams such as adult and child and adolescent mental health teams.

11. A national forensic unit should be provided for specialist residential care for low mild, and moderate range of intellectual disability. This unit should have ten beds and be staffed by a multidisciplinary MHID team.

CHAPTER FIFTEEN

Special categories of service provision

This chapter describes specific services for people who need interventions not typically provided by specialist CMHTs. Some of the categories of service described here concern people who may not usually come into contact with community-based specialist mental health services, e.g. homeless people, people in general hospitals.

The needs of others are specifically addressed because they require a range of interventions not routinely offered by any of the CMHTs discussed previously, e.g. people in forensic settings, people with co-morbid mental health and addiction problems or severe cognitive impairment.

In some cases the numbers in each category described are small, and proposed models of intervention accordingly rationalise service provision across catchments and regions within the HSE.

15.1 FORENSIC MENTAL HEALTH SERVICES

Forensic mental health services (FMHS) are primarily concerned with the mental health of persons who come into contact with law enforcement agencies, the Garda Síochána, the Courts and the Prison Service. FMHS teams also provide consultation services to generic mental heath services on the assessment and management of mentally ill persons whose disorder is characterised by challenging and aggressive behaviour.

FMHS, in addition to providing secure in-patient care, should have a strong community focus, and should be provided by multidisciplinary teams offering specialist assessments and consultation services to generic mental health teams, specialist assessments for court diversion schemes, and a service to prisons within the region.

15.1.1 PRINCIPLES CENTRAL TO THE DELIVERY OF CARE BY FMHS

FMH teams should embody the values and principles espoused throughout this policy:

- Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done.

Needs-

- Forensic mental health services should be person-centred, provide best practice assessment and intervention, and offer recovery-oriented and integrated care plans.
- Involvement of service users and their families and provision of advocacy services for service users need to be developed and incorporated into forensic mental health services.
- Forensic mental health units need to be clearly identified as being intervention and rehabilitation facilities that operate in particular conditions of security rather than facilities offering mainly containment.

RECOMMENDATION 15.1.1: Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done. Where mental health services are delivered in the context of prison, they should be person-centred, recovery-oriented and based on evolved and integrated care plans.

It should always be borne in mind that as the State has legislative power to remove liberty it also the responsibility to restore it when this is just and appropriate. As matters stand, and despite the impending safeguards under new legislation (Mental Health Act,

based

- Priority should be given to the care of individuals with severe and enduring illness, in the least restrictive environment possible.
- In addition to these principles, other ethical considerations are fundamental to provide for a group of fellow citizens who are doubly stigmatised – as prisoners and as people who are mentally ill. Negative perceptions applied to this group take the form of denying equity of medical care, equity of housing provision and of a range of other elements of 'citizenisation' enjoyed by the 'normal' community.

2001[82]) providing for mental health tribunals, there are still constraints to equity, such as the lack of access to adequate review processes for transferred prisoners in the Central Mental Hospital (CMH) at Dundrum and restrictions on access to the Circuit Court in the case of civil commitment.

15.1.2 PREVALENCE OF MENTAL HEALTH PROBLEMS IN PRISONS

At any one time the 14 prisons in Ireland accommodate approximately 3,200 prisoners and, during the course of a year, upwards of 12,000 committals are made to the prisons, consisting of a mixture of committed and

sentenced prisoners in a proportion of 60/40. Male prisoners make up the vast majority; the number of female prisoners varies between 100 and 120 (with about 1,000 female committals annually) detained mainly in Mountjoy with a small number in Limerick.

A recent survey of the extent of mental illness in prisoners revealed that 2.6% of sentenced prisoners suffered from severe or enduring mental illness, rising to 7.6% among remand prisoners; 70% were addicted to alcohol or other drugs[154]. These figures are far above those prevailing in the general population.

In addition prisoners have a far greater extent of mental health co-morbidity, have serious social and educational disadvantage, with 10% being illiterate and with an over-representation of the Traveller and homeless populations.

The burden of mental health and social morbidity is clearly substantial. Because of physical and human resource limitations at the CMH – currently catering for 74 residents, about six of whom are women – many seriously ill prisoners cannot be immediately transferred there for the treatment they need but instead are often contained in special-cell confinement, particularly in Cloverhill.

15.1.3 CURRENT FMHS IN IRELAND

The FMHS functions mainly as an 'in reach' service to the prisons, holding clinics there and providing emergency and other consultations on request and in association with the general medical service to the prisons, including advising transfer to the CMH when this is deemed necessary.

Currently FMHS in Ireland are based in Dundrum at the CMH from which five multidisciplinary consultant-led teams operate (see Annex 15.1 'Central Mental Hospital'). In addition, there are two part-time 'special interest' consultant posts covering the Cork and Limerick prisons. These posts are structured so as to give two sessions to the local prisons and three to generic mental health and other services. The CMH teams cater for other places of detention including Portlaoise prison. Some local service is available at Castlerea prison. It is proposed to strengthen and increase these services.

15.1.4 GAPS IN CURRENT FMHS PROVISION

Traditionally, FMHS have been perceived as, and functioned as, a service to the CMH, the prisons and to a limited extent to the general mental health service. FMHS in the future must widen their remit to work with An Garda Síochána in pre-charge, pre-court diversion schemes, although there is no actual or proposed statutory basis for this (see Annex 15.1.2 'The Gardai and Mental Illness'). There is currently a limited consultation role in relation to mental health services in the management of individuals with challenging or aggressive behaviour. FMHS should be available in all areas where law enforcement agents are likely to encounter individuals with severe mental health problems.

The Criminal Law Insanity Bill, 2002[155] places an onus on generic mental health services, through committal orders, to assess, care for and treat people coming before the courts in a variety of situations and relies on them for guidance in the disposal of such cases. There has however been a culture of suspicion within services, as far as individuals with both mental illness and a forensic history are concerned, evolving into a covert policy of having nothing to do with such a clientele. Barriers must be overcome to allow a more open and accepting attitude to mentally ill persons who have, as is the case most often, been guilty only of minor public order offences.

There is a lack of understanding and training in risk-assessment and risk-management processes in generic mental health services. This, coupled with the absence or inadequacy of safe acute observation areas in general hospital mental health units, has led to many demands being made on FMHS by generic mental health services. These deficiencies in service provision, particularly in the older units, have led to the transfer to the CMH of

patients under section 208 of the Mental Treatment Act, 1945[80]. Some of these have become long-stay at the CMH, further reducing the acute capacity available there for prisoners.

15.1.5 COURT DIVERSION

Court diversion schemes are available in a number of overseas jurisdictions, but not currently in Ireland. These schemes seek to promote diversion as a means of ensuring that mentally ill offenders do not get involved needlessly in the criminal justice system. Where offending behaviour is clearly related to mental illness, a diversion scheme can allow offenders to be diverted to the care of the mental health services rather than into the prison service where there may be a delay in identifying and responding to their mental health needs.

There is no single model on which court diversion services are based. Some schemes seek to screen all detainees, but most operate a filter system, accepting referrals from non-health care staff who raise suspicions of underlying mental disorder. In England and Wales the court diversion scheme operates through the magistrates' courts, equivalent to the District Court in Ireland. The magistrates' court was chosen for diversion intervention because it is located near the beginning of the criminal justice process and therefore provides a cost-effective filter through which all cases must pass[156].

Diversion schemes operate by performing or organising mental health assessments, gathering information and presenting a comprehensive report to the court with recommendations. All defendants coming before the courts have the right to due process and court diversion schemes operate by informed consent. A person charged with an offence may deem it to be in their best interests in particular circumstances to refuse diversion and instead opt for their case to be heard in the normal way under the criminal justice system.

15.1.6 FRAMEWORK FOR FORENSIC MENTAL HEALTH SERVICES

At present FMHS are largely centralised in Dublin and hospital-based at the CMH. It is proposed that four multidisciplinary, community-based forensic mental health teams be provided, one in each of the HSE regions. It is recommended that the location of these teams be carefully considered in light of their functions outlined below. Their location in proximity to prisons and regional ICRUs would be desirable.

These teams should be closely linked with the FMHS in the CMH and should provide advice and consultation to local generic mental health services to facilitate the management of people with challenging or aggressive behaviour locally. These teams could also help build capacity locally in risk assessment and risk management therefore increasing the confidence of generic mental health teams in handling these cases. The four teams recommended here are in addition to the five teams already operating from the CMH.

In addition, it is recommended that FMHS be expanded to incorporate diversion schemes and to build strong links with An Garda Síochána, which is the agency most likely to come into contact – through domestic disturbance, minor offences or homelessness – with people whose needs would be more appropriately served by being diverted from the criminal justice system to the mental health services. Legislation in Ireland needs to be designed to facilitate the process of court diversion.

All forensic mental health teams (both the regional teams recommended here and those in the CMH) should provide a service to those individuals with a co-morbid substance misuse and mental disorder. This should be done in close liaison with addiction and other health services that already exist in prisons. This issue is also discussed in the following section (15.1.7).

These community-based forensic mental health teams should also be linked to ICRUs in the regions

(proposed in Chapter Eleven for difficult to manage patients). To accommodate the needs of acutely disturbed individuals in the forensic system, a regional provision of ICRUs is necessary both to provide for short-term acute disturbance and to provide for people with more enduring illness characterised by on-going disturbance who are in need of intensive rehabilitation. It is anticipated that these units should be the clinical responsibility of specialised multidisciplinary teams that will call on the expertise of forensic mental health teams as circumstances dictate. The provision envisaged for this particular group is elaborated in the chapter dealing with generic adult services (Chapter Eleven, section 11.9). It is also recommended that plans to upgrade, improve and increase the capacity of the CMH proceed as quickly as possible.

RECOMMENDATION 15.1.2: FMHS should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place.

RECOMMENDATION 15.1.3: Four additional multidisciplinary, community-based forensic mental health teams should be provided nationally on the basis of one per HSE region.

RECOMMENDATION 15.1.4: The CMH should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and the capacity of the CMH should be maximised.

15.1.7 HEALTH SERVICES FOR PRISONERS

Currently health services for prisoners form a dichotomy between primary care (with general practitioners being responsible for physical health and routine mental health complaints) and specialist social work, psychology, addiction, and forensic psychiatry services (which are broadly responsible for prisoner's mental health needs).

The prison psychology service and social work element (probation and welfare) provide broad-based rehabilitation and re-integration schemes that include programmes for offending behaviours, for life-skills training and for sex offenders, whilst the current FMHS provide for serious mental illness.

The issue as to whether all health services to prisoners, physical, mental health and addiction, should not be provided by the same agency - specifically a health agency – to ensure coordination, integration and continuity of care inside and outside of prison is important because of the extensive co-morbidity pattern between mental health, physical health and addiction problems.

Given the profile of complex psychological morbidity, substance abuse and social disadvantage in this population, forensic mental health services cannot function in isolation from other aspects of the prison, health and social services. The input of a mental health service that links only to the prison health services is likely to be limited in its effectiveness in addressing the complexities of intervention, rehabilitation and re-integration. Mental health services need to be interwoven with the other services addressing the psychological, social, educational and addiction counselling needs of the prison population.

Close liaison with specialist substance misuse teams (see 15.3) will be required with prisoners who have complex mental health and co-morbid addiction problems.

RECOMMENDATION 15.1.5: Prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care. Efforts should be made to improve relationships and liaison between FMHS and other specialist community mental health services.

15.1.8 CHILDREN AND ADOLESCENTS

In addition to St. Patrick's Institution in the prison system, specialised residential settings exist at a number of locations throughout the country, at Ballydowd, Portrane and Trinity House (publicly provided special units) and at Upton in Cork and at Clonmel (units provided by the voluntary sector). These units all cater for severely disturbed adolescents who have come into contact with the criminal justice system.

It is recommended that one specialist residential unit with ten beds for children and adolescents be established with a fully resourced, multidisciplinary, mental health team.

There are also a considerable number of troubled children and adolescents in community settings who come before the courts. This group of offenders should be catered for by their local community-based child and adolescent CMHTs. To provide specialist advice, consultation and liaison to generic child and adolescent mental health teams, it is proposed to provide one community-based child and adolescent forensic mental health team. A central function of this team should be to provide the type of specialist advice, support and training required by generic child and adolescent mental health teams to manage these cases locally.

RECOMMENDATION 15.1.6: A dedicated residential 10-bed facility with a fully resourced child and adolescent mental health team should be provided with a national remit. An additional community-based, child and adolescent forensic mental health team should also be provided.

15.1.9 INTELLECTUALLY DISABLED OFFENDERS

In conjunction with the recommendation elsewhere in this policy document that there should be a community-based mental health service for people with intellectual disability and mental disorders, it is recommended that a specialist team be established with the expertise to provide services for intellectually disabled offenders, who constitute a sizeable proportion of offenders. This team should be based in a facility that has a 10-bed capacity for intellectually disabled persons requiring in-patient care.

RECOMMENDATION 15.1.7: A 10-bed residential unit, with a fully resourced multidisciplinary mental health team should be provided for care of intellectually disabled persons who become severely disturbed in the context of the criminal justice system.

15.1.10 THE PROBATION SERVICE

The nationwide Probation Service carries an extensive caseload of ex-prisoners and people who have not served sentences. Many have had, or currently have, mental health problems. Some may be in contact with mental health services and others may not be, even though they require such contact. Therefore it is essential that there are linkages between the Probation Service and the relevant generic mental health services and, where appropriate, FMHS to ensure a linked approach and, particularly, continuity of care.

15.1.11 EDUCATION AND TRAINING

There is an identified need for better educational opportunities for staff of all kinds in the field of forensic mental health. Some progress had been made in this regard recently with some care officers in the CMH undertaking training in mental health nursing.

The introduction of nurses to the prison system is also important and training for prison officers in broad mental health principles is being pursued. Training of this kind should have a strong multidisciplinary component.

One of the advantages of having mental health trained staff (medical, nursing and prison officers) in the prisons is to enable the routine screening of committed prisoners for mental health problems and their referral to appropriate sources. Training in mental health is essential for gardaí and should be put in place without delay. In addition, each major Garda division should have a senior

garda, specially trained, to act as mental health resource and liaison officer both for the purposes of advising and educating gardaí on the management of routine mental health issues and of working closely with local mental health and specialised FMHS personnel. The task of establishing and developing links with local mental health services should be entrusted to this individual so as to foster the principle and practise of shared care.

It is essential that educational modules incorporating mental health be part of Garda training. In addition there should be training manuals provided to each garda, setting out comportment and procedures to be adopted when a mentally ill person is encountered.

RECOMMENDATION 15.1.8: Education and training in the principles and practices of FMH should be established and extended to appropriate staff, including An Garda Síochána.

RECOMMENDATION 15.1.9: A senior garda should be identified and trained in each Garda division to act as resource and liaison mental health officer.

15.1.12 LEGISLATIVE CONSIDERATIONS

A major conceptual and practical change in the legal approach to crime and mental illness was made with the introduction of the Criminal Law Insanity Bill, 2002[155]. This Bill is the first initiative of a statutory nature to define insanity for the purposes of determining 'fitness to be tried' and whether 'not guilty by reason of insanity' is appropriate as a verdict. Up to now the matter has been dealt with through the mechanism of common law.

Other innovative provisions of the Bill include the new concept of diminished responsibility in the case of murder and the establishment of Mental Health Review Boards. The powers given to courts under the proposed provisions will allow for the committal of persons appearing before the courts to mental health centres for assessment and treatment. It is difficult to determine what the implications for local mental health services will be, with possibly a disproportionate demand on some services in areas, such as in inner city Dublin.

It is noted that the Bill gives Clinical Directors some discretion in the matter of accepting individuals from the courts and it is regretted that the Bill, as it stands, does not allow for assessment and treatment to be conducted other than on an in-patient basis. It should be understood that these comments on forthcoming legislation are made without knowledge of the outcome of proposed amendments that may be made before the Bill is finally enacted.

RECOMMENDATIONS: FORENSIC MENTAL HEALTH SERVICES

1. Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done. Where mental health services are delivered in the context of prison, they should be person-centred, recovery-oriented and based on evolved and integrated care plans.

2. FMHS should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place.

3. Four additional multidisciplinary, community-based forensic mental health teams should be provided nationally on the basis of one per HSE region.

4. The CMH should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and the capacity of the CMH should be maximised.

5. Prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated

and effective care. Efforts should be made to improve relationships and liaison between FMHS and other specialist community mental health services.

6. A dedicated residential 10-bed facility with a fully resourced child and adolescent mental health team should be provided with a national remit. An additional community-based, child and adolescent forensic mental health team should also be provided.

7. A 10-bed residential unit, with a fully resourced multidisciplinary mental health team should be provided for care of intellectually disabled persons who become severely disturbed in the context of the criminal justice system.

8. Education and training in the principles and practices of FMH should be established and extended to appropriate staff, including An Garda Síochána.

9. A senior garda should be identified and trained in each Garda division to act as resource and liaison mental health officer.

15.2 MENTAL HEALTH SERVICES FOR HOMELESS PEOPLE

Homelessness is an important social and public health challenge in Ireland. It has become a significant feature of urban settings and is associated with physical and mental ill-health and difficulty in accessing services.

The Housing Act, 1988[157], sets out the legal definition of homeless persons to include those for whom no accommodation exists, which they could be reasonably expected to use, or those who could not be expected to remain in existing accommodation and are incapable of providing suitable accommodation for themselves. A person is to be regarded by a housing authority as being homeless for the purposes of the Act if one of the following is the case:

- there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably be expected to reside with him, can reasonably occupy or remain in occupation.

- he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no other accommodation[157].

The homeless initiative, defined homeless people thus: 'those staying in a hostel, women's refuge, B&B, sleeping rough or staying with friends or family because they had nowhere else to stay'[158].

Studies that have tracked the experience of homeless people over time show that for single adults 'the state of homelessness appears to be more a drift between atypical living situations and the street, than between normality and street life'[159]. Similarly, many homeless people with severe mental illnesses and substance abuse problems travel 'institutional circuits' that include mental hospitals, prison, shelters, shared or doubled-up arrangements, and the street (see Annex 15.2.1 for discussion of the causes and consequences of homelessness).

15.2.1 THE EXTENT OF HOMELESSNESS IN IRELAND

Although by far the largest homeless problem in this country is in the Dublin area, there are small pockets in the other major cities, such as Cork, Limerick and Galway. However little is formally known about the extent of the problem in these locations nor about its relationship to mental illness. The number of homeless people has been estimated to be 2,501 nationally, 1,776 in the ERHA (71%)160. The Simon Community estimates that nationally there are currently at least 4,176 adults and 1,405 children experiencing homelessness, according to the statutory definition.

15.2.2 THE MENTAL HEALTH NEEDS OF HOMELESS PEOPLE

Homeless people with mental health problems are exposed to all the same difficulties that other homeless people encounter but have more trouble meeting their needs because of their mental health condition. Estimates of the prevalence of severe disorder among the homeless in other jurisdictions range from 25%-50%. An Irish study of hostel dwellers in inner city Dublin, revealed 52% suffered from depression, 50% from anxiety and 4% from other mental health problems[158]. This survey also found that 72% of homeless men in hostels, who met criteria for serious mental health problems, were not in receipt of care.

Alcohol abuse has been cited as the single most prevalent health problem for homeless persons. The prevalence ranges from 29% to over 50%[161]. Alcohol and substance abuse may be the primary cause of their homelessness and contribute to or cause their health problems; it may also be the case that alcohol and substance abuse may be a result of a person's homelessness.

RECOMMENDATION 15.2.1: A data base should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.

RECOMMENDATION 15.2.2: In the light of this information, scientifically acquired and analysed, make recommendations as to requirements and implement them.

15.2.3 GAPS IN CURRENT SERVICE PROVISION

Homeless people are more likely to be hospitalised, but less likely to use community-based mental health services, than the general population. Lack of resources for survival and inability to access existing services to meet their needs have been cited by homeless people as a factor in their high readmission rate to psychiatric hospitals. The catchment-based nature of mental health services can also mitigate against homeless people receiving a mental health service.

The statutory housing authorities in Ireland make negligible provision for the mentally ill. A direct consequence of this is that mental health services are currently funding and staffing over 3,000 places in over 400 residences for persons whose housing needs should more properly be the responsibility of the housing authorities. The Homeless Agency produced an *Action Plan on Homelessness in Dublin 2004–2006*[162] which offers a strategy to redress this problem and should be accorded full support to achieve its objectives.

RECOMMENDATION 15.2.3: The *Action Plan on Homelessness*[162] should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.

RECOMMENDATION 15.2.4: A range of suitable, affordable housing options should be available to prevent the mentally ill becoming homeless.

15.2.4 DELIVERING MENTAL HEALTH SERVICES TO HOMELESS PEOPLE

Two general principles should guide service delivery to this group;

- all service users should have an identified catchment area and CMHT. Should they become homeless, the responsibility for their continuing care devolves without ambiguity to that team. There are however limitations to the application of this principle as many persons drift into the city areas while their prior service contact, if they had one at all, may have been elsewhere in the country, or abroad;
- services for the homeless, as for all other groups, must, first and foremost, adopt the principle of community-based care, the service modality for this group being assertive outreach.

RECOMMENDATION 15.2.5: The CMHT team with responsibility and accountability for the homeless population in each catchment area should be clearly identified. Ideally this CMHT should be equipped to offer assertive outreach. Two multidisciplinary, community-based teams should be provided, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population.

A range of practices should be adopted by all mental health services and teams to prevent service users becoming homeless. These might include an assessment of the housing need and living circumstances of all people referred to mental health services, linking with local housing authorities as appropriate, and the implementation of discharge planning and policies with a specific focus on accommodation.

RECOMMENDATION 15.2.6: Community mental health teams should adopt practices to help prevent service users becoming homeless, such as guidelines for the discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services.

RECOMMENDATION 15.2.7: Integration and coordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.

The Homeless Agency has clearly stated its aspiration that there will be no long-term homelessness – whether through mental illness or otherwise – in Dublin by 2010. It would be wrong to become entrenched in a specialism that exists by default; by its very existence it might delay the primary prevention of homelessness in the mentally ill by unnecessarily stepping in to absolve local authorities from fulfilling their statutory obligations in the area of housing for homeless people with mental health problems.

In light of this, it is recommended that the CMHT with responsibility for the catchment area of the service user should have responsibility for providing a mental health service to that person.

However, given that many homeless people drift into urban areas, and that the largest problem is in Dublin, it is recommended that two multidisciplinary, community-based mental health teams, one each for Dublin North and South, should provide a mental health service to this group. This should be primarily an outreach service provided on an extended hours basis (08.00 to 23.00 daily).

Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

The physical resources for these two teams should include a crisis house of ten beds for people not seriously psychotically ill and not requiring admission to acute in-patient units. Acute in-patient beds should be provided from the overall complement in the Dublin area.

In addition, these teams should have accommodation in a community mental health centre, and should be provided with two day centres and one day hospital. It is envisaged that some of the physical premises required could be met by adaptation of existing facilities.

RECOMMENDATIONS: MENTAL HEALTH SERVICES FOR HOMELESS PEOPLE

1. A data base should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.

2. In the light of this information, scientifically acquired and analysed, make recommendations as to requirements and implement them.

3. The Action Plan on Homelessness in Dublin[162] should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.

4. A range of suitable, affordable housing options should be available to prevent the mentally ill becoming homeless.

5. The CMHT team with responsibility and accountability for the homeless population in each catchment area should be clearly identified. Ideally this CMHT should be equipped to offer assertive outreach. Two multidisciplinary, community-based teams should be provided, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population.

6. All community mental health teams should adopt practices to help prevent service users becoming homeless, such as guidelines for the discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services.

7. Integration and coordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.

15.3 MENTAL HEALTH SERVICES FOR PEOPLE WITH CO-MORBID SEVERE MENTAL ILLNESS AND SUBSTANCE ABUSE PROBLEMS

The major responsibility for care of people with addiction lies outside the mental health system. These services have their own funding structure within Primary and Continuing Community Care (PCCC) in the HSE. The responsibility of community mental health services is to respond to the needs of people with both problems of addiction and serious mental health disorders.

Acute presentations by service users with co-morbid mental health and addiction problems will be mostly seen by general adult CMHTs, who offer both addiction counselling expertise and mental health intervention as part of an integrated care plan. These teams will also be responsible for linking these service users to community-based recovery and support programmes as part of facilitating full community re-integration.

RECOMMENDATION 15.3.1: Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.

RECOMMENDATION 15.3.2: General adult CMHTs should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem.

The term 'dual diagnosis' is sometimes used to describe conditions where an individual presents with a mental health disorder and a substance abuse problem concurrently. As this term has been used in the past to describe other areas of mental health, the term 'co-morbid' is used in this policy document. Mental disorders are almost three times as common among those with alcohol dependence, compared to the general population[163], and 40% of service users managed by CMHTs reported drug or alcohol misuse problems[164].

In one Irish study of in-patients with schizophrenia, 39% fulfilled diagnostic criteria for lifetime history of substance misuse. The main substances of misuse were alcohol, cannabis or a combination of both[165]. This clinical presentation presents a challenge to mental health services and requires a clearly articulated service policy. Co-morbidity of this nature contributes to greater severity of addiction and to the severity of mental disorders. Rates of relapse are higher, service utilisation is increased, in-patient treatment is more common and treatment outcome is poor for both conditions.

The NACD (National Advisory Committee on Drugs) commissioned a report on the dual diagnosis issue[166]. They advocated much closer collaboration between addiction programmes and general mental health services in order to improve outcomes for individuals with dual diagnosis. Overall, service users with co-morbid mental health and substance abuse problems respond well to case management, and use of multi-profession teams. Programmes for co-morbid individuals should have a defined structure, a clear target and a minimum treatment period of three to six months.

15.3.1 SERVICE PROVISION FOR PEOPLE WITH CO-MORBID SUBSTANCE ABUSE AND MENTAL ILLNESS

The majority of individuals with co-morbid conditions should be managed by their local general adult CMHT. Individuals whose primary problem is substance abuse and who do not have mental health problems will not fall within the remit of mental health services.

Different models of intervention exist for dealing with problems of co-morbidity. Simultaneous interventions may be offered that address separately the problems of mental illness and addiction; or services that deal with each of these problems may be offered in succession. The service model proposed here involves specialist mental health teams to provide a service to those individuals in the catchment areas with complex or severe substance abuse problems and severe mental disorders.

15.3.2 HEALTH PROMOTION AND EARLY INTERVENTION

Primary care and community interventions are targeted at individuals across the entire population who are considering or commencing experimentation with drugs or alcohol. A national consensus regarding policy at this level is not in place but is desirable. The post of National Policy Coordinator is required to deliver national objectives and standards, and should be within the remit of the PCCC programme.

RECOMMENDATION 15.3.3: The post of National Policy Coordinator should be established to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol abuse and their linkage to mental health services.

There is growing evidence of the cost effectiveness of addiction treatments for both alcohol and drug treatment programs, in settings from GP/primary care to residential services[167,168]. Previous reports indicated the need for treatment to move from care provided in mental hospitals to locally based outpatient services. A recent research project in Ireland has demonstrated that with minimal up-skilling and additional resources, rates of harmful alcohol use can be reduced by staff working in the primary care setting[169]. The further scope for social interventions for many who wish to reduce harm is considerable, but such interventions are still in their infancy.

Many community-based professions including teachers, gardaí, GPs, nurses in primary care, and occupational medicine practitioners can contribute to primary prevention. Approaches in this area are already in place, e.g. Social, Personal and Health Education (SPHE) in schools. This involves such bodies as health promotion, education officers, the voluntary sector, community representatives and the Department of Education and Science. Approaches of this kind need to be standardised and disseminated on a national basis and this requires education officers to coordinate activities. There are currently eighteen education officers in the country. Two education officers per local health office are necessary.

15.3.3 SPECIALIST MENTAL HEALTH SERVICES

The majority of individuals with co-morbid substance abuse problems should be managed by their local general adult CMHT. They should provide whatever care is required to respond to a service user's mental health needs, applying core best practice principles including user involvement, care planning, recovery orientation and attention to their housing/employment needs and difficulties.

Reintegration in the community is an especially important feature of service with these service users, and attention must be given to linking to community-based addiction services as a vital component of any comprehensive care plan. 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.

In addition, it is also recommended that a specialist team be established in each catchment area of 300,000 population, to care for people with severe mental disorder and long-standing, complex co-morbidity. These teams should be targeted at people whose mental health problems are driven by substance misuse. Rehabilitation should be a strong feature of care provision by these teams.

Each team should establish clear linkages with general adult, forensic and rehabilitation teams, and should act as an advice and consultation resource for these teams. It is important that this specialist team act primarily as a catchment area resource for those with severe co-morbid problems. General adult teams and forensic mental health teams should deal with most of the co-morbidity in their area of responsibility.

These specialist substance abuse mental health teams should be comprised of the following members:

- one consultant psychiatrist
- one doctor in training
- four substance misuse and dependency key workers/ counsellors
- two clinical nurse specialists
- one clinical psychologist
- two social workers
- one occupational therapist

Each member should have specialist expertise in the field of addiction in addition to mental health expertise.

These teams should develop very clear links with the general adult CMHT they will receive referrals from. Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

Pathways in and out of this catchment specialist service should be made clear to everybody involved, especially service users and their carers. If beds are required by this team, they should negotiate access to facilities under the jurisdiction of the addiction services, both public and voluntary bodies. In specific cases, they may choose to make a business case that they be provided in the independent sector. These beds should not be utilised for routine detoxification, which should be done on an outpatient basis. More complex detoxification should take place in general hospital settings.

RECOMMENDATION 15.3.4: Specialist adult teams should be developed in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder.

RECOMMENDATION 15.3.5: These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service users and referring adult CMHTs.

15.3.4 SERVICES FOR CHILDREN AND ADOLESCENTS

Uncomplicated substance abuse and alcohol addiction is not the responsibility of child and adolescent mental health services. There is an urgent need to establish specific mental health services for adolescents who have co-morbid addiction and mental health problems. A Department of Health and Children working group recommended that adolescent addiction services should be locally delivered, holistic in approach, developmentally appropriate with an emphasis on family involvement

and should be separate to adult addiction services[170]. For the small number of adolescents with co-morbid abuse and mental health problems, the number of specialist adolescent teams should be increased from the current number of two in the Dublin area to four nationally (i.e. an additional one in Cork and one in Galway). These teams should have the following composition:

- one consultant child and adolescent psychiatrist (with speciality in addiction)
- one doctor in training
- one clinical psychologist
- two clinical nurse specialists, with expertise in adolescent mental health &/or skills in relevant individual or family therapy.
- one social worker (ideally with skills in family therapy)
- three counsellors with expertise in Motivational Enhancement Therapy or CBT
- two family therapists
- two youth workers

These teams should be based in Community Mental Health Centres, either as stand-alone units or sharing space with other community-based teams.

RECOMMENDATION 15.3.6: Two additional adolescent multidisciplinary teams should be established outside Dublin to provide expertise to care for adolescents with co-morbid addiction and mental health problems. This provision should be reviewed after five years.

RECOMMENDATIONS: MENTAL HEALTH SERVICES FOR PERSONS WITH CO-MORBID SEVERE MENTAL ILLNESS AND SUBSTANCE ABUSE PROBLEMS

1. Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.
2. General adult CMHTs should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem.
3. The post of National Policy Coordinator should be established to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol abuse and their linkage to mental health services.
4. Specialist adult teams should be developed in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder.
5. These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service users and referring adult CMHTs.
6. Two additional adolescent multidisciplinary teams should be established outside Dublin to provide expertise to care for adolescents with co-morbid addiction and mental health problems. This provision should be reviewed after five years.

15.4 MENTAL HEALTH SERVICES FOR PEOPLE WITH EATING DISORDERS

It is recognised that there are three main types of eating disorder: anorexia nervosa, bulimia nervosa, and binge eating. Eating disorders have a high rate of mental health and general medical co-morbidity that often conceals, clinically and statistically, the underlying eating disorder condition.

Epidemiological data from other jurisdictions suggest an annual incidence of 10 cases of anorexia nervosa per 100,000 population for females and of 0.5 for males. All eating disorders are estimated to have an upper prevalence of 5,000 per 100,000, translating to approximately 200,000 in Ireland. The ratio of anorexia nervosa to bulimia nervosa is usually given as four to one. In terms of outcome, anorexia nervosa must be regarded

as a very serious condition with a mortality of 20 percent for patients longitudinally followed up by services for long periods of time. (For more detailed information on epidemiology of eating disorders see Annex 15.5)

15.4.1 GAPS IN CURRENT SERVICE PROVISION FOR PEOPLE WITH EATING DISORDERS

Currently Ireland has only three designated specialist beds for the treatment of eating disorders in the public mental health service and two eight-bed units in the private sector. The two private services, while mainly catering for private patients, also take public patients, estimated to be approximately one tenth of their clientele, paid for mainly by two particular HSE areas.

In terms of in-patient resources, the private sector is better catered for, with a general lack of facilities for public patients. While the two private services have multidisciplinary teams, in whole or in part, this is not true of services offered in the public sector. A number of individuals also travel to specialised residential facilities in the United Kingdom, some of this being paid for by the HSE.

It is clear that the national stock of in-patient beds available for eating disorders is inadequate. These beds have a very slow turn-over, as the length of stay can be long. It is not possible to say how many individuals with eating disorders were treated in the public community mental health services on an outpatient or day hospital basis.

Although the three services have some outpatient follow-up dimensions to their in-patient programmes, their Dublin-based location makes attendance difficult for people living outside the capital.

There are a small number of children admitted annually to mental health facilities. However, some eating disorder cases are admitted to the specialised children's hospitals in Dublin and to paediatric accommodation in other general hospitals throughout the country. The Hospital In-patient Enquiry (HIPE) recorded 77 discharges of children and adolescents (41 aged 10–14 and 36 aged 15–19) in 2002, all with anorexia nervosa; there were no bulimia nervosa admissions.

Specialist provision for children with eating disorders is deficient. In particular there is little communication or cohesion between child and adolescent mental health services and adult mental health services in relation to service provision, early identification and continuity of care.

15.4.2 HEALTH PROMOTION AND EARLY DETECTION

School children, particularly girls, are continually bombarded with influential cultural material relating to their shape, suggesting to them what is fashionably acceptable and politically correct in terms of their appearance. The consequence is that many, perhaps the majority, engage in some degree of dieting at some time or other in childhood or adolescence, though usually without proceeding to developing an eating disorder.

Nevertheless, it is important to view the progress from dieting to eating disorder as a continuum, so responsibility and accountability on the part of those disseminating messages that indiscriminately promote thinness need monitoring.

There is a need for greater public awareness of eating disorders at community and family level. This can be brought about by general publicity campaigns by national public and voluntary bodies. Targeting young people in schools is best accomplished through general mental health education modules as part of positive mental health awareness rather than as a module devoted specifically to eating disorders, for example in the SPHE programme. This education should stress positive healthy eating and positive body image following a general prevention model.

RECOMMENDATION 15.4.1: Health promotion initiatives that support greater community and family awareness of eating disorders should be supported and encouraged.

RECOMMENDATION 15.4.2: The activities of voluntary agencies in promoting awareness and responses to eating disorders should be supported.

Because of the denial associated with eating disorders, early intervention is difficult, and it is not unusual to encounter first presentations in the Accident and Emergency (A&E) unit because of some serious medical condition. This being the case, early detection becomes of singular importance, with primary care having a key role.

Unfortunately there is strong evidence that general practitioners in this country are ill-equipped for the task because of lack of education in the field of eating disorders. This deficit should be addressed in undergraduate and on-going medical education. The same is also true for other professional workers, such as public health nurses and other nurses, teachers and parents, all of whom are obviously strategically placed to encounter the early signs. Once early signs have been detected by them, it is important that they have specialist advice and support available to give them guidance and support.

It is important that professionals, including those working in general hospitals without specialist understanding of eating disorders, are trained to be aware of eating disorder patients particularly at risk for complications and poor outcome. These include patients with low body mass index (BMI), pregnant women and older patients.

A particularly important group are those with Type I diabetes who are at special risk for retinopathy and other co-morbid pathologies. While medication, per se, has little role in treatment, those prescribed anti-depressants and anti-psychotics should be carefully monitored in relation to cardiac function because of the particular risk for underweight, physically compromised persons. Persistent vomiting is also a risk condition needing particularly close observation.

RECOMMENDATION 15.4.3: Special emphasis should be placed on including training modules on eating disorders in the undergraduate and postgraduate training of health professionals.

15.4.3 SPECIALIST MENTAL HEALTH SERVICES FOR EATING DISORDERS

(a) Services for children and adolescents

Dealing with eating disorders is within the remit of child and adolescent mental health services. With the increased provision of these services recommended in Chapter Ten, there should be capacity for these services to deliver evidence-based interventions in the most appropriate community setting.

However, there is a general lack of in-patient beds for children and adolescents nationally. The proposals for an additional 80 beds, to bring the national complement up to 100 should address this. These units should allocate some beds for eating disorders. These child and adolescent in-patient units should be closely associated with general hospitals to ensure easy access to the full range of medical diagnostic and treatment inputs, including those of dieticians and other relevant personnel which are essential for comprehensively dealing with eating disorders.

For the small number of children and adolescents who require specialist input above and beyond that provided by the child and adolescent CMHT and in-patient unit, there should be a National Centre for Eating Disorders, located in one of the main national children's hospitals. This centre should be staffed by a multidisciplinary team with appropriate skills and training to deal with the very complex cases that will be referred to it. Figure 15.4.1 shows the care pathway for children and adolescents.

RECOMMENDATION 15.4.4: Eating disorders in children and adolescents should be managed by the child and adolescent CMHTs on a community basis, using beds in one of the five in-patient child and adolescent units if required.

RECOMMENDATION 15.4.5: There should also be a full multidisciplinary team in a National Centre for Eating Disorders, to be located in one of the national children's hospitals, for complex cases that cannot be managed by local child and adolescent CMHTs.

(b) Services for adults

As with children and adolescents, referrals for adults with eating disorders should be made to the general adult CMHT. It may be possible for these teams to manage uncomplicated cases on a community basis. However, it is recognised that because of the complexity of the psychological and familial nexus within which eating disorders are encountered, specialist inputs may be required.

While service users with eating disorders should be followed up in the long term by their local sector general adult CMHT, the availability of specialist residential programmes will be critical for some individuals with eating disorders to address their destructive eating patterns and explore personal and family conflicts that may be maintaining them.

It is recommended that four specialist eating disorder teams for adults be provided nationally, one in each of the HSE regions. Each of these should have six beds in a regional mental health unit (i.e. per million population). This should provide 24 adult eating disorder beds nationally in the public sector. It is envisaged that not all members of the eating disorder team should work full-time in the speciality because of the intense and demanding nature of this work and the need for wider professional interest, practise and contact with colleagues in other areas to avoid professional isolation.

RECOMMENDATION 15.4.6: There should be four specialist multidisciplinary teams providing specialist in-patient, outpatient and outreach services for eating disorders; one team per HSE region. These teams should link closely with local adult CMHTs to ensure continuity of care.

RECOMMENDATION 15.4.7: Each team should manage an eating disorder sub-unit in a regional general hospital mental health unit. These subunits should have six beds each, thereby contributing 24 public ED beds nationally.

It is essential that the full range of best-practice interventions are made available to individuals with eating disorders. The four specialist teams should also provide out patient and outreach work, which should take up more working time than in-patient care. This work is a vital component of the comprehensive care they should provide.

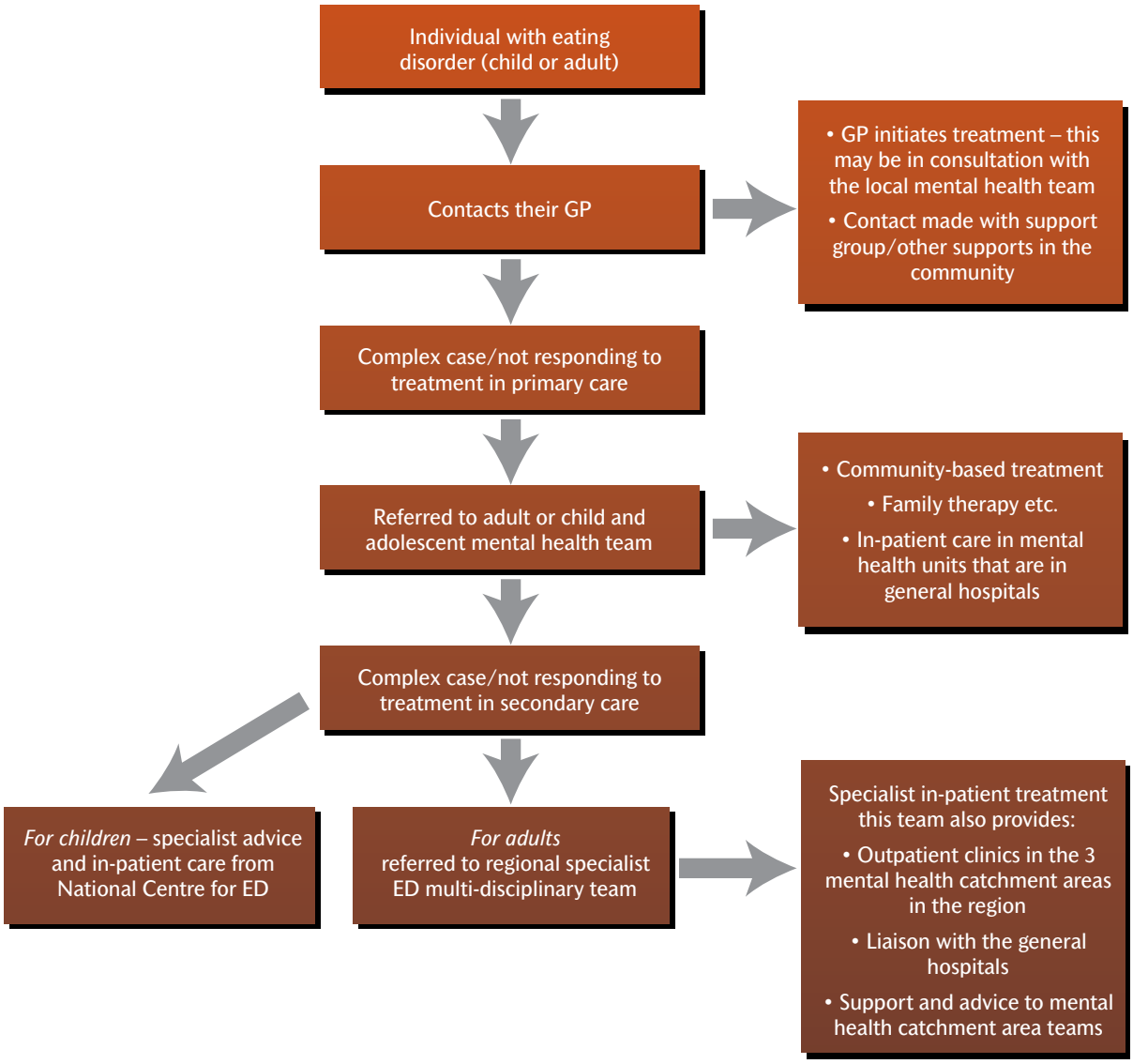
CMHT outpatient care will also coordinate care provision with primary care, educational and voluntary agencies, and with child services, thus ensuring continuity of care. Provision of consultation and advice to primary care and to all relevant community-based voluntary input will also be a prime activity.

Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

RECOMMENDATION 15.4.8: The four specialised multidisciplinary adult teams, and the national team for children and adolescents, should provide community-based consultation, advice and support to all agencies in their area.

Figure 15.4.1 shows the care pathway for children and adults with eating disorders.

Figure 15.4.1: Care pathway for children and adults with eating disorders.



RECOMMENDATIONS: MENTAL HEALTH SERVICES FOR PERSONS WITH EATING DISORDERS

1. Health promotion initiatives that support greater community and family awareness of eating disorders should be supported and encouraged.

2. The activities of voluntary agencies in promoting awareness and responses to eating disorders should be supported.

3. Special emphasis should be placed on including training modules on eating disorders in the undergraduate and postgraduate training of health professionals.

4. Eating disorders in children and adolescents should be managed by the child and adolescent CMHTs on a community basis, using beds in one of the five in-patient child and adolescent units if required.

5. There should also be a full multidisciplinary team in a National Centre for Eating Disorders, to be located in one of the national children's hospitals, for complex cases that cannot be managed by local child and adolescent CMHTs.

6. There should be four specialist multidisciplinary teams providing specialist in-patient, outpatient and outreach services for eating disorders; one team per HSE region. These teams should link closely with local adult CMHTs to ensure continuity of care.

7. Each team should manage an eating disorder sub-unit in a regional general hospital mental health unit. These subunits should have six beds each, thereby contributing 24 public ED beds nationally.

8. The four specialised multidisciplinary adult teams, and the national team for children and adolescents, should provide community-based consultation, advice and support to all agencies in their area.

15.5 LIAISON MENTAL HEALTH SERVICES

Liaison mental health services (LMHS) provide clinical services and education, teaching and research in general hospital settings. They are concerned with helping patients in hospital to process and cope with the impact of major illness and surgical procedures, and with loss and trauma. They can also identify those patients with severe mental health problems that may have been aggravated by their admission to hospital, or may be manifesting as physical symptomatology.

Research has established that the incidence of depression is higher in general hospital settings than in the normal population, but that this is often unrecognised. Physically ill patients with depression are less likely to comply with their treatment, have longer hospital stays, higher health-care costs, more disability, poorer quality of life and higher mortality than those without depression[171].

Other mental health problems, such as anxiety disorders, are similarly over-represented, with similar consequences. Rates of depression are higher with certain patient groups, such as those with cancer or neurological disorders, where rates of 25-35% can occur. Liaison services also intervene in A&E departments where the presentation of suicidal behaviour and substance abuse requires expert assessment and management.

The main benefits of liaison mental health services are the identification and treatment of mental health problems in the general medical and A&E settings. This leads to reduced morbidity, reduced hospital admission, reduced inappropriate physical investigations, reduced length of stay, reduced outpatient attendances, reduced anxiety and depression and improved quality of life[172]. Liaison mental health services also have an excellent opportunity to promote mental health through direct intervention with in-patients and through the training of hospital staff.

15.5.1 CURRENT SERVICE PROVISION IN IRELAND

There are currently nine liaison mental health teams in Ireland with varying degrees of multidisciplinary composition. Seven are in Dublin, one each in Cork and Limerick. Nationally, liaison mental health services are patchy with certain areas having no access to such services[173].

Most liaison mental health services are delivered by a multidisciplinary team using a consultation model. In the consultation model, referrals are received principally from hospital doctors.

Another model employed is the liaison model. In the liaison model, the liaison psychiatrist becomes part of an existing hospital team e.g. specialist HIV service. In practice, most liaison mental health services use both models of service delivery.

15.5.2 PROPOSED SERVICE FRAMEWORK FOR LIAISON MENTAL HEALTH SERVICES

Every acute admitting hospital in Ireland should have access to liaison mental health services. The number of teams required will depend on the volume and type of workload. A minimum of one liaison mental health team equivalent is required per 500-bed general hospital to provide a daytime service for secondary care needs serving local populations. In addition to the existing nine teams operating in general hospitals, it is recommended that a further four mental health liaison teams be established nationally, to result in a complement of one liaison mental health team per regional hospital. Existing liaison mental health teams should have the full multidisciplinary team put in place.

The composition of a liaison mental health team should be as follows:

- one consultant liaison psychiatrist
- one doctor in training
- two clinical psychologists
- five clinical nurse specialists to include two specialist nurse behaviour therapists or psychotherapists
- two secretaries/administrators.

Other staff usually required include:

- one neuropsychologist (sites with neurology/ neurosurgery departments)
- one mental health social worker
- one occupational therapist with vocational rehabilitation skills
- one substance misuse counsellor
- one family therapist.

Governance should be in accordance with the leadership model described for multidisciplinary teams (see Chapter Nine); each team should have a clearly identified clinical leader, team coordinator and practice manager.

Adequate facilities should be provided for the LMHS team to carry out its functions, bearing in mind the needs and sensitivities of their service users. The need for extra provision for national referral centres should be evaluated when all these teams have been in place for some time.

RECOMMENDATION 15.5.1: The existing provision of nine LMHS teams nationally should be increased to thirteen.

15.5.3 THE NEEDS OF CHILDREN AND ADOLESCENTS FOR LIAISON MENTAL HEALTH SERVICES

Children and adolescents with physical ill health have three times the risk of developing a mental health problem as a child with no physical health difficulties.

There are four categories of problems that require referral to a child and adolescent liaison service:

- children and adolescents with chronic physical illness
- children and adolescents with chronic unexplained organic symptoms that have perpetuating and precipitating and psychogenic factors
- children and adolescents who overdose and engage in deliberate self-harm who present to the hospitals
- children and adolescents with mental health disorders and coexisting physical illness.

All hospitals engaged in assessing and treating these categories of children and adolescents require specialist liaison mental health services.

It is recommended that there be full multidisciplinary teams in each of the three main national children's hospitals each covering a catchment area. There is currently a child and adolescent liaison service operating without a complete team in each of these hospitals. In addition, one child and adolescent CMHT should be provided for the other catchment areas (300,000) to provide liaison services to paediatric and general hospitals (see Chapter Ten).

RECOMMENDATION 15.5.2: Complete multidisciplinary LMHS should be established in the three national children's hospitals.

RECOMMENDATION 15.5.3: Liaison child and adolescent mental health services should be provided by a designated child and adolescent CMHT, one per 300,000 population (see Chapter Ten).

15.5.4 TRAINING AND EDUCATION

An important part of the liaison mental health service is to educate and train hospital staff in the detection and initial management of common mental health problems.

Liaison mental health teams have a role in teaching communication skills and providing expertise in areas such as 'breaking bad news'.

Liaison mental health services are also involved in the area of staff support, for example, supporting oncology ward staff. This consists of delivering advice, supervision and education within the broader hospital, for example to clinical nurse specialists and junior doctors within medicine, surgery and the emergency department.

One third of the liaison mental health team time is expended in education and training and this should be reflected in service agreements and contracts.

15.5.5 LINKS TO OTHER MENTAL HEALTH AND COMMUNITY SERVICES

Links should be formally established and protocols and service agreements agreed with the following services:

- Community Mental Health Teams
- substance misuse and addiction services
- rehabilitation and recovery mental health teams
- community forensic mental health teams
- community care and community vocational rehabilitation or occupational therapy
- local medical social work and health psychology staff.

This is best achieved by local agreements, integrated planning, service mapping and integrated management as proposed in this policy document.

15.5.6 PERINATAL PSYCHIATRY

The specialty of perinatal psychiatry is concerned with a very small group of women who are at high risk of having mental health problems during pregnancy and up to one year postpartum (after giving birth). Women are at peak risk of having mental illness in the perinatal period, contrary to commonly held beliefs that this is a wholly healthy time in a woman's life. The three main areas of clinical focus in perinatal psychiatry are depression, bipolar disorder and schizophrenia.

Approximately half of women with a history of bipolar disorder relapse during pregnancy, and this is probably largely associated with discontinuation of psychotropic medication. Even if a woman with a history of bipolar disorder is well at the time of delivery, she has a 50% risk of developing a post-partum psychosis. The post-partum period is the time of highest risk for the development of an episode of illness in women with bipolar disorder[174,175].

Post-partum psychosis is a severe and acute onset mood disorder occurring in the first two weeks post-partum (typically day three or day four) and is unique in that it occurs at a very specific time, has some distinguishing clinical features and is a psychiatric emergency because unless treated vigorously it can result in suicide and death of the baby (infanticide).

Perinatal mental health services require both a specialist mental health service and obstetric services. Specialist perinatal psychiatry services may be required for the following reasons:

- Post-partum psychosis is a severe and difficult-to-treat illness, requiring specific expertise. Women with serious mental illness require coordinated care

across disciplines: psychiatry (general and perinatal), obstetric, general practice and child and family social services.

- Women are rarely medicated during pregnancy, as general psychiatrists are reluctant to prescribe medication. Expert knowledge of the altered physiology of pregnancy on psychotropic drug metabolism and their possible effects on the baby are necessary to treat pregnant women requiring these medications.

RECOMMENDATION 15.5.4: One additional adult psychiatrist and senior nurse with perinatal expertise should be appointed to act as a resource nationally in the provision of care to women with severe perinatal mental health problems.

RECOMMENDATIONS: LIAISON MENTAL HEALTH SERVICES

1. The existing provision of nine LMHS teams nationally should be increased to thirteen.
2. Complete multidisciplinary LMHS should be established in the three national children's hospitals.
3. Liaison child and adolescent mental health services should be provided by a designated child and adolescent CMHT, one per 300,000 population (see Chapter Ten).
4. One additional adult psychiatrist and senior nurse with perinatal expertise should be appointed to act as a resource nationally in the provision of care to women with severe perinatal mental health problems.

15.6 NEUROPSYCHIATRY SERVICES

Neuropsychiatry is the speciality that provides for the mental health needs of persons with brain and nervous system disorders. Clinical neuropsychiatry is a subspecialty of psychiatry devoted to the assessment and management of mental and behavioural problems in nervous system as well as unexplained neurological symptoms.

Typical clinical presentations requiring the specialist skills of neuropsychiatry services include brain injury sequelae, early-onset dementia, psychological morbidity related to epilepsy and other neurological disorders and psychogenic non-epileptic seizures. A key role of neuropsychiatry services is the assessment of these complex cases, which are often beyond the skills and service remit of general adult mental health services.

Neuropsychiatry service needs are largely unmet in Ireland and where they are met, it is by existing liaison psychiatry mental health services[173]. Additional expertise and treatment is purchased from abroad but should and can be provided here. Neuropsychiatry should become established in Ireland to meet this need.

Neurology services are typically the highest referrers to neuropsychiatry. Neurology is greatly understaffed and under-resourced in Ireland though neurological diseases are common. A likely increase in neurology services will lead to greater recognition and thus more frequent referral and heightened demand.

15.6.1 THE NEED FOR NEUROPSYCHIATRY SERVICES

A year after traumatic brain injury, approximately 20% of people will have diagnosable mental disorders and 40% will have neurobehavioral problems. These figures estimate a neuropsychiatry need in traumatic brain injury of approximately 80 cases per 100,000 population.

Neuropsychiatric needs are also present in service users with acquired brain injury from encephalitis, meningitis, subarachnoid haemorrhage and anoxic brain as shown in the experience at National Rehabilitation Hospital (NRH). Similar estimates are available for epilepsy (600–1,500 cases per 100,000 population), early-onset dementia (50 cases per 100,000 population age 46-64), unexplained

neurological symptoms including non-epileptic seizures and motor conversion disorders (300 cases per 100,000 population) and other disorders.

Taken together, these estimates suggest that it is reasonable to expect 30–35 new referrals to specialist neuropsychiatry services per 100,000 population per year whose needs cannot be met by local mental health services.

It has been a view of the NRH that Ireland needs a challenging behaviour unit similar to services of this type provided in the UK. Since the NRH set up its neurobehavioural clinic, where patients are reviewed by neuropsychiatrists, neuropsychologists and rehabilitation medicine brain injury specialists, it has become concerned about the overlap in challenging behaviour care with the forensic mental health services.

There appear to be a number of brain injury patients whose frontal lobe disorders have led to challenging behaviour and subsequent incarceration in prison. It would appear more appropriate that patients with challenging behaviour due to brain injury are rehabilitated in a non-custodial challenging behaviour unit rather than in a prison. Neuropsychiatry should have a key role in any proposed challenging behaviour unit for patients with acquired brain injury.

15.6.2 PROPOSED MODEL OF NEUROPSYCHIATRY SERVICE PROVISION

Key representatives from liaison mental health services, neurology, rehabilitation medicine and MHSOP in each neuroscience centre should establish a working group to plan neuropsychiatry services. The proposed model will still not service all the needs of those who need neuropsychiatric expertise, especially for patients with enduring neuro-behavioural-rehabilitation needs residing at a distance from centres.

The working group should consider the needs of these individuals in the context of evolving national provision for neuro-rehabilitation in the future.

There is a requirement for two multidisciplinary neuropsychiatry teams nationally. These multidisciplinary teams should consist of at least:

- one consultant psychiatrist
- two doctors in training
- one to two clinical neuropsychologists
- two cognitive-behavioural therapists
- one to two occupational therapists
- two social workers.

They should have defined access to neurophysiology, neuro-radiology and imaging, physiotherapy, and speech and language therapy. These teams should have close working relationships and develop shared-care protocols with neurology, LMHS, general adult and recovery and rehabilitation CMHTs, and MHSOP.

These teams should be established and based in the two major neuroscience centres nationally:

- Dublin (Beaumont Hospital, with sessional commitments outreaching to other acute sites including the NRH)
- Cork (Cork University Hospital, with sessional commitments outreaching to Waterford, Kerry, Limerick and Galway).

RECOMMENDATION 15.6.1: Two specialist neuropsychiatry multidisciplinary teams should be established in the major neuroscience centres in Dublin and Cork.

Defined sessions in each of the four other Dublin-based neuroscience centres – St Vincent's University Hospital, St James's Hospital, Tallaght Hospital and Mater Misericordiae University Hospital should be funded to allow a named key clinician take the lead in developing regional neuropsychiatry services.

There will also be a requirement for in-patient neuropsychiatry beds for both assessment and

management of the most complex cases. A national in-patient neuropsychiatry unit with six to ten beds will ideally be based in or near a clinical neuroscience centre and have a working relationship with neurology and rehabilitation medicine.

RECOMMENDATION 15.6.2: As a national resource, a special neuropsychiatric in-patient unit with six to ten beds should be established.

RECOMMENDATION 15.6.3: Facilities for video-conferencing and telemedicine should be considered to extend the expertise located in these units nationally, and to enable them to become a consultation and training resource.

Continuing care needs of neuropsychiatry patients are best provided in consultation with rehabilitation medicine services and recovery and rehabilitation mental health services. Mental health services for older persons are best positioned to address the continuing care needs of early-onset dementia patients. Guidelines and service agreements for this will be required and must be developed.

RECOMMENDATIONS: NEUROPSYCHIATRY

1. Two specialist neuropsychiatry multidisciplinary teams should be established in the major neuroscience centres in Dublin and Cork.

2. As a national resource, a special neuropsychiatric in-patient unit with six to ten beds should be established.

3. Facilities for video-conferencing and telemedicine should be considered to extend the expertise located in these units nationally, and to enable them to become a consultation and training resource.

15.7 SUICIDE PREVENTION

The consistently high rates of death by suicide in Ireland over the past 20 years, particularly among young men, have made it an issue of major public concern. No matter what the particular route to suicide, it is without doubt one of the saddest events in human experience. It can leave devastation in its wake as relatives, friends and local communities struggle with the trauma of inexplicable loss, shock and feelings of rejection.

Disturbing suicidal behaviour statistics have alerted us to the reality of the intense emotional distress that gives rise to this behaviour and to the range of factors that cause people to resort to self-harm.

15.7.1 WHO IS AT RISK?

Suicidal behaviour covers a broad spectrum of behaviour ranging from feelings of hopelessness to passive death wishes, to suicidal ideation and planning, self-injury and self-harm, and behaviour that leads to untimely death.

The evidence internationally strongly suggests that suicide and suicidal behaviour is not simply a response to a single stress[176], but the outcome of a build-up of stresses, which leads to a feeling of entrapment and hopelessness[177].

With few protective factors – resilience, connectedness, effective problem-solving skills – to draw on, and with the growing perception that escape or rescue from their predicament is unlikely, the option of suicidal behaviour may be pursued an individual, particularly where there is access to means of self-harm.

Effective action to prevent suicidal behaviour requires the cooperation of the whole community, including education, health and social services, business and voluntary organisations, agencies committed to positive health promotion and to reducing stigma surrounding mental health problems, and ordinary people who are often the first to become aware of crises arising in their friends, colleagues and loved ones.

Within mental health care settings, it is critical that there are agreed protocols and guidelines for engaging with people who are themselves assessed to be at high risk of suicidal behaviour, and for engaging with people who are particularly vulnerable in the wake of someone else's suicide.

There is consistent evidence from retrospective studies that mental health problems, notably depression, constitute the most important risk factor for suicide and self-harm, particularly where the person has multiple problems or is involved in harmful drug use. Engaging in deliberate self-harm is the strongest predictor of future suicidal behaviour, both non-fatal and fatal[178]. Other risk factors that have been noted include socio-economic stresses, suicide or violence within the family, anxieties about gender and sexuality, same-sex attraction, incarceration in custody, and homelessness.

Some older people may find themselves suddenly physically and economically dependent on others and affected by mental and physical problems. Depression in older people is strongly linked to suicidal thoughts and acts. Pain, loss and grief, loneliness or alcoholism may also contribute. A suicidal act by an older person tends to be less impulsive and more likely to result in death than in a younger person.

Research has consistently shown that people with a serious mental illness have a high risk of dying by suicide. Conditions such as major depression, bipolar mood disorders, schizophrenia and personality disorders all show a significantly increased risk of suicide compared to the general population[181,182].

Interpreting the findings of psychological 'autopsy' studies, it is important to consider that the information has been obtained retrospectively and indirectly through others, such as next of kin and health care professionals.

Annex 15 details the epidemiology of suicidal behaviour in Ireland and the known factors associated with these behaviours. It also describes broad guidelines to encourage health promotion, and specific guidelines for prevention, intervention and postvention in respect to suicidal behaviour in mental health care settings.

RECOMMENDATION 15.7.1: There should be agreed protocols and guidelines for engaging with those assessed to be at high risk of suicidal behaviour, and for engaging with those who are particularly vulnerable in the wake of a suicide, within mental health care settings.

RECOMMENDATION 15.7.2: Particular care should be given to service users of mental health services who have been identified as being at high risk of suicidal behaviour, e.g. those with severe psychosis, affective disorders, and individuals in the immediate aftermath of discharge from in-patient settings.

15.7.2 REDUCING SUICIDE IN THE COMMUNITY

Suicide prevention encompasses the following broad goals:

- to identify individuals at high risk of suicidal behaviour and intervene with strategies that reduce the likelihood of choosing suicidal behaviour as a means to resolve their distress
- to promote those factors that act as protective factors in a suicidal crisis, e.g. positive coping strategies and resilience, communication and sense of belonging in local community
- to increase support for those bereaved by suicide
- to establish training programmes that equip everybody in the community with skills to respond effectively to someone in crisis
- to promote research to identify specific determinants of suicidal behaviour in an Irish context, and to evaluate the effectiveness of a range of interventions in health, educational and community settings.

Suicide is a complex multifaceted problem that poses a challenge to the whole community. Many initiatives are under way across the country in terms of research, prevention, intervention and postvention (i.e. intervention with the bereaved after a suicide has occurred) but the problem continues to rise. A lack of integration and coordination of statutory, voluntary, and community agencies has been identified as a barrier to the implementation of effective suicide prevention initiatives[183].

Integration and rationalisation of initiatives across the community requires leadership and coordination. The recent establishment of a National Office for Suicide Prevention within the HSE will hopefully redress the current leadership vacuum and provide a means for ensuring that effective strategies within the community are supported and that protocols for responding to suicidal behaviour in mental health settings are standardised and effectively implemented.

RECOMMENDATION 15.7.3: Integration and coordination of statutory, research, voluntary, and community activities is essential to ensure effective implementation of suicide prevention initiatives in the wider community. In this regard the National Office for Suicide Prevention should be supported and developed.

15.7.3 A NATIONAL STRATEGY FOR ACTION ON SUICIDE PREVENTION

The Health Boards Executive (HeBE) and the National Suicide Review Group, in partnership with the Department of Health and Children, commissioned a National Strategy for Action on Suicide Prevention, in consultation with the statutory, voluntary and community stakeholders. The thrust of the project was to adopt a broad-based public health approach as well as targeting the high-risk and vulnerable groups.

Priority areas of service development within the strategy were identified including risk management and assessment, treatment after deliberate self-harm, bereavement support and recording practices. The framework was informed by feedback from the national consultation process as well as approaches employed by other countries in developing their strategies.

The results of this project have been published as *Reach Out*, which details a range of actions that should be implemented across society to reduce suicide[184]. In relation to mental health services, it details specific actions to be taken to improve mental health service provision for people engaging in suicidal behaviour. These include the following:

- standardising pre-discharge and transfer planning from or between mental health service settings
- delivering basic suicide awareness and specialist skill-based training programmes for mental health staff
- providing psychological support for staff working closely with the distress of individuals in suicidal crises, and for those involved in the aftermath of suicidal incidents
- developing and evaluating pilot service initiatives aimed at improving intervention with psychological distress and self-harm behaviours.

RECOMMENDATION 15.7.4: The strategies recommended in *Reach Out* to prevent suicide and to improve mental health provision for people engaging in suicidal behaviour should be adopted and implemented nationally.

RECOMMENDATIONS: SUICIDE PREVENTION

1. There should be agreed protocols and guidelines for engaging with those assessed to be at high risk of suicidal behaviour, and for engaging with those who are particularly vulnerable in the wake of a suicide, within mental health care settings.

2. Particular care should be given to service users of mental health services who have been identified as being at high risk of suicidal behaviour, e.g. those with severe psychosis, affective disorders, and individuals in the immediate aftermath of discharge from in-patient settings.

3. Integration and coordination of statutory, research, voluntary, and community activities is essential to ensure effective implementation of suicide prevention initiatives in the wider community. In this regard the National Office for Suicide Prevention should be supported and developed.

4. The strategies recommended in *Reach Out* to prevent suicide and to improve mental health provision for people engaging in suicidal behaviour should be adopted and implemented nationally.

15.8 PEOPLE WITH BORDERLINE PERSONALITY DISORDER

Borderline personality disorder is one of a number of personality disorders that can pose serious behavioural challenges to services. People with this disorder can present with histories of abusive relationships, repeated self-harm behaviour, emotional instability and failure to sustain steady employment or housing. Their behaviour on presentation can be quite erratic and they can find it difficult to engage with the standard care options available in community services.

Problems arising from borderline and other personality disorders often lead to individuals coming to the attention of forensic and substance abuse services.

The term borderline personality disorder carries great stigma from the point of view of service users. From their perspective the term carries a strong implication that their behaviour is manipulative, attention-seeking, and that they are to blame for their maladaptive behaviours. They seldom experience validation of their emotional distress or receive confirmation that they merit the same investment of time and expertise which is extended to mental health problems[185].

Notwithstanding a certain ambivalence towards people with borderline personality disorder, their mental health needs cannot be ignored by mental health services. The presence of this personality disorder can seriously aggravate existing mental health vulnerabilities.

Within mental health services, borderline personality disorder is a feature of 11–20% of clinical presentations to outpatient clinics. It presents as a co-morbid condition in depression, anxiety and substance abuse and carries a high risk of suicidal behaviour[186]. Estimates of as high as 67% of co-morbid personality disorder in those with diagnoses of psychosis have been reported[187,188].

In spite of the clinical challenges these conditions represent, current research is optimistic about the possibility of treating mild to moderate borderline personality disorders provided the right interventions are made available[189,190,191].

Therapeutic approaches provided by skilled practitioners usually combine a number of core interventions: acceptance and validation, emotional regulation and problem-solving skills, and therapeutic exploration of dysfunctional attachment styles, which reflect destructive early experiences. Medication and social care also have an important role with some individuals.

Dialectic Behaviour Therapy (DBT) is one approach which combines these elements in a very systematic way[189]. Its credibility as an intervention with borderline personality disorder has grown as an increasing number of research trials have shown it to be effective[192,193]. The HSE has invested in specialised DBT training for clinical teams from different catchment services, and this has produced pockets of specialised programmes in a small number of community-based services.

It is clear that all members of CMHTs need to evolve an agreed policy on the management of service users with

personality disorders in both outpatient and in-patient settings. In addition, catchment services should consider establishing a centralised service for people with very severe borderline personality disorder.

This service could be in the form of a dedicated DBT team specifically designed for the needs of people with borderline personality disorder. This resource would be available on a catchment basis rather than merely sector basis. Individuals who commit to developing this specialist therapeutic service could be seconded for dedicated weekly sessions from their sector CMHTs.

RECOMMENDATION 15.8.1: The needs of people with mental health problems arising from or co-morbid with borderline personality disorder should be recognised as a legitimate responsibility of the mental health service, and evidence-based interventions provided on a catchment area basis.

RECOMMENDATION 15.8.2: Specialised therapeutic expertise should be developed in each catchment area to deal with severe and complex clinical problems that exceed the available resources of generic CMHTs.

RECOMMENDATIONS: PEOPLE WITH BORDERLINE PERSONALITY DISORDER

1. The needs of people with mental health problems arising from or co-morbid with borderline personality disorder should be recognised as a legitimate responsibility of the mental health service, and evidence-based interventions provided on a catchment area basis.

2. Specialised therapeutic expertise should be developed in each catchment area to deal with severe and complex clinical problems that exceed the available resources of generic CMHTs.

Implementa

Multidisciplinary management teams should be in place at the local, catchment area and national level

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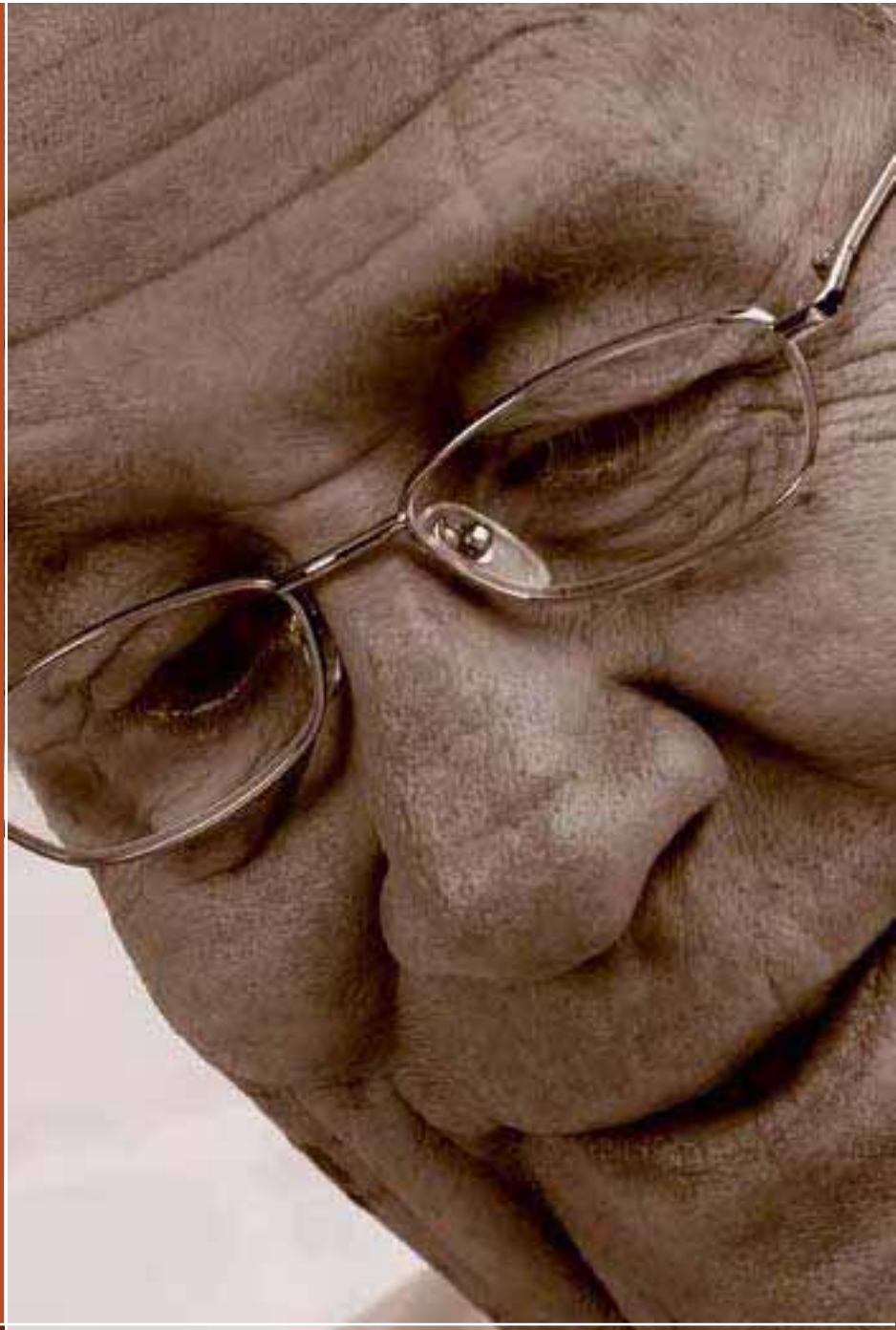

CHAPTER SIXTEEN

Management and organisation of mental health services

16.1 CURRENT SITUATION

In most areas, mental health services are managed by the structure recommended in *Planning for the Future*[75], which consists of three key individuals - the Clinical Director, Director of Nursing and Hospital Administrator. While no formal division of roles is defined, the following distinctions generally apply:

The **Clinical Director** in addition to statutory responsibilities under the Mental Treatment Act, 1945[80], is expected to provide service vision, general supervision of clinical activity and to ensure clinical probity.

The **Director of Nursing** is responsible for managing by far the largest category of staff and is concerned with policy matters, the coordination of activities and ensuring nursing staff are trained for proper function.

The **Hospital Administrator**, in partnership with the Clinical Director and Director of Nursing, is responsible for the administration and business management of the service.

While this system of management had obvious application to a hospital-based programme of care in smaller catchment areas, it now needs to be enhanced to take on board the development and integration of increasingly dispersed, multidisciplinary, specialist mental health services in larger catchment areas.

The current structure of services has encouraged isolation of catchments from each other and has hindered the development of specialist services. There is considerable variation across catchments in service planning and innovation, with consequent variation in admission rates, certification rates, availability of specialisms, use of treatment procedures and in the range and availability of community and home based treatment options and facilities[79].

Account

16.2 NEW ORGANISATIONAL STRUCTURES

Catchment size needs to take into account the range of developing specialisms in mental health care (described in this document from Chapters Ten to Fifteen), which includes mental health services across the lifespan and a variety of mental health services for people with specific

mental health needs. This range of specialisms requires a minimum catchment population of 250,000–400,000. The arguments for the larger catchment areas and the requirements of these areas have already been put forward in Chapter Eight (section 8.2).

Catchment areas of this size are considerably larger than current catchments that have average populations of around 120,000 with wide variation, from around 280,000 in West Dublin to around 50,000 in West Cork. The larger catchments proposed here are essential to provide for the full range of specialty services required to produce a comprehensive mental health service, and to allow coordination and continuity of care.

The new catchment areas should have a population of 250,000 to 400,000, depending on local circumstances, which would result in a total of 12–13 Mental Health Catchment Areas in the country. In general, the population range of 250,000 to 400,000 would be expected to encompass two or three local health offices, depending on local population and dispersal. It is strongly recommended that local health office catchment areas should not be split into different Mental Health Catchment Areas.

While the final decision regarding the boundaries of Mental Health Catchment Areas rests with the HSE and the National Mental Health Service Directorate (section 16.3 below), Table 16.1 gives an illustrative example of how the local health offices might be divided into Mental Health Catchment Areas. Most of the catchment areas in this table are around 300,000 although some are smaller or larger depending on local factors.

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Catchments of this size are also required to allow the efficient placement of a range of facilities which these various specialty services require. These include acute in-patient units, community mental health centres, day-hospital and day-centre accommodation and community residences.

These larger catchments should also facilitate the provision of other specialist residential units on a catchment area or regional basis. The recommendations in Chapters Ten to Fifteen on the range of specialist mental health services required should result in a total of 23 teams in each catchment area of 300,000, and an additional three teams for regional specialties.

Table 16.1: Example of Mental Health Catchment Areas

Region	Population
East Coast Area Catchment	331,385
South Western Area Catchment (Community Care Areas 3 & 5)	258,728
South Western Area Catchment (Community Care Areas 9 & 4)	324,394
Midlands Catchment Area	227,436
Total HSE Dublin Mid-Leinster Region	**1,141,943**
Northern Area Catchment (Community Care Areas 6 & 7)	282,944
Northern Area Catchment (Community Care Area 8)	203,990
North East Area Catchment	341,704
Total HSE Dublin North Region	**828,638**
Carlow/Kilkenny/Wexford/Waterford/ South Tipperary Area Catchment	423,616
North Cork/North Lee Area Catchment	229,547
South Lee/West Cork/Kerry Area Catchment	350,809
Total HSE Southern Region	**1,003,972**
Mid-Western Area Catchment	339,591
Western Area Catchment	380,297
North West Area Catchment	222,762
Total HSE Western Region	**942,650**
National Population	**3,917,203**

RECOMMENDATION 16.1: Mental Health Catchment Areas should be established with populations of between 250,000 and 400,000 with realigned catchment boundaries to take into account current social and demographic realities. These catchment areas should be coterminous with local health office areas and the new regional health areas. They should take into account the location of acute psychiatric in-patient units in general hospitals.

This substantial alteration in current catchment populations will afford an opportunity to have the first significant redesign of mental health catchment areas in many cases since their establishment in the mid-nineteenth century.

Catchment redesign will involve considerable discussion and will need to take into account many factors, including current location of in-patient units, staff arrangements, population distribution, deprivation, communication networks, and other local factors. This exercise should

afford an opportunity for bringing about greater equity in the resources available to catchments. This redesign will also need to respect the recent reorganisation of the structure of health care.

The new catchments should take into account the HSE regional areas and should also be consistent with the boundaries of the new local health offices. It will be a matter for the HSE, through local health offices, to make the final decision concerning the composition of mental health catchment areas.

This new organisational structure of mental health services requires a management structure that will facilitate the local and national management of a greatly increased range of mental health services. This management structure is described below.

In addition, support infrastructure, particularly information systems will be required to provide the information needed to ensure appropriate governance of this new structure and for continuous monitoring and evaluation. This type of information system is outlined in Chapter Nineteen.

RECOMMENDATION 16.2: Substantial upgrading of information technology systems should occur to enable the planning, implementation and evaluation of service activity.

16.3 NATIONAL MANAGEMENT OF MENTAL HEALTH SERVICES

There has never before been a single national management structure for mental health service provision. This has been a major factor in the continuing marked disparity in catchment service provision. It has also prevented the development of regional and national specialist mental health services, which require large population bases. Other consequences have been the failure to achieve and sustain realistic national mental health budgets and to plan appropriate national training programmes for the relevant professional groups.

It is recommended that a **National Mental Health Service Directorate** be established to fulfil this need. Mental health services are now managed by the Primary, Continuing and Community Care (PCCC) Programme which has statutory responsibilities for mental health care at a national level. This new National Mental Health Service Directorate would act as an advisory group to facilitate this responsibility.

16.3.1 RESPONSIBILITIES OF THE NATIONAL MENTAL HEALTH SERVICE DIRECTORATE

The National Mental Health Service Directorate should be responsible for advising the National Care Group Manager for Mental Health in

- establishing national service priorities
- agreeing national mental health service budgets
- reshaping the new larger catchment boundaries
- ensuring equity in Mental Health Catchment Area resources
- facilitating adequate manpower planning and training programmes for mental health professionals
- monitoring the effectiveness of Mental Health Catchment Area Management Teams
- developing a national range of appropriately structured and located services for specialist areas which require a regional or national catchment population.

The National Mental Health Service Directorate will be of central importance in facilitating the modernisation of the Irish mental health services. It should have formally agreed responsibilities and its successful linkage to the senior management structure of the **Primary and Continuing Community Care Directorate** is vital.

The proposed management and organisational structure is shown in Figure 16.1. The three levels of management should have clear and formalised mechanisms for communication and accountability.

16.3.2 STRUCTURE OF THE NATIONAL MENTAL HEALTH SERVICE DIRECTORATE

The structure of the National Mental Health Service Directorate should include senior professional managers and senior clinical staff.

It should consist of:

- the National Care Group Manager for Mental Health
- senior management staff
- a national medical director
- a national director of nursing
- representatives of other clinical professions in mental health services
- a service user representative.

Appointees should have demonstrated competency and interest in service planning and management and should have training to equip them for this national role.

Criteria for the selection of the service user for the National Mental Health Service Directorate should be devised by the National Service User Executive (described in Chapter Three).

The advisory positions on the Directorate should be filled following open competition and appointments should be for a period of five years, renewable following competition.

RECOMMENDATION 16.3: A National Mental Health Service Directorate should be established, which includes senior professional managers, senior clinicians and a service user. The new National Mental Health Service Directorate should act as an advisory group and be closely linked with the management of the Primary and Continuing Community Care Division of the Health Service Executive.

16.4 MENTAL HEALTH CATCHMENT AREA MANAGEMENT TEAMS

The new recommended catchments with their larger size and their range of specialisms will require a new management structure. The duties of the catchment management team should include:

- in-depth planning for the range of appropriate specialty services
- facilitating CMHTs in their obligations to achieve agreed services goals
- ensuring that community mental health teams in all specialties are delivering agreed service programmes in an effective and efficient manner
- ensuring the availability of appropriate information management systems for the catchment
- monitoring the achievement of agreed objectives and targets by the community mental health teams and ensuring the achievement of objectives and targets by the overall catchment area
- agreeing overall catchment priorities, plans and budgets with the National Mental Health Service Directorate
- being accountable to the National Care Group Manager for Mental Health and the National Mental Health Service Directorate.

Competent management requires inputs from clinicians and management professionals. The new multidisciplinary clinical services will result in a need for management involvement by all clinical disciplines. It is proposed that these new catchments are best managed by a **Mental Health Catchment Area Management Team** comprising:

- managers of 2–3 local health offices
- medical director
- nursing director
- heads of discipline for psychology, social work and occupational therapy, all based in the mental health services
- service user.

The people on these teams should have a general remit for the mental health services in the entire catchment area – not just their discipline or specialty. The composition of this team should ensure that all specialties are adequately represented within the above structure.

Clinical professionals appointed to this team will be from personnel working within the range of specialist mental health services in the catchment area. Appointees should have demonstrated competency and interest in service planning and management and ideally should have training to equip them for this role.

Appointment to the Mental Health Catchment Area Management Team should be for a period of five years, renewable following competition. The clinical managers on the management team should continue to have clinical responsibilities albeit at a reduced level. Criteria for the selection of the service user for the mental health catchment area management team should de devised by the National Service User Executive (described in Chapter Three).

RECOMMENDATION 16.4: Multidisciplinary Mental Health Catchment Area Management Teams should be established. These teams should include both professional managers and clinical professionals along with a trained service user and should be accountable to the National Care Group Manager and the National Mental Health Service Directorate.

16.5 COMMUNITY MENTAL HEALTH TEAMS (CMHTS)

The **Community Mental Health Team** is the model of care that best provides for the implementation of the key guiding principles for the organisation of mental health services described in this document (Chapter One). The ideal model for a community mental health team across all specialties is for the team to contain the core range of disciplines involved in mental health care – psychiatrist, mental health nurse, clinical psychologist, social work practitioner and occupational therapist. Teams providing specialist services require other, additional therapists.

The management and organisation of these teams is crucial. These teams should self-manage through the provision of a team coordinator, team leader and team practice manager. This model has been described in detail in Chapter Nine.

RECOMMENDATION 16.5: Community Mental Health Teams should self-manage through the provision of a team coordinator, team leader and team practice manager.

16.5.1 CLINICAL GOVERNANCE

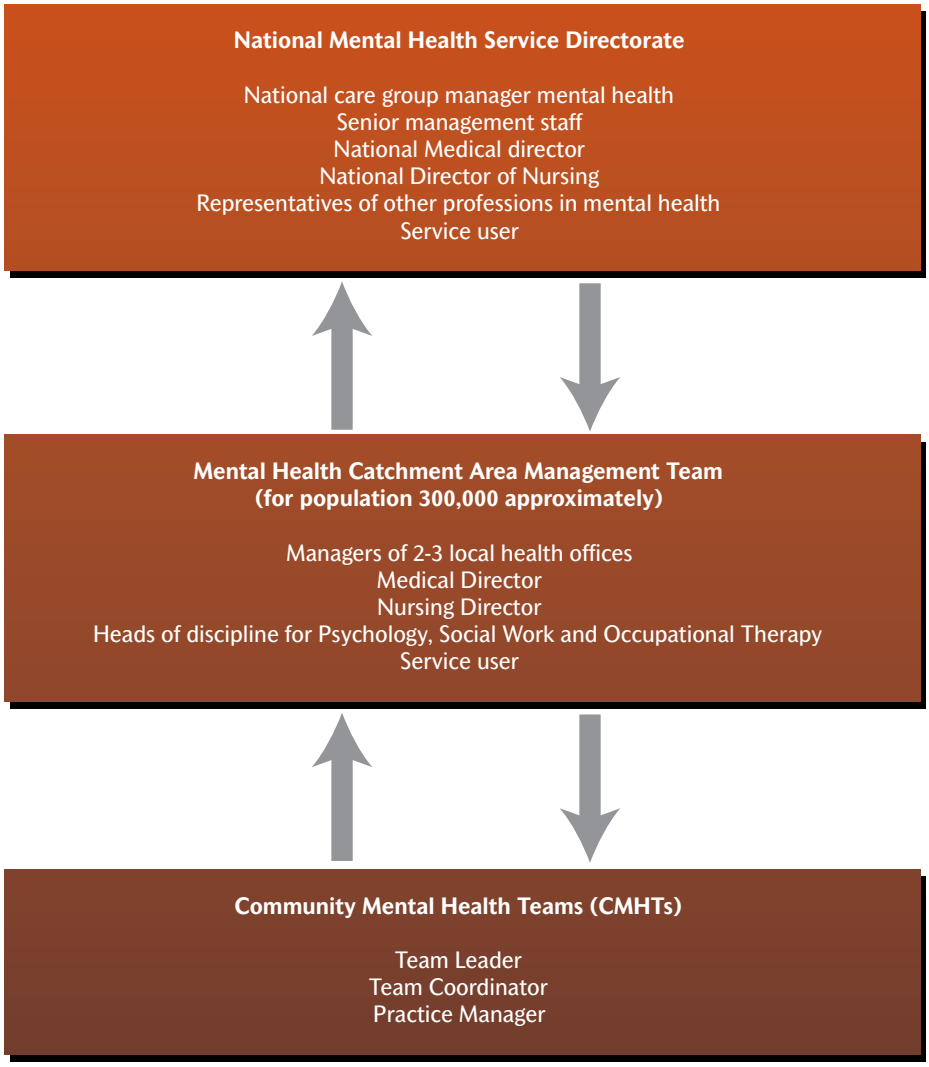
A central responsibility of multidisciplinary community mental health teams is the implementation of systems of clinical governance. In this way effective planning, implementation and evaluation of treatment programmes can be instituted. Clinical activity to be monitored should centre increasingly on clinical outcomes as distinct from clinical inputs and outputs, and objective measurement

instruments will be essential in achieving this end. CMHTs should be expected to prepare detailed service plans that should include specific service protocols and costings. Community Mental Health Teams should be accountable to Mental Health Catchment Area Management Teams in achieving these targets.

RECOMMENDATION 16.6: Community Mental Health Teams should be responsible for developing costed service plans and should be accountable for their implementation.

RECOMMENDATION 16.7: A management and organisation structure of National Mental Health Service Directorate, a multidisciplinary Mental Health Catchment Area Management Team and local, self-managing CMHTs, should be put in place.

Figure 16.1: Proposed Management Structure for Mental Health Services: local to national



16.6 SERVICE USER INVOLVEMENT IN SERVICE MANAGEMENT

Service user involvement is fundamental to quality service provision. Service users should be involved at all levels of service planning, management and delivery and a model to achieve this is described in Chapter Three. Service users are particularly valuable in providing skilled input into the assessment of services from a service user perspective and have much to offer in comprehensive service audit. These essential contributions can best be implemented by the presence of a service user as a member of the catchment area management team and the National Mental Health Service Directorate.

16.7 INTEGRATION OF MENTAL HEALTH SERVICES

Mental health services are unique in requiring significant inputs at both community and hospital level. The core principles of effective delivery of mental health services include coordination and continuity of care and it is essential for this reason that mental health services are centred in a single programme.

Strategic partners in mental health care delivery are mostly community-based in Primary Care and in formal and informal community-care structures. The formal placement of Mental Health Care in the Primary, Continuing and Community Care programme involves a significant shift in the orientation of current mental health care providers who still have a tendency to prioritise the acute hospital care element of the service. In this formal move into the Primary and Continuing Community Care programme it is essential to protect mental health budgets and the overall integrity of the mental health service.

It is important that mental health staff working in in-patient units in general hospitals are seen as part of the overall mental health team. Their appointment and management should be the responsibility of the Primary, Continuing and Community Care Programme and opportunities should be available for staff to provide services at both hospital and community level.

As community mental health services develop further there should be increasing opportunities for utilisation of other relevant community-based services, self-help groups and voluntary organisations. This integration of community care will require much closer relationships between mental health services and the other relevant organisations. This integration should be facilitated by mental health services being part of the full range of services available within the local health office areas.

The potential for the coordination of the range of community health and welfare provision is enormous if the large range of service provisions can be presented in an integrated fashion. This will have a major effect in eliminating the current defensive fragmentation of services and should be helpful in reducing the stigma associated with mental illness. The involvement of self help and voluntary organisations is also very valuable. It is proposed that Mental Health Catchment Area Management Teams establish a coordinating group to fulfil these functions. Membership of this group should reflect the local agencies that are involved in service provision.

RECOMMENDATION 16.8: Mental Health Catchment Area Management Teams should facilitate the full integration of mental health services with other community care area programmes. This should include the maximum involvement with self-help and voluntary groups together with relevant local authority services.

It is estimated that 90% of the formal care provided for mental illness is provided in primary care, with 10% being referred to specialist mental health services. Mental health services, in this sense, have their workload defined by decisions taken in primary care.

Much closer working relationships are required between primary care and formal mental health services. The

advantages of this are many: agreement on methods of case referral, including emergency referrals, agreement on appropriateness of case referral and opportunities for shared care. This area of coordination between primary care and specialist mental health services is of major importance and requires ongoing practical review.

The team coordinators of the new CMHTs should facilitate the ideal single pathway of referral and promote communication between the two services. It is suggested that Catchment Area Mental Health Management Teams and Primary Care Teams set up joint working groups to facilitate better integration of primary care and community mental health services and in particular to increase opportunities for 'shared care' programmes.

RECOMMENDATION 16.9: Community Mental Health Teams and Primary Care Teams should put in place standing committees to facilitate better integration of the services and guide models of shared care.

16.8 RECOMMENDATIONS

1. Mental Health Catchment Areas should be established with populations of between 250,000 and 400,000 with realigned catchment boundaries to take into account current social and demographic realities. These catchment areas should be coterminous with local health office areas and the new regional health areas. They should take into account the location of acute psychiatric in-patient units in general hospitals.

2. Substantial upgrading of information technology systems should occur to enable the planning, implementation and evaluation of service activity.

3. A National Mental Health Service Directorate should be established, which includes senior professional managers, senior clinicians and a service user. The new National Mental Health Service Directorate should act as an advisory group and be closely linked with the management of the Primary and Continuing Community Care Division of the Health Service Executive.

4. Multidisciplinary Mental Health Catchment Area Management Teams should be established. These teams should include both professional managers and clinical professionals along with a trained service user and should be accountable to the National Care Group Manager and the National Mental Health Service Directorate.

5. Community Mental Health Teams should self-manage through the provision of a team coordinator, team leader and team practice manager.

6. Community Mental Health Teams should be responsible for developing costed service plans and should be accountable for their implementation.

7. A management and organisation structure of National Mental Health Service Directorate, a multidisciplinary Mental Health Catchment Area Management Team and local, self-managing CMHTs, should be put in place.

8. Mental Health Catchment Area Management Teams should facilitate the full integration of mental health services with other community care area programmes. This should include the maximum involvement with self-help and voluntary groups together with relevant local authority services.

9. Community Mental Health Teams and Primary Care Teams should put in place standing committees to facilitate better integration of the services and guide models of shared care.

CHAPTER SEVENTEEN

Investing in the future: Financing the mental health services

17.1 THE COSTS OF MENTAL ILLNESS

It is now recognised that the cost of mental illness is very high. Studies by the WHO suggest that mental health problems account for 2.5% of GNP in the United States[194]. In the member-states of the European Union the cost of mental health problems is estimated at between 3% and 4% of GNP[12]. Studies estimated the aggregate cost of all mental health disorders in the United Kingdom at £32 billion (1996/97 prices), 45% of which was due to lost productivity[195].

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A study by the Sainsbury Centre for Mental Health in Northern Ireland estimated the total annual cost of mental illness at £2,852 million, the majority of which related to lost output and human costs[196]. The Northern Ireland costs of mental illness translated to the Republic of Ireland on a pro rata population basis would suggest a total annual cost of mental ill health of €11 billion.

Given that the major costs of mental ill health relate to output losses and human costs it is reasonable to expect that increased spending on mental health services which are delivered within a modern policy framework would have a significant effect on reducing the overall societal cost. Studies published by the WHO suggest that there are potentially enormous economic benefits to be gained by preventing mental health problems in the work place though the effectiveness of programmes of intervention still need to be evaluated[197]. Funding the mental health services in this context can be seen as a sound financial investment by government.

17.2 FINANCING THE MENTAL HEALTH SERVICE

There is a general perception among the providers of mental health care that the mental health service is grossly under-resourced, both in financial terms and in the range of staffing and physical resource required to provide a quality service. This perception is pervasive and has increasingly had the effect of lowering staff morale. There is general agreement among those involved in providing mental health services that resources made available at government level are disproportionately low in relation to general health spending.

This sense of poverty while justified in some catchment areas makes no sense at all in other catchments, which – by international as well as Irish standards – are richly endowed, presenting the possibility in these areas of providing very high quality services.

There is a general lack of the type of management structures, capacity and resources required to evaluate the quality and value of mental health services provided. The development of managed-care programmes with clinical governance and service evaluation procedures has not taken place to any significant extent[79].

In the context of ever-rising demands for health resource, mental health expenditure will have to be increasingly monitored to ensure that services demonstrate both effectiveness and efficiency.

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In the approach to financing this new mental health policy, a number of factors need to be taken into account:

- substantial change in the organisation and delivery of mental health services is required
- mental health services currently have significant resources, including human resource, capital and revenue
- resources, both capital and revenue, in the current mental health service should be retained within mental health, with the reconfigured mental health services having priority in their disposal
- in addition to the re-allocation and re-modelling of existing resources, extra funding and personnel are required to finance the policy
- resources need to be remodelled within re-organised catchment-based services to ensure equity and priority in service developments
- the new management systems at service team, catchment and national levels (Chapter Sixteen) must ensure performance management and accountability and introduce financial incentives for service providers
- core services must be adequately funded, but there must also be scope to reward excellence and for funding to follow service volume activity
- recognition must be given to the need for extra funding for areas that exhibit social and economic disadvantage with associated high prevalence of mental ill health
- in relation to capital expenditure, bridging finance from government will be required in implementing the recommendations of this policy
- services should use their funding for mental health responsibilities. Mental health services cannot continue to provide a broad range of services which should be provided by other, more appropriate agencies (e.g. housing, vocational training). Other agencies must take up their responsibilities in full
- this new 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)

- new funding should follow the implementation of the recommendations in this policy and a mechanism by which this can be achieved should be devised.

17.3 ANALYSIS OF CURRENT MENTAL HEALTH FUNDING

Table 17.1 gives information on the non-capital funding of mental health services in Ireland in 1984, 1994 and 2004. Details of funding for the past 20 years are in Annex 17.

There has been an increase in expenditure on the mental health services over the past two decades, but of a much lower order than the increase in total health expenditure. Consequently there has been a progressive decline in the percentage of total health spend being allocated to mental health from 13% in 1984 to 7.3% in 2004.

The implementation of the recommendations of *Planning for the Future* was associated with the progressive decline of mental health funding relative to general health funding in the following two decades. In the context of the proportion of overall ill health caused by mental ill health (estimated at 20–25%[10]) it is evident that the progressively declining percentage of total health funding devoted to mental health is inequitable.

There is no equivalent advocacy for improving mental health services as exists for various other health services. There are a variety of reasons for this. Users tend to be poor advocates, especially because of stigma, which remains an enduring factor and inhibits open discussion of service shortfalls. Political interest has always been difficult to engage and to sustain because of the stigma factor and also because other health care issues more easily attract general public interest. Advocacy given by service providers can be unduly influenced by their own professional interests.

This problem is recognised in some jurisdictions where there has been an attempt to establish a floor percentage of total health funding being reserved for mental health services. In England and Wales between 1998 and 2003, the percentage of total health spend devoted to mental health has remained between 12% and 13%[198]. Cross-national comparisons of mental health funding are unreliable using these crude instruments, however.

It is recommended that there be a commitment in Ireland to progressively increase over the next seven to ten years the proportion of funding given to mental health services. If the recommendations of this policy are implemented, this will increase the percentage total health fund spend on mental health to 8.24% (based on 2005 figures). But principles of effectiveness and efficiency should also pertain. Efficiency in the use of resources demands that funding be allocated only to services that are effective. It is necessary to demonstrate that money spent on mental health services is efficiently used.

Table 17.1: Non-capital expenditure on mental health as a percentage of total health expenditure 1984, 1994 and 2004

Year	Total Health Expenditure	Mental Health Expenditure	Mental Health Percentage
1984	€1,413 million	€184 million	13.0%
1994	€2,145 million	€216 million	10.1%
2004	€9,766 million	€717 million	7.3%

RECOMMENDATION 17.1: Substantial extra funding is required to finance this policy. A programme of capital and non-capital investment in mental health services as recommended, adjusted in line with inflation, should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.

17.3.1 INEQUITABLE FUNDING OF MENTAL HEALTH SERVICES

There is wide variability in the provision of mental health funding across current catchment areas and this has been highlighted in several reports[199,200]. It is difficult to interpret the ten-fold variations in per capita funding for mental health across different services because it is not possible to obtain disaggregated financial figures for all mental health services in such a way that meaningful comparisons can be made.

The new management systems recommended in the previous chapter can be expected to address the issue of resource inequities. There are clear opportunities for a more appropriate use of overall current national resource. This process should be facilitated by the development of the new larger catchments. It will be important that this exercise is not misinterpreted: it should not be addressed by a levelling-down of current catchment resourcing. A more appropriate approach would be to target new resources initially to catchments with below average funding.

It is important to recognise that 90% of public mental health services are provided at primary care level. Services provided by primary care are much less expensive than those provided in the secondary mental health care services. There is limited information available on the cost and effectiveness of mental health services provided by primary care. Given that this is where the majority of formal care takes place there is an urgent need for service research in this area. In the context of the service changes recommended in Chapter Seven on primary care, consideration will need to be given by the HSE and primary care providers to the allocation of appropriate resources to improve the quality of mental health care provided at primary care level.

RECOMMENDATION 17.2: Capital and human resources should be remodelled within re-organised catchment-based services to ensure equity and priority in service developments.

17.4 COSTING THE NEW MENTAL HEALTH SERVICE MODEL

There are still substantial resources, both revenue and capital, tied up in residual institutions and the release of these could form a significant part of the investment required in funding the new model of care. Resources that do become available must be used in a flexible and efficient manner so that requests for new resources can be assessed for appropriateness and credibility. A comparison of the resources needed for the comprehensive service envisaged in this policy, with the resources contained in the current service, reveals a need for further investment to achieve the required supply of services, teams and units.

The overall objective is to make the full range of modern mental health services uniformly available across the whole country, based in suitable buildings that are unaffected by institutionalisation or stigma. It is important to identify the scale of the non-capital and capital investments needed to bring workforce, physical infrastructure and services to the levels recommended in this policy framework.

Estimates of resource requirements are based on the 2002 Census population and do not provide for future population changes. However, since services are based on sectors, catchments and regions of 50,000, 300,000 and 1,000,000 respectively, with estimates calculated accordingly, the effects of real future population changes may be easily calculated in the future. Costs are based on rates applicable in August 2005.

The estimates do not include costs associated with standard housing, training and employment. While the mental health service assists and facilitates referral and access to these important elements it is not appropriate that it should provide them and thus impair the service user's personal capacities, integration with community life and rights (as a citizen) to standard services.

RECOMMENDATION 17.3: Other agencies must take up their responsibilities in full so mental health services can use their funding for mental health responsibilities. Mental health services should not provide the broad range of services which are more appropriately provided elsewhere.

The shortfall in information and information systems affects the detail achievable in the estimates. Nationwide, it is not known to what extent current resources in the traditional service are transferable to any specific element of the new service, as resource circumstances vary widely from area to area. To deal with this issue in this costing exercise, composite national service needs have been compared with composite existing resources. The costed difference represents the new national investment requirement.

17.5 NON-CAPITAL FUNDING

Delivery of the mental health service is based primarily on personal communication between service user and health care professional. Consequently the workforce element of the service is paramount and accounts for over 80% of non-capital expenditure.

A modern service is delivered by a wide range of teams with varied specialist skills focused on diverse health conditions and target groups. The base service resource is that of the old district mental hospitals and, despite substantial re-deployment to community services and some new investment in specialist skills, the full range and quantum of skills required remains far from complete. New investment is needed to achieve the service structure described in this document as deficits already exist in the availability of many mental health professionals and support staff.

A detailed description of the workforce described for this model of recommended services is shown in Annex 17. In summary, this new workforce would comprise close to 11,000 staff. Allowing for the assimilation of all existing posts within the new service, the net result is a requirement of 1,803 new posts and a non-capital investment of €151 million per annum in addition to existing funding.

This investment estimate is based on current pay rates with standard provision for non-pay costs. However, this investment will be incremental due to the current non-availability of certain health professionals, resulting in a proposed non-capital investment of an additional €21.6 million each year for the next seven years. This should be targeted mainly at catchments with below-average funding. It should also be used in part to maintain developmental progress and momentum in all catchments to achieve full multidisciplinary working and effective equitable services. Actions already in train to match supply and demand in many mental health professional areas will take some years to achieve.

Availability of the required professional workforce is vital to achieve policy implementation and service modernisation. Workforce planning should proceed along with training, both within mental health services and in third-level institutions (further detail on this is in Chapter Eighteen).

RECOMMENDATION 17.4: Approximately 1,800 additional posts are required to implement this policy. This significant non-capital investment will result in mental health receiving approximately 8.24% of current, non-capital health funding, based on 2005 figures.

RECOMMENDATION 17.5: Recognition must be given to the need for extra funding for areas that exhibit social and economic disadvantage with associated high prevalence of mental ill health.

17.6 CAPITAL FUNDING

Capital funding within the mental health services has traditionally been very low. The proportion of the total health capital spend that has been devoted to mental health services has fluctuated between 2% in 1997 to the unusually higher figure of 5.7% in 2000 before reverting to lower percentages in later years.

In England and Wales capital spending was much higher in these years. In the years 2000, 2001 and 2002, the percentage of total health capital expenditure allocated to mental health has been respectively 23%, 24% and 15% with most of the money being spent on buildings[198].

Planning for the Future[75] recommended a variety of new service structures to facilitate the new model of community care for mental health services. However, the recommended capital funding was not made available for the provision for these structures.

As a result, service management had little choice but to take an ad hoc approach to the provision of the required service facilities. Great efforts were made to provide the new structures, often by using resources from the old mental hospital structures and a wide variety of buildings in the community designed originally for other purposes.

It was unusual for planned, custom-built facilities to be provided in appropriate settings. As a consequence, much of the current mental health service activity now takes place in unsuitable and sometimes institutionalised and stigmatised structures that do not provide the quality of accommodation necessary for modern mental health care.

There are exceptions to this bleak picture; there has been significant provision of acute units in general hospitals. There are currently over 900 beds available in acute units placed in 24 general hospitals. In addition there are over 400 acute beds in residual psychiatric hospitals.

This document suggests a requirement of 650 acute beds in notionally 50-bed units in major general hospitals. Some acute beds are currently provided in 20-bed to 30-bed units in smaller general hospitals. A significant rationalisation of this acute bed resource will be required. In some rural areas, it may be thought more appropriate to provide the acute psychiatric beds in two 25-bed units in separate hospitals.

Most major hospitals have acute psychiatric units. A small number of current acute units are unsuitable or need extensive refurbishment. The acute beds still being used in residual psychiatric hospitals will need to be progressively phased out. Specialist acute beds will also be required for Child and Adolescent Mental Health Services, Intellectual Disability Mental Health Services and in Neuropsychiatry, with a total requirement nationally of 758 beds (see Annex 17).

The rationalisation of the current unsatisfactory provision of acute in-patient units can most appropriately be made by the National Mental Health Service Directorate. The full economic value of acute units in general hospitals should be realised in any reorganisation that takes place.

This policy recommends that mental health services in the future should be delivered by a range of specialised multidisciplinary community mental health teams based in community mental health centres. These community mental health centres will serve populations of 50,000 to 300,000 depending on the nature of the speciality. Some of these centres will need to be large enough to accommodate at least three teams. They should be located close to, or on the same campus as, other community health facilities, to ensure ease of integration with all other activities in the PCCC programme.

It is also recommended that most outpatient services should be provided in these centres and that accommodation should also be available there for limited day hospital functions. Community mental health centres are best planned on the basis of a core unit of accommodation for each community mental health team. In most areas, community mental health centres should consist of three to four such core units. The full range of proposed mental health service units required nationally is described in detail in Annex 17.

To assess the quantity and quality of the structures currently available in the mental health services, and their adaptability to serve as the high-quality service structures that will be required, a questionnaire was drawn up and issued to local service managers under the aegis of the National Director of Mental Health Services.

The information obtained suggested that, apart from acute units in general hospitals and approximately 50% of current staffed community residences, other existing facilities were unsuitable for the new services recommended in this document. Descriptions of the structures required were submitted to the Hospital Planning Division in the Department of Health and Children, which provided advice on unit sizes and costings. Table 17.2 gives information on the national costings of the new units required.

Table 17.2: National costings of the new units required

	Units Required	€ million
Modular Community Mental Health Centres with one unit of accommodation per community mental health team	311	497.6
Mental Health Crisis Houses	13	20.8
Upgrading of crisis house for homeless		0.5
Continuing Care Beds		
Later Life Challenging Behaviour	360	64.8
Day Hospitals		
13 – Child & Adolescent*		
13 – Older people*		
1 – Homeless Service	27	48.6
Day Support Centres		
Homeless Service	2	2.4
User-run Day Support Centres or equivalent	39	46.8
Staffed Hostel places	650	91.0
Intensive Care Rehabilitation Unit places	120	24.0
TOTAL		€796.5m

Note: No new funding for acute beds is requested as there are sufficient in the system.

**It is envisaged that the day hospitals for child and adolescent mental health services and mental health services for older people will be part of the relevant community mental health centres, which will be multifunctional.*

The capital cost of providing and equipping the new mental health service infrastructure is estimated at €796 million. Site acquisition costs are not included due to local cost variations and the consequent difficulty in estimating with reasonable accuracy. Also the existing extensive landbank of the Health Service Executive should provide many suitable integrated sites promoting both cost efficiency and service effectiveness.

While the capital costs implicit in this policy are substantial, so also are the capital assets reposing in psychiatric hospital buildings and lands. Already some vacated buildings are being used productively for various public and private sector purposes and this trend should continue. However the stigmatised traditional psychiatric hospital buildings are totally unsuitable for modern mental health service delivery.

The existing public psychiatric hospitals have substantial areas of land located within urban settings across the country. This land may contain suitable sites for health service infrastructure, including infrastructure for the mental health service. The full economic value of psychiatric hospital buildings and lands should be professionally assessed towards identifying appropriate future use and maximum value and benefit. The value of these assets significantly counterbalances the capital cost of the new mental health service infrastructure requirement.

RECOMMENDATION 17.6: Resources, both capital and revenue, in the current mental health service must be retained within mental health.

RECOMMENDATION 17.7: The full economic value of psychiatric hospital buildings and lands should be professionally assessed and realised.

A commitment to a programmed annual capital investment is needed to achieve the implementation of this policy over its proposed seven to ten year development period. Provision of community mental health centres as service bases for multidisciplinary CMHTs should be given priority. Such a commitment is essential to achieve the full decommissioning of the district mental hospital system after 150 years of service and the establishment of a full, national, integrated community mental health service appropriate to the twenty-first century.

RECOMMENDATION 17.8: Provision of community mental health centres as service bases for multidisciplinary community mental health teams should be given priority.

RECOMMENDATION 17.9: The comprehensive and extensive nature of the reorganisation and financing of mental health services recommended in this policy can only be implemented in a complete and phased way over a period of seven to ten years.

17.7 RECOMMENDATIONS

1. Substantial extra funding is required to finance this policy. A programme of capital and non-capital investment in mental health services as recommended, adjusted in line with inflation, should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.

2. Capital and human resources should be remodelled within re-organised catchment-based services to ensure equity and priority in service developments.

3. Other agencies must take up their responsibilities in full so mental health services can use their funding for mental health responsibilities. Mental health services should not provide the broad range of services which are more appropriately provided elsewhere.

4. Approximately 1,800 additional posts are required to implement this policy. This significant non-capital investment will result in mental health receiving approximately 8.24% of current, non-capital health funding, based on 2005 figures.

5. Recognition must be given to the need for extra funding for areas that exhibit social and economic disadvantage with associated high prevalence of mental ill health.

6. Resources, both capital and revenue, in the current mental health service must be retained within mental health.

7. The full economic value of psychiatric hospital buildings and lands should be professionally assessed and realised.

8. Provision of community mental health centres as service bases for multidisciplinary community mental health teams should be given priority.

9. The comprehensive and extensive nature of the reorganisation and financing of mental health services recommended in this policy can only be implemented in a complete and phased way over a period of seven to ten years.

CHAPTER EIGHTEEN

Manpower, education and training

18.1 INTRODUCTION

This chapter reviews the education and training required to produce competent professional personnel who are capable of delivering quality mental health services.

Education may be defined as the process by which knowledge is acquired. Training is the process by which a student is brought to a required standard of competency and proficiency in the practise of professional tasks. In mental health service provision, competence includes interpersonal sensitivity in delivering expertise in a person-centred and respectful manner.

This chapter also considers manpower requirements in key professions to ensure the delivery of a quality mental health service, and the training programmes required to ensure adequate manpower in the coming years. A detailed account of manpower requirements is set out in Annex 17.

18.2 EDUCATION AND TRAINING: GENERAL PRINCIPLES

The key themes suggested in the consultation process, which inform this policy – the need for greater multidisciplinary cooperation in service provision, community-based rather than hospital-based delivery of services; the need for greater emphasis on mental health promotion and the potential for recovery from mental illness – have direct implications for education and training of mental health professionals.

Best pr

Undergraduate and postgraduate programme leaders need to consider how relevant training in these service provision principles can be incorporated in the courses they offer. Consideration should also be given to the option of providing joint training modules across the various disciplines to facilitate collective training in fundamental values and principles, to promote understanding of the unique role that each professional specialty plays in mental health, and to encourage a recognition of the value of multidisciplinary teamwork. In addition to these core considerations the following principles should inform education and training:

- all education and training must be directed at equipping personnel to deliver a service that is user-centred and should instil ethical values that respect the worth, rights and integrity of service users
- policy-makers, planners and employers must understand and acknowledge the centrality of education and training in delivering high-quality services to the service user; consequently education and training programmes must be adequately funded and supported
- learning, through education and training and reflective practice must be a life-long process

18.3 SHORTCOMINGS IN CURRENT EDUCATION AND TRAINING

To develop a shared perception of education and training (E&T) as a seminal activity in the provision of a mental health service, it is critical that the relevance and benefit of E&T to service users and practitioners is clarified. In the past, the establishment of training courses has often proceeded in a fragmented and uncoordinated manner with little regard for how their graduates can adapt their skills to service structures and to the needs of service users.

A key finding in the consultation process (Chapter One) was the concern that education and training of mental health professionals did not fully take account of the needs of service users and carers. It is therefore important that the user and carer interest be represented in the devising of training courses, and in their implementation and evaluation.

Employers and practitioners have been confused by the proliferation of courses and qualifications and have had difficulty in identifying their relevance to any particular task. Some E&T is over-reliant on academic achievement to the detriment of practice skills, communication abilities, interpersonal skills and capacity for multidisciplinary team working and team leadership. Too many E&T institutions operate in isolation from one

actice

- processes of education and training must be embedded in the working situation and protected time must be available to educator, trainer and trainee
- education and training programmes should be subject to ongoing review, monitoring and evaluation
- programmes should incorporate and transmit a broadly-based research culture to students
- appropriate administrative structures should be funded and put in place to ensure the delivery of high-quality education and training.

another, between and within disciplines, duplicating course content and offering few opportunities for shared learning. This not alone is not cost-efficient but militates against joint working or teamwork.

Given the above shortcomings in planning and coordination of training, and the lack of clarity regarding how E&T activity benefits mental health services, health managers and service providers have often been reluctant to provide funding and protected time for E&T. Potential students and existing practitioners have also had difficulty in determining the appropriateness and relevance of courses and qualifications to the choosing of career and professional paths.

Training courses also need to consider the needs of clinical staff to become better versed in management skills, as the recommendations in this policy will require them to assume a more active role in service management.

In summary, there is a requirement to ensure that the training undertaken by staff is appropriate to their individual needs and focussed on the needs of the service. Courses need greater coordination and integration across multiple disciplines, as well as within individual disciplines. In addition, there is a need for greater information about the skills of the workforce and the skills of those with the ability and training to supervise others. The provision of flexible, modular and distance-learning delivery to encourage part-time students to participate should also be considered.

RECOMMENDATION 18.1: E&T should be directed towards improving services as a primary goal and must have the welfare of service users as its ultimate objective.

RECOMMENDATION 18.2: Training programmes should emphasise the acquisition of skills that are clinically meaningful, should train personnel for leadership and innovative roles, and should foster an attitude of critical enquiry and self-scrutiny in relation to service delivery.

18.4 THE ROLE OF THE NATIONAL DIRECTORATE IN COORDINATING EDUCATION AND TRAINING

The National Mental Health Service Directorate (see Chapter Sixteen) should take a central role in E&T provision for mental health services. This would rationalise the splintering and confusion that currently characterises education and training in this area and ensure equitable distribution of manpower resources across the regions. Further advantages are that E&T programmes can then be based on a service-needs basis and rational, coherent and dependable funding can ensue to eliminate the periodic gaps and consequent uncertainty all too frequently encountered.

RECOMMENDATION 18.3: There should be centralisation of the planning and funding of education and training for mental health professionals in new structures to be established by the HSE in close association with the National Directorate of Mental Health Services. This centralised E&T authority should be constituted to represent stakeholder and service user interest and E&T bodies representing all disciplines.

RECOMMENDATION 18.4: The HSE should commit itself to adequate, rational and consistent funding of E&T. However the accreditation of courses should remain the responsibility of the respective professional bodies.

18.5 SPONSORSHIP OF TRAINING

The HSE continues to pay the fees and a bursary to trainees in some professions (psychology for example) on the understanding that the trainees on qualification will return to work for the board for a number of years thereafter.

Funding arrangements for these courses need to be established on a more secure basis, to safeguard these essential resources for manpower provision, and to enable

course directors to expand and develop these courses in line with service user requirements.

RECOMMENDATION 18.5: Funding of HSE sponsored training courses should be established on a secure basis to allow for expansion and development of these courses and to ensure manpower requirements in mental health services can be met in coming years.

18.6 MANPOWER PLANNING

This policy has major implications for manpower requirements in the mental health service. Manpower planning is a challenging area because of a variety of factors that are difficult to control and which change over time. The following are among the many issues that need to be considered in manpower planning:

- recruitment difficulties, where a scarcity of numbers entering training may be a problem in the future
- uncertainty of training places
- early retirement, particularly in nursing where the retirement opportunities commence at age 55
- gender issues, which include an imbalance between male and female staff and the need to address the necessity for flexible work and training arrangements to facilitate parenting and other work-life considerations
- promotional outlets draw staff away from clinical work towards administrative posts with a resultant shortage of experienced senior clinical staff
- unpopularity of working in Dublin, for cost and other reasons, particularly in nursing, with migration to provincial services due to the quality of life and accommodation expenses
- in all professions there has been a drain of personnel from the public sector to the private sector
- the absence of adequate human resource databases to track and trend personnel movement.

RECOMMENDATION 18.6: A multi-profession manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this report, and should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers. This should include consideration of a re-allocation of resources working group to ensure equitable distribution of manpower resources across the four regions.

RECOMMENDATION 18.7: Family friendly staff policies and flexible rostering with provision of suitable child care facilities is an important issue for the recruitment and retention of staff, as is help with housing, particularly for foreign nationals.

RECOMMENDATION 18.8: A flexible retirement package should be considered to make the best use of valuable experienced staff. This would enable staff nearing retirement to move into part-time work without reducing pension benefit or to retire while carrying on with full or part-time work. Staff earlier on in their career should be able to take a career break and still contribute to their pension benefits.

RECOMMENDATION 18.9: Future manpower requirements must be driven by service requirements rather than historical factors and should not be wedded to the perceived needs of any single discipline.

Databases should be established for all professions and assistant grades to identify and track location and career progression of professionals. Little of this information is available and this deficiency impedes manpower planning.

18.7 LINKING EDUCATION AND TRAINING TO MANPOWER REQUIREMENTS

To produce an adequate number of graduates and competent professionals across disciplines requires a review of the E&T undergraduate and postgraduate programmes currently on offer. This review should ensure that particular courses address the skills required by the mental health service and also that they have capacity to produce the numbers to meet proposed manpower requirements.

There will also be a need to upgrade the skills of existing staff to enable them adopt different roles within the community mental health team, and to support and develop their competencies in order to maintain morale and increase the likelihood of retention.

RECOMMENDATION 18.10: Within the context of overall service changes, many currently employed staff will need to redefine their role in the light of the development of new community-based teams focusing on early intervention, assertive outreach, crisis resolution and home treatment. Appropriate training should be available for affected staff.

RECOMMENDATION 18.11: A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services. This should help managers set priorities for the use of resources in order to meet common needs more efficiently, organise staff release and target and schedule in-house education and training. In this regard it is also important to make available clear information about routes to employment training and career progression within the mental health service.

Arrangements governing E&T for professionals in the mental health services are complex and are put in place by a number of independent bodies. A summary is provided here of the current training systems in place across disciplines. Recommendations are made as to how E&T programmes need to develop and expand in the light of increasing manpower requirements. Any changes made in the structure or content of these programmes should be made in close liaison with the relevant accrediting bodies.

18.7.1 MEDICAL EDUCATION IN PSYCHIATRY

Undergraduate medical education is the responsibility of the five medical schools, which between them provide 14 professors of psychiatry, the majority of whom are based in Dublin. There is general agreement that the quality of undergraduate medical training and education is unsatisfactory (as perceived by recent Irish graduates) and the matter has been addressed in the recent *Report on Medical Undergraduate Education* (known as the Fottrell Report)[201]. Among the main findings and recommendations of the Fottrell Report was that the number of undergraduate places in medical education must increase to 725 in order to meet future medical manpower requirements.

Furthermore, Fottrell recommended that the proportion of non-EU places should be capped at 25%. The reason for the dearth of undergraduate medical places for Irish students is that the points requirements for places is kept artificially high because of the scarcity of places – currently only 4% of those wishing to pursue medicine as a career obtain sufficient points for a medical school place. Two of the five medical schools have announced that they are proceeding to a policy of graduate entry for some students.

RECOMMENDATION 18.12: The quality and scope of undergraduate medical education programmes should be reviewed and the recommendations of the Fottrell report to increase intake should be adopted.

The ultimate responsibility for ensuring and monitoring standards in medical postgraduate education rests with the Medical Council. However the body immediately

tasked with responsibility is the Postgraduate Medical and Dental Board. This Board operates through 13 bodies representing the various medical specialties.

In the case of psychiatry, the body in question is the Irish Psychiatric Training Committee (IPTC), which was set up on the formation of the Postgraduate Board. It comprises representation from the medical schools, the professional organisation, currently the Royal College of Psychiatrists (RCP) in the United Kingdom, and the Department of Health and Children. The training course and syllabus is devised by the RCP and administered by the IPTC.

The Irish training centres (34 of them) are inspected and accredited by the RCP as are the trainers (in practice all Irish consultants). Currently all Irish services are training-accredited. Psychiatry is the only medical speciality that relies on a UK body to both devise and control education in this jurisdiction; other specialities have established their own programmes and examinations.

There is general recognition that the present Irish training arrangements need considerable revision. The IPTC has established a working group to examine and advise it on the appropriate steps to be taken in moving towards training arrangements and organisation more attuned to present realities and needs in the Irish mental health services of the future.

RECOMMENDATION 18.13: Current steps to revise post graduate training in psychiatry should be undertaken with a view to increasing the number of graduates in this speciality and equipping them with the range of skills required within the proposed restructured mental health service.

18.7.2 MEDICAL EDUCATION IN GENERAL PRACTICE

Education in psychiatry for general practitioners is not formalised. However a number of GP training schemes have psychiatric placements in operation. These arrange for general practitioner trainees to take up non-consultant hospital doctor postings for a six-month period. As much of this work involves hospital-based psychiatry it is questionable how valuable it is for those whose professional lives will be spent in primary care.

This issue of mental health training for GPs needs urgent joint review by the general practice and psychiatry training bodies.

RECOMMENDATION 18.14: The GP training body and the psychiatry training bodies should jointly review all issues in relation to mental health training for GPs.

18.7.3 PSYCHIATRIC NURSING

Psychiatric nurses remain the largest staff group involved in the provision of mental health care. An Bord Altranais is the statutory body responsible for education, training, registration and regulation of nurses in Ireland. The National Council for the Professional Development of Nursing and Midwifery (NCNM) has the responsibility for the approval of clinical nurse specialist (CNS) and advanced nurse practitioner (ANP) roles. Currently there are 450 CNSs and no ANPs in the mental health service.

Nurse training in Ireland is divided, from the outset, into five separate and independent programmes. A qualification in one allows graduates to practice only in that speciality, and if a student wishes to pursue another branch of nursing, it is necessary to spend a further four years in training. Considering the cost and international trends in nurse education at an undergraduate level, it is difficult to see why a separate training programme should be maintained.

Potential developments could include the development of a common foundation core programme for all students for a specific period of time, followed by specialist training up to the point of registration as a mental health, general or intellectual disability nurse.

RECOMMENDATION 18.15: A common foundation core programme for all student nurses, followed by specialist training up to the point of registration as a psychiatric, intellectual disability or general nurse should be given serious consideration. In the interim, shortened training should be available for all qualified nurses wishing to register in any of the other nursing disciplines.

In July 2002, the Minister for Health and Children published a final report of the Nursing and Midwifery steering group entitled *Towards Workforce Planning*[202]. This was the first large-scale work undertaken with a view to setting out a comprehensive approach to nurse workforce planning.

Half of the qualified psychiatric nurses are aged over 45 years. Projecting forward to the year 2007, over 65% of psychiatric nursing personnel will be aged 45 years or over, and only 14% under the age of 34 years. With the retirement age of 55 years possible for the majority, this is a matter of concern for services. The number entering psychiatric nurse training has increased from 83 nationally in 1998 to 342 in 2004. The number of psychiatric nurses in training allows limited scope for future development in the field of mental health care, treatment and prevention, nor does it accommodate the identified needs for the development of primary care teams and child and adolescent mental health services.

There are approximately 9,575 nurses maintained on the active register of An Bord Altranais, yet only 5,834 are employed in the public mental health system, providing 5,370 whole time equivalent (WTE) posts, with a further 340 employed in the private system. Ninety per cent of psychiatric nurses remain hospital-based, and there is an inequitable distribution of nursing staff across the country. In some areas, where there are staff shortages and an over-reliance on agency staff, the focus on care tends to be on providing a safe service, rather than on delivering quality patient contact and therapeutic relationships.

Serious reconsideration is required in relation to the re-training and re-deployment of nursing staff across the country to meet the requirements of this policy. There should be a critical examination of the manner in which the professional skills of a reducing supply of psychiatric nurses are utilised.

Some nurses are still engaged in tasks below their level of expertise, where they have little opportunity to deploy their expensively acquired skills. Nursing assistants with the appropriate training and supervision could just as easily perform some current roles, leaving nurses free to work at a level more in keeping with their training and experience.

RECOMMENDATION 18.16: The recommendations of the Nursing and Midwifery Resource, July 2002 Final Report of the Steering Group 'Towards Workforce Planning' should be implemented in full and further developed on a multidisciplinary basis.

RECOMMENDATION 18.17: The number of psychiatric nurses in training should be kept under constant review to allow scope for the future development of general adult, child and adolescent and other specialist mental health services and primary care teams.

RECOMMENDATION 18.18: The sponsorship scheme for experienced care assistants to train as nurses should be maintained and extended to ensure appropriate, mature applicants are attracted into the psychiatric nursing profession.

RECOMMENDATION 18.19: There is no official requirement to involve service users and carers in the education and training of psychiatric nurses. It is recommended that service users and carers should be consulted and involved in the development of educational programmes.

18.7.4 INTELLECTUAL DISABILITY NURSING

Registered nurses in intellectual disability are central to the provision of effective service delivery to individuals with an intellectual disability. Currently, there are 3,752 registered nurses on the active intellectual disability nurses' register maintained by An Bord Altranais.

The present intellectual disability nursing course is a four-year pre-registration degree programme leading to a B.Sc. degree in nursing. There are eight courses annually with a total of 240 places. Post-registration and post-graduate diploma programmes offered to registered nurses in intellectual disability have increased in the last two years but are limited to certain geographical areas.

There are 117 clinical nurse specialists (CNS) working in the intellectual disability sector, with no advanced nurse practitioners (ANP) at present. Specialist and advanced nurse practitioner roles for nurses in intellectual disability should be developed in response to identified needs of people using the service. Intellectual disability nursing should develop a level of skills within this particular domain of competency to meet the recommendations for the development of intellectual disability mental health services as set out in Chapter Fourteen.

RECOMMENDATION 18.20: Specialist and advanced nurse practitioner roles for nurses in intellectual disability should be developed in response to identified needs of people using the service.

18.7.5 SOCIAL WORK

The National Social Work Qualifications Board, (NSWQB), soon to be subsumed under the terms of the Health and Social Care Professionals Act, 2005, is responsible for the accreditation of professional education and training and recognition of social workers. The qualification required for practice is the National Qualification in Social Work (NQSW), or an equivalent in the case of non-nationals.

There are approximately 110 mental health social worker practitioners employed in the mental health services. In order to increase the attractiveness of mental health social work posts, existing deficiencies in terms of professional and geographical isolation, lack of supervision, and poor facilities, need to be overcome. As well as the development of multidisciplinary teams for existing services, the development of specialist services within mental health would mean increased demand for social work staff for those services, e.g. rehabilitation and recovery services for severe or enduring illness. Because of the relationship between mental ill health and deprivation, particularly deprived areas should receive special recognition in the provision of services[173].

Student placements are crucial to social work training and have been identified as such by the NSWQB[203]. Good quality placements made available in the mental health services, will augment student training in such a way that they will feel more inclined to work in the area of mental health.

Because of the scarcity of social work posts in mental health generally, social workers have undertaken tasks which could effectively be carried out by social work assistant grade. The introduction of such a grade should be considered by the HSE. A panel could be formed of service users or prospective social work students who could be employed as social work assistants on a contract basis.

RECOMMENDATION 18.21: A mental health training module should be mandatory and standardised in social work training to ensure all staff especially those without practice experience have a basic understanding of mental health issues and mental health services.

18.7.6 CLINICAL PSYCHOLOGY

The total number of psychology whole time equivalent (WTE) posts in clinical, counselling, health, educational, and neuropsychology services in the health service, was

632 at the end of 2004. These figures include posts in both the public and private or voluntary sectors. Out of this total number, 471.2 posts were filled.

Within the mental health services there was a total of 180 clinical psychologists employed in child and adult mental health services at the end of 2004 and a further 150 (including some educational psychologists) within intellectual disability services. In the light of manpower requirements outlined in this policy, there will be a need to considerably increase the numbers of psychologists in every aspect of the mental health service.

Clinical and counselling post-graduate training programmes have to be approved by The Psychological Society of Ireland (PSI) for graduates to work within the health service. Four university-based doctoral courses in clinical psychology currently produce an annual output of about 40 graduates.

This means that it would take over ten years to produce the additional 300 clinical psychologists to work in mental health recommended in the report, given that some clinical psychology graduates migrate to other areas of service. Accordingly, it is critical that these courses are securely funded and allowed to increase their intake of students to meet mental health service requirements.

The course entry criteria for these courses are quite stringent, and the establishment of an Assistant Psychologist post would both increase the opportunities for candidates to acquire the necessary experience for entry to clinical training courses, and also enhance the psychology services within mental health, through the performance of basic tasks such as assisting with assessments, in-service audit and research activities.

Postgraduate training courses, including training for counselling psychologists – whose graduates form the majority of the 80 psychologists working in community care programmes – should be reviewed to ensure that their course content is in keeping with the model of mental health service described in this policy.

RECOMMENDATION 18.22: A significant increase in the number of funded postgraduate training places for clinical psychology is needed urgently to fill the current shortfall and meet projected manpower requirements. Additional appointments at senior grade should be established to facilitate supervised clinical placements for those in training. The use of the Assistant Psychologist grade as a career step should also be considered.

18.7.7 OCCUPATIONAL THERAPY

There are currently 131 occupational therapists employed in the mental health service (ten of them in the child and adolescent mental health service). The annual attrition rate is 4% and presently there are 19.5 posts vacant and 4.5 posts frozen, due to employment ceilings.

The Bacon Report indicated a situation of severe undersupply in the labour market for occupational therapists[204]. It estimated that by 2015, 1,425 occupational therapy posts would be required to meet predicted demand. This constituted a 159% increase over existing supply. Following the recommendations of the Bacon Report, three new courses were established in 2003.

With the advent of 75 new undergraduate training places for occupational therapists, the demand for supervised fieldwork education has risen sharply and a shortfall in clinical placements has resulted. Other issues for occupational therapy include lack of investment in service development, too few occupational therapy posts nationally, scarcity of specialist posts, lack of capacity for student fieldwork education and employment ceiling constraints/frozen posts.

In addition, a recent decision by the World Federation of Occupational Therapists (WFOT) has lifted the ruling regarding 300 protected hours of psychosocial fieldwork experience. This may have negative implications for the education and training of Irish occupational therapists in the future.

There is an initial and subsequent seven-year system of accreditation by the AOTI (Association of Occupational Therapists Ireland) accreditation board, adhering to WFOT guidelines. Service users provide tutorials on all the courses.

The new Health and Social Care Professionals Act 2005[205], deals with registration and course accreditation for 12 professions, including occupational therapy. The Department of Health and Children is currently working with the HSE to introduce formal Therapy Assistant grades, together with appropriate training courses.

RECOMMENDATION 18.23: In order to increase the attractiveness of mental health social work and occupational therapy posts, existing deficiencies in terms of professional and geographical isolation, lack of supervision and poor facilities should be addressed.

18.7.8 HEALTH CARE ASSISTANTS

The report of the Commission of Nursing[206] recommended that the Department of Health and Children, health service employers and nursing organisations examine opportunities for the increased use of care assistants and other non-nursing staff. The *Effective Utilisation of the Professional Skills of Nurses and Midwives* report recommended that the grade of health care assistant be introduced as a member of the health care team, to assist and support the nursing and midwifery functions. This recommendation has been endorsed by the Minister for Health and Children.

18.7.9 NON-NURSING AND ANCILLARY STAFF

All of the mental health services have groups of domestic attendants and nursing assistant staff. Some services have grades of ward clerks. These groups of staff are utilised in the main to carry out specific duties not performed by others. However, in some settings, non-professional staff are given extended roles that include the delivery of direct care to patients.

The work of non-professional groups in the mental health services and in the health service needs to be assessed. Roles need to be redefined as services expand and develop, and in-service education programmes need to include these groups in particular areas of training.

Consideration needs to be given to career development opportunities for this group of staff and a national education programme, allowing non-professional staff to develop their skills so they can participate more fully in appropriate care, needs to be considered.

18.7.10 MENTAL HEALTH SUPPORT WORKERS

Within the expanded model of the community mental health team (see Chapter Nine), it is proposed to create a new position of mental health support worker. These new workers in the mental health system will provide service users with companionship, friendship and practical support with daily living activities. They will help service users gain access to services and resources such as housing and employment.

These new staff may come from a wide range of educational backgrounds with diverse personal experience and qualifications. Some may be users, carers, nursing assistants or retired staff. They should be offered flexible arrangements in terms of working hours to maximise their value to the service user.

RECOMMENDATION 18.24: It is recommended that the position of mental health support worker be established in the mental health system to support service users in achieving independent living and integration in their local community.

18.7.11 MANAGERS, CLERICAL AND ADMINISTRATIVE STAFF

Mental health service managers have diverse professional backgrounds, including public health service administration, the health professions and the private sector, and have followed diverse pathways in education

and career progression. Although managerial education and training within mental health services is not service specific, the requirement for specific knowledge, experience and expertise in the planning, development and management of particular services must be given due weight. The concept of service-specific management should be accommodated and supported through dedicated training programmes.

Staff recruitment and retention is generally satisfactory in management, administrative and clerical grades, except at Grade III level in Dublin services. While public mental health services employ approximately 640 clerical and administrative personnel, this resource is unevenly distributed nationally and the public service employment ceiling exacerbates local establishment difficulties.

These combined factors impede efficient organisation, operation and development of clinical and multidisciplinary practice and affect the quality of new administrative activities such as servicing Freedom of Information requests. These workforce problems should be addressed by nationally defining and establishing an administrative structure for local mental health services.

18.8 ADVOCACY

The development of specific training courses on all types of advocacy as set out in Chapter Three (service users and carers) should be encouraged and financed appropriately.

RECOMMENDATION 18.25: Advocacy training programmes should be encouraged and appropriately financed.

18.9 SOME GENERAL ISSUES

18.9.1 FOREIGN NATIONALS

In all of the above professions, overseas graduates seek recognition and registration in this country. Many come to Ireland for short periods only and some (as in the case of medicine) for training only. Their contribution to mental health services is considerable and greatly appreciated by service providers.

In the case of medicine, NCHD staffing would be even more precarious than it is without this additional manpower resource. For example, in January 2004, 62% of NCHDs in psychiatry were comprised of foreign nationals.

In other instances, e.g. nursing, most foreign nationals arrive through active recruitment by Irish health services in the non-nationals' home country. As some of these countries are underdeveloped, particularly their health services, there is an ethical issue that requires consideration to ensure that recruitment be limited to such countries where the national government in question supports the process[207].

What overall impact these groups have on manpower resources is unclear. It is vitally important when foreign national staff are recruited and employed, that they are properly inducted and informed about how our health services function and about relevant cultural factors.

18.9.2 OTHER GROUPS

Training for other professional groups is also necessary. One of the most important of these is An Garda Síochána because of its members' frontline profile and activity in the community. This inevitably and frequently brings them in contact with many mentally ill people. Up to now they have received minimal training and advice as to how to relate to those mentally ill persons they encounter in their daily duties. More detailed training and education is required. There are others, too, such as ambulance staff, community welfare officers and A&E staff who also require training inputs in mental health.

18.9.3 TRAINING IN COUNSELLING AND PSYCHOTHERAPY

The consultation process that informed this policy revealed a concern on the part of many service users

with the predominance of drug treatments and the limited opportunities for discussion and resolution of their problems through counselling and psychotherapy.

Counselling and psychotherapy may be described as interventions that, through the use of the therapeutic relationship and of psychological techniques, aim to reduce distress and symptoms, enhance coping skills and self-knowledge (see also Annex 11).

In general terms, counselling is concerned with a circumscribed difficulty arising from an identified precipitating cause and is short-term in application, whereas psychotherapy is concerned with more fundamental and inherent difficulties of longer duration and with less easily identified causes.

More recently there has been an expansion of techniques and target subjects deemed relevant for these interventions, for example family therapy, cognitive behaviour therapy, dialectic behaviour therapy, psychoanalytic therapies and so on. It appears that the availability of counselling and psychotherapy interventions is not equitably distributed across different income groups, however.

The structure and quality of training courses for these various therapies vary considerably, ranging from introductory weekend courses to accredited, university-based, masters and doctoral level courses.

Some of these courses form regular components of education and training for professional groups working in the health services, such as psychiatrists, psychologists and social workers. Others agencies such as the Irish Association of Counselling and Psychotherapy and Irish Council for Psychotherapy accredit their own courses.

This diversity of training bodies, courses, and target groups is of little help to service administrators attempting to answer the call for more counselling and psychotherapy. A training strategy is required to promote, fund and accredit psychotherapy courses that provide the required skills to respond to the needs of service users.

Currently, most counselling and psychotherapy programmes recruit students with a variety of professional backgrounds. This approach to multidisciplinary education and training has been cited as an example of best practice and should be considered for other post-graduate mental health training programmes.

RECOMMENDATION 18.26: A National Manpower Planning Group should be established to make recommendations regarding the education, training and workforce issues arising from this report, with reference to clinical psychology, counselling psychology and psychotherapy.

18.9.4 INDUCTION

The importance of inducting students and new employees is an important and neglected issue. Among the many issues that should feature in induction instruction are matters such as service policy and organisation, mental health legislation and health and safety issues.

18.9.5 MANDATORY TRAINING IN LIFE SUPPORT

A policy on mandatory training in basic life supports, moving and lifting, and health and safety issues should be available in each service, highlighting which staff are to be trained and the level of training required. Appropriate records of training undertaken and who participated should be maintained.

RECOMMENDATION 18.27: A variety of programmes should be in place for the workplace such as induction programmes, health and safety programmes (for example, cardio-pulmonary resuscitation) and training in conducting staff appraisals.

18.9.6 MENTAL HEALTH LEGISLATION

Training in and familiarisation with mental health legislation, including the Mental Health Act, 2001, should be provided for all professionals, administrators and others by the Mental Health Commission in consultation with the HSE.

18.9.7 ASSISTANT GRADES

There will, in the future health services, be an expanding requirement for Mental Health Care Assistant grades in areas such as social work, psychology and occupational therapy, with defined roles and responsibilities. Training courses should be devised and it is important that training be generic, flexible and shared or common between the assistant training courses for the different professions. The entry requirements for, and the nature and extent of, this training and education need to be planned appropriately. The nature of training, for example the balance between didactic and practical content, will have to be decided.

18.9.8 VOLUNTEERS

There is need to recruit and train mental health support volunteers who will work locally at tasks such as accompanying patients on outings and undertaking other relatively unskilled tasks. An initiative on the part of Mental Health Ireland led to the setting up of a course at Waterford Institute of Technology in 2004/5 to provide skills for volunteers in the South Eastern Region so that they should be informed and educated in order to fulfil their roles as volunteers. The volunteers themselves identified, at the outset, the need to provide a structured and accredited training programme.

RECOMMENDATION 18.28: The establishment of structured, accredited training courses and other measures to support and encourage volunteering in the mental health service should be considered within the broad context of education and training.

18.10 RECOMMENDATIONS

1. E&T should be directed towards improving services as a primary goal and must have the welfare of service users as its ultimate objective.

2. Training programmes should emphasise the acquisition of skills that are clinically meaningful, should train personnel for leadership and innovative roles, and should foster an attitude of critical enquiry and self-scrutiny in relation to service delivery.

3. There should be centralisation of the planning and funding of education and training for mental health professionals in new structures to be established by the HSE in close association with the National Directorate of Mental Health Services. This centralised E&T authority should be constituted to represent stakeholder and service user interest and E&T bodies representing all disciplines.

4. The HSE should commit itself to adequate, rational and consistent funding of E&T. However the accreditation of courses should remain the responsibility of the respective professional bodies.

5. Funding of HSE sponsored training courses should be established on a secure basis to allow for expansion and development of these courses and to ensure manpower requirements in mental health services can be met in coming years.

6. A multi-profession manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this report, and should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers. This should include consideration of a re-allocation

of resources working group to ensure equitable distribution of manpower resources across the four regions.

7. Family friendly staff policies and flexible rostering with provision of suitable child care facilities is an important issue for the recruitment and retention of staff, as is help with housing, particularly for foreign nationals.

8. A flexible retirement package should be considered to make the best use of valuable experienced staff. This would enable staff nearing retirement to move into part-time work without reducing pension benefit or to retire while carrying on with full or part-time work. Staff earlier on in their career should be able to take a career break and still contribute to their pension benefits.

9. Future manpower requirements must be driven by service requirements rather than historical factors and should not be wedded to the perceived needs of any single discipline.

10. Within the context of overall service changes, many currently employed staff will need to redefine their role in the light of the development of new community-based teams focusing on early intervention, assertive outreach, crisis resolution and home treatment. Appropriate training should be available for affected staff.

11. A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services. This should help managers set priorities for the use of resources in order to meet common needs more efficiently, organise staff release and target and schedule in-house education and training. In this regard it is also important to make available clear information about routes to employment training and career progression within the mental health service.

12. The quality and scope of undergraduate medical education programmes should be reviewed and the recommendations of the Fottrell report to increase intake should be adopted.

13. Current steps to revise post graduate training in psychiatry should be undertaken with a view to increasing the number of graduates in this speciality and equipping them with the range of skills required within the proposed restructured mental health service.

14. The GP training body and the psychiatry training bodies should jointly review all issues in relation to mental health training for GPs.

15. A common foundation core programme for all student nurses, followed by specialist training up to the point of registration as a psychiatric, intellectual disability or general nurse should be given serious consideration. In the interim, shortened training should be available for all qualified nurses wishing to register in any of the other nursing disciplines.

16. The recommendations of the Nursing and Midwifery Resource, July 2002, Final Report of the Steering Group *Towards Workforce Planning* should be implemented in full and further developed on a multidisciplinary basis.

17. The number of psychiatric nurses in training should be kept under constant review to allow scope for the future development of general adult, child and adolescent and other specialist mental health services and primary care teams.

18. The sponsorship scheme for experienced care assistants to train as nurses should be maintained and extended to ensure appropriate, mature applicants are attracted into the psychiatric nursing profession.

19. There is no official requirement to involve service users and carers in the education and training of psychiatric nurses. It is recommended that service users and carers should be consulted and involved in the development of educational programmes.

20. Specialist and advanced nurse practitioner roles for nurses in intellectual disability should be developed in response to identified needs of people using the service.

21. A mental health training module should be mandatory and standardised in social work training to ensure all staff especially those without practice experience have a basic understanding of mental health issues and mental health services.

22. A significant increase in the number of funded postgraduate training places for clinical psychology is needed urgently to fill the current shortfall and meet projected manpower requirements. Additional appointments at senior grade should be established to facilitate supervised clinical placements for those in training. The use of the Assistant Psychologist grade as a career step should also be considered.

23. In order to increase the attractiveness of mental health social work and occupational therapy posts, existing deficiencies in terms of professional and geographical isolation, lack of supervision and poor facilities should be addressed.

24. It is recommended that the position of mental health support worker be established in the mental health system to support service users in achieving independent living and integration in their local community.

25. Advocacy training programmes should be encouraged and appropriately financed.

26. A National Manpower Planning Group should be established to make recommendations regarding the education, training and workforce issues arising from this report, with reference to clinical psychology, counselling psychology and psychotherapy.

27. A variety of programmes should be in place for the workplace such as induction programmes, health and safety programmes (for example, cardio-pulmonary resuscitation) and training in conducting staff appraisals.

28. The establishment of structured, accredited training courses and other measures to support and encourage volunteering in the mental health service should be considered within the broad context of education and training.

CHAPTER NINETEEN

Mental health information and research

19.1 INTRODUCTION: WHY IS HEALTH INFORMATION IMPORTANT?

There is a perception that health information is a 'bureaucratic' activity, peripheral to the provision of health care, and that money spent on the people and technology needed to support health information would be better spent on providing 'real' health care. This has impacted spending on health information and as a consequence, Ireland, as a nation, suffers from a deficiency of health information.

One of the central issues in health information is the ability to transform the myriad of raw data collected in the health system into useful information that can then provide the knowledge needed to plan, develop and evaluate health services and to formulate health policy. The system needs individuals with the expertise to do just this – experts in health information who can make raw data meaningful and useful.

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One health information problem is that very little is known about the mental health of people living in Ireland. The number of people with depression in the country is not known, although it can be estimated, based on information from other countries. Nor is it known what type of mental health care these individuals receive.

The various reports driving the Health Service Reform Programme in Ireland have all decried the lack of information on health services and the health of the population. Without this information, services cannot be rationally planned, for example decisions about where services should be located, and about how much and what type of service is needed.

If the information collected is more immediately useful to those collecting it, this can help bring about the much-needed change in the culture of the health services, so that information is recognised as a central tool in the provision of high quality health care, and not just a bureaucratic exercise.

19.2 WHAT IS HEALTH INFORMATION?

In the *National Health Information Strategy*[208] the term 'health information' is used to refer to 'any information used to help make an informed health-related decision or to inform oneself of health-related issues, whether at the personal, professional, managerial or political level'.

This is a very broad definition and when applied to mental health information it is useful to break down this definition into different information categories depending on the primary users of the information and the function of different types of information.

The following categories are listed in the National Health Information Strategy and are modified here to be relevant to mental health information:

1. Information for mental health service users and carers about mental health topics and services to empower them to make decisions

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2. Information to assist mental health professionals in clinical decision-making and to provide quality care (i.e. access to best practice guidelines, knowledge databases, library services etc.)

3. Information to support the planning, monitoring and evaluation of mental health services, specifically information on the outcomes for mental health service users, e.g. how has a particular service input helped a service user/carer? Have their symptoms lessened? Is their quality of life improved? Are they able to do more in social or occupational terms? Other information in this category includes human resource management and planning, resource allocation and information that demonstrates service quality and value for money

4. Information on mental health status and determinants

5. Information to support the development and implementation of policies and the allocation and utilisation of resources to promote, protect and restore mental health.

19.3 INFORMATION FOR MENTAL HEALTH SERVICE USERS ON MENTAL HEALTH TOPICS

One of the messages from the consultation process was that service users and carers want easy access to a wide variety of information. This information needs to be in a user-friendly format and be readily available.

The information sought was in the following main areas:

- Information about specific mental health problems
- Information about mental health services
- Information about medication and other aspects of mental health service delivery such as involuntary admission
- Information about rights and information about the Mental Health Act, 2001[82]
- Information on complaint procedures.

Many organisations currently provide much of this information, including voluntary organisations, the Mental Health Commission and the Department of Health and Children (see Annex 19 for further details). However, there is no single, readily available source of information on what mental health services are provided locally and nationally.

The *National Health Information Strategy*[208] recommends that information on specific health conditions and information on services be provided in a single, easily accessible format. This matter is to be pursued by the Health Information and Quality Authority.

Information about medication needs to be provided by mental health services in a written, easily understood format, and every mental health service user should be provided with a copy of their care plan.

Service users and their carers also need information on the Mental Health Act, 2001 and how it will work, for example the procedures for involuntary admission. This information is currently being prepared by the Mental Health Commission. Information is also required on complaint procedures locally. Details of how to go about making a complaint, who to contact and so on should be available in each mental health service. Provision has been made in the Health Act, 2004 for statutory complaints procedures to be put in place in the HSE.

RECOMMENDATION 19.1: Service users and carers should have ready access to a wide variety of information. This information should be general (e.g. on mental health services in their area) and individualised (e.g. information on their medication).

19.4 INFORMATION TO ASSIST MENTAL HEALTH PROFESSIONALS

Much is currently known on particular types of interventions or ways of delivering services that are both effective and acceptable to service users (for example assertive outreach). Mental health professionals have identified access to this type of information as a particular need. If mental health services are to be evidence-based and use the latest information and developments to inform practice and service delivery, this type of information needs to be readily available to mental health professionals.

The National Institute for Clinical Excellence (NICE) is an independent organisation that fulfils this function in England and Wales. For example, assessments have been made of the new 'atypical' antipsychotic medication and recommendations on its use were made and a guideline on the management of depression in primary and secondary care has recently been published[209].

The Health Information and Quality Authority (HIQA), which will be established under primary legislation in 2006, will be responsible for health information, promoting and implementing quality assurance programmes nationally, and overseeing health technology assessment. (The term health technology assessment is used to describe a systematic evaluation of a medical device, for example an x-ray machine, or an evaluation of an intervention, such as family therapy.)

RECOMMENDATION 19.2: The HIQA should put mechanisms in place to carry out systematic evaluations on all forms of interventions in mental health and this information should be widely disseminated.

19.5 MENTAL HEALTH INFORMATION FOR PLANNING AND MONITORING SERVICES

This is arguably the most important type of information for all stakeholders as it is this information that should lead to the improvement of mental health services for service users and carers. Much of the mental health information currently generated is under this heading and details of the information now available are in Annex 19.

However, the system currently lacks timely, high quality data on community-based mental health services, outcomes for mental health service users and the prevalence and incidence of mental health problems. There is no individualised data from either community or in-patient services.

A small number of mental health services have comprehensive, computerised information systems that can supply this information. The HRB has developed and is piloting a system (COMCAR – community care) to address the need for information from community-based mental health services. This may provide the basis for further development in this area.

RECOMMENDATION 19.3: Measures should be put in place to collect data on community-based mental health services.

19.5.1 INFORMATION CURRENTLY AVAILABLE

Compared to other health sectors, the mental health services are fortunate in having several sources of information that have been running for several decades. The National Psychiatric In-patient Reporting System (NPIRS) is run by the Health Research Board (HRB) and has provided a continuous source of information on the in-patient part of mental health services for 30 years.

The mental health section of the HRB has also carried out decennial census of psychiatric in-patients. Published annual reports from the NPIRS system have provided the only readily available detailed information on the activity of in-patient services. In recent years, these reports have included information on other aspects of the in-patient services and information on the activity of community mental health services collected by the Department of Health and Children.

Other mental health service information has been provided over the years in the annual Inspector of Mental Hospitals reports, and the end-of-year returns compiled by the mental health section of the Department of Health and Children to the end of 2003.

These reports have been the only published source of information on community mental health services nationally. The information is of variable quality and doesn't generally address the needs of services for broader information of high quality delivered in a timely manner. In particular, none of these reports have the individualised data required to report on service outcomes.

19.6 MENTAL HEALTH INFORMATION SYSTEM

This leads to one of the main shortcomings of mental health information; that is the lack of a mental health information technology and telecoms (IT&T) system to support the provision of information.

The health sector generally has been poor at exploiting information technology. Much of the information from mental health services is collected manually – entailing a significant time and manpower commitment. Mental health is even further behind other health sectors in IT&T in terms of having a comprehensive mental health information system with full coverage of all mental health services and input from all mental health professionals. Many mental health services still have very few computers and only one or two have computers available in all the locations in which mental health care is delivered.

The provision of comprehensive information on mental health care is more challenging than in, for example, the acute hospital sector, as mental health care involves a wide range of community services in a variety of locations, whose interaction in patient care is complex, whereas most care in an acute general hospital occurs on one site.

A comprehensive, integrated IT system is a central requirement for mental health services. This needs to be designed specifically to collect all the information

required in the various locations where mental health services are provided.

There are several factors that need to be in place to have an effective, computerised Mental Health Information System (MHIS) that addresses both local and national needs. Most of these factors need some national action and include:

- an electronic patient record (EPR)
- a unique patient identifier
- an agreed national minimum data set for mental health
- one national mental health information system that receives information from local mental health services.

These requirements are discussed below.

19.6.1 THE ELECTRONIC PATIENT RECORD

The concept of the EPR is central to the development of a computerised information system. Although technological advances in science have improved medical care in recent decades, improvements in managing patient information have been less rapid. Yet providing excellent health care for a patient needs an accurate and organised record of the patient's medical history.

Most mental health care providers in Ireland continue to rely on paper-based medical records as the primary source of patient information and base their care decisions on the information stored in these charts.

Frequently, the chart is thick, tattered, disorganised and at least partially illegible. Progress notes, consultant's notes, nurse's notes, psychology notes, social work notes and investigation results are all mingled in accession sequence and they pose an inhospitable challenge to anyone who tries to understand what is happening to the patient.

To compound this problem, in mental health all too often a patient's notes are dispersed over a number of geographically distinct sites. As community mental health services develop further this dispersion will increase.

The EPR can improve the quality of information available to clinicians and improve patient care. Records are more likely to be legible, accurate, safe, secure, and available when needed, and they can be readily and rapidly recovered and communicated. Additionally, it is easier to audit response to treatment for a given patient or across patient groups and easier to track service usage by individuals and patient groups.

An EPR has been introduced successfully in many centres in both the UK and the USA, but there have been many failures also. Implementation of clinically driven and locally developed systems that mesh with local services have been shown to have a vastly higher success rate than simply imposing generic systems. It is considered better to have a minimum data set presented in a common format to which all local systems adhere than attempt to roll out a single system nationally.

Issues such as involving key stakeholders and understanding their needs, training and support for users, and developing standards and quality checking all play an important role in setting up appropriate EPRs. While there are many benefits in adopting EPRs, it is important to make doctors and health care professionals aware that they cannot fully evaluate and appreciate the benefits until the system is entirely completed. An example is given in annex 19 of the process of developing and adopting an EPR from the point of view of a clinician.

RECOMMENDATION 19.4: In accordance with the recommendation in the National Health Information Strategy, an electronic patient record (EPR) should be introduced with a unique identifier for every individual in the state.

19.6.2 THE UNIQUE PATIENT IDENTIFIER

A unique patient identifier simply means a number that every individual in the state has from birth that they keep for life. In a health context it means that all relevant health information about the different health services used by an individual would be available as and when required. In discussing unique identification of service users, the *National Health Information Strategy*[208] notes that:

> The only safe and practical method of being able to draw together the separate parts of an individual's health record is through the use of unique identification. In the absence of this it is not feasible to plan, manage, deliver or evaluate services on a person-centred basis … (p. 61).

An important distinction is made between unique identification and information sharing. The use of a unique identifier does not in any way presume the sharing of information with other users of that identifier.

Unique identification is very important in mental health, where mental health care can be delivered in many locations, as well as in other parts of the health service, such as primary care. Box 19.1 gives an illustrative example of the many different contacts made in a mental health service and how a unique identifier would be useful.

Box 19.1: Example of an individual's journey through the mental health system

John sees his doctor (GP) because he has been feeling depressed. His GP keeps a paper chart on each of his patients in which he records details of visits and prescriptions etc. by hand. John's GP decides to refer him to a psychiatrist as he needs more specialist help than he as a GP can provide. A letter is written giving a number of identifying details on John such as his name, address and date of birth.

The psychiatrist sees John and a chart is made up for him at the mental health centre he attends. All the information in it is written by hand. A letter is sent back to his GP to let him know how John is getting on.

John also sees a social worker at the mental health centre and the social worker keeps her own set of notes on John.

John is admitted as an in-patient for a short time and a chart is made up for him in the in-patient unit in the hospital.

The nurses in the in-patient unit also have nursing notes on John.

So far there are at least four different people involved in the care of John, in three different locations. At least four sets of notes/charts have been created, duplicating essential identifying information each time. Each of the four people involved in John's care have only part of the full information that is held by all four.

There are also many practical advantages to the use of a unique identifier, such as the lack of duplication of work involved in entering an individual's administrative details onto forms and charts and information systems several times. A unique identifier is also essential to facilitate effective epidemiological research.

Having considered different options for unique identification of health service users, and the many benefits accruing from it, Action 16 of the *National Health Information Strategy* proposes that 'A system for unique identification within the health sector using the PPS number will be introduced.'

There have been some impediments to the implementation of the PPS number in the General Medical Service (GMS) database, arising from the interpretation of the Data Protection Acts. However, other proposed actions of the *National Health Information Strategy* should be implemented to overcome potential problems, such as the preparation of a legislative framework to support the *Information Strategy* (Action 17) and the development of a robust framework for information governance (Action 18).

This system of governance and legislation will ensure the correct use of such identifiers and the protection of the rights of individuals, and should therefore help assuage concerns in this area.

19.6.3 MINIMUM DATA SET

In view of the fact that only a small number of mental health services have computerised mental health information systems, while many are 'partially computerised', and that mental health services are provided differently around the country according to local and historical circumstances, a nationally defined mental health information IT system may be too unwieldy to develop and implement.

However, an agreed national minimum data set for mental health is a prerequisite for the development of a coherent mental health information system.

A minimum data set is a nationally agreed data set that is designed to meet national needs for information required to plan, monitor and evaluate services. While a minimum data set should be developed and agreed by all stakeholders, policy-makers and planners should have the central input, along with public health information specialists. A national minimum data set may be quite small, concentrating on 10–20 key pieces of information that allow comparative evaluation of mental health services. For example, the mental health minimum data set in the British NHS has been designed to provide local clinicians and managers with better quality information for clinical audit, service planning and management.

It is person-centred so that all the care received by individuals can be studied and includes details of clinical problems, treatments given, aspects of social care and outcomes. Geographic markers are also included. The provision of this data set became mandatory for mental health service providers in 2003.

Data records are extracted from local systems and assembled into a patient-linked format using a data manual and assembler software provided nationally. The data are compiled centrally and fed back to local services.

The most important benefit of a national minimum data set is that it allows for outcomes to be measured and evaluated, thus ensuring that services continually improve and develop to provide effective mental health care for each service user.

This model should be deployed in Ireland. Every local mental health service should be required to collect the national mental health minimum data set. Local mental health information systems should also be required to be developed and defined in such a way that they could link in with and feed information into a national mental health information system.

The national minimum data set will need to be standardised and clearly defined and should be developed with all the relevant stakeholders. The feasibility of legislative and/or financial incentives to encourage the collection of the mental health minimum data set should be explored.

The Mental Health Commission may have a role in this as the Commission has statutory responsibility for maintaining a register of approved centres under the Mental Health Act, 2001. The provision of the mental health minimum data set could be one of the conditions of registration for an approved centre.

The possibility of using the information derived from the minimum data set in some way to make decisions about the funding of services would also be a powerful incentive to the timely collection of high quality data.

RECOMMENDATION 19.5: A national mental health minimum data set should be prepared, in consultation with relevant stakeholders.

19.6.4 A NATIONAL MENTAL HEALTH INFORMATION SYSTEM

National action is needed to develop the EPR and to agree on a unique identifier and a mental health minimum data set. With these in place, local MHIS can be developed to satisfy both local and national information needs. The local requirements to implement an IT system in mental health include the following:

- the agreement of the service users and carers
- commitment to the process by all – in particular support from management
- willingness by all to invest the time to develop the system, i.e. to decide and define what information is required
- IT support and IT personnel with an understanding of health information and how mental health services operate. Ongoing IT support is also required
- training for all involved in using the system. Setting aside time for training and providing cover for personnel are essential if training is to be effective
- additional human resource for inputting the initial administrative details of service users and managing the information will be required. However, each mental health professional will have to be responsible for inputting their own information on each patient contact
- culture change – all mental health professionals need to recognise the importance of the information and the need to input it at source. In order to make the information system as useful as possible and to get as much cooperation as possible, it is essential that mental health professionals are involved in the process of determining the data to be collected and how it might operate
- resources to purchase and develop an appropriate system.

RECOMMENDATION 19.6: Mental health services should implement mental health information systems locally that can provide the national minimum mental health data set to a central mental health information system.

19.7 INFORMATION ON MENTAL HEALTH STATUS AND DETERMINANTS

Information on mental health status and factors that affect mental health is generally obtained from a national morbidity survey. This type of survey is carried out on a large, representative sample of the population. Using standardised measures, a concerted effort is put into identifying all those with mental health problems, including people who have not been in contact with any services.

A national morbidity survey carried out in this way gives an estimate of the number of people with mental health problems in the population (also called the prevalence of psychiatric morbidity).

This type of survey can also identify social disabilities or limitations in function associated with mental health problems, the different use of services, lifestyle indicators and recent life events which may be associated with the development of a mental health problem.

This type of national information is currently not available in Ireland, though this country does have a good record in psychiatric genetic epidemiology, with several studies currently examining the genetic component of schizophrenia and alcohol disorders. The data from the NPIRS also facilitates some research, although its usefulness is limited in two ways: firstly it relates only to in-patient admissions, secondly, there is no unique identifier for patients and therefore no way of using this information to inform prevalence rates (i.e. the data records admissions and not persons).

However, with a unique identifier it will be possible to get a picture of the incidence of different disorders as individuals make a first contact with the mental health services and are given a specific diagnosis. Particular diagnostic groups can also be followed through the system to see what services are being used and to assess the impact this has on individuals through outcome assessment.

RECOMMENDATION 19.7: A national morbidity survey should be carried out to determine the prevalence of mental health problems in the population.

19.8 INFORMATION TO SUPPORT THE NATIONAL MONITORING OF MENTAL HEALTH SERVICES

The information collection systems described above are required to effectively monitor and support the implementation of policy. Information with that very specific function is also obtainable by the performance indicator (PI) process.

A set of PIs for all health services, including all mental health services, is currently in use. Unfortunately, the mental health PIs have been driven by what is currently available in terms of information, rather than what ought to be measured in the mental health services.

Because of the manual information system currently in place in mental health services, it has not been possible to collect more sophisticated PIs, for example concerning patient outcome.

The availability of a national minimum data set, for example, would enable the collection of relevant, service-specific PIs that would enable meaningful comparisons to be made across services in their achievement of service objectives and their implementation of mental health policy.

19.9 RESEARCH

It is the aim of everyone involved in providing mental health treatment and care that services operate to the highest standards. Service users and carers want to be sure that services are effective and of the highest quality. Mental health service research can help to bring this about by:

- providing the information needed for effective service planning. For example, information on population needs is required if mental health services are to be provided equitably;
- ensuring effective, high quality mental health services - the information needed to develop best practice guidelines and evidence-based care is derived from research;
- driving mental health service development - high quality mental health research, designed with a view to dissemination, is required to drive further mental health service developments;

- driving staff development – for most professionals in mental health services, carrying out research is part of their ongoing professional development. Furthermore, a commitment to research is enshrined in the contracts of some mental health professionals. A study in the UK found that the facility to carry out research was the most important factor in retaining mental health professionals.

The WHO report *Mental Health: New Understanding, New Hope*[10] outlined four areas of mental health research that are vital to improve mental health services:

1. **Epidemiological research** – epidemiological data are essential for setting priorities within mental health and for designing and evaluating public mental health interventions.

2. **Treatment, prevention and promotion outcome research** – WHO believes there is a 'knowledge gap' concerning the efficacy and effectiveness of pharmacological, psychological and psychosocial interventions. A distinction is made between efficacy research, which refers to 'the examination of an interventions effects under highly controlled experimental conditions', and effectiveness research, which 'examines the effects of interventions in those settings or conditions in which the intervention will ultimately be delivered.' There is a scarcity of effectiveness and implementation research in Irish mental health services.

3. **Policy and service research** – among the priorities for WHO under this heading is the need to review training requirements for mental health professionals, given the critical importance of human resources in service provision, and also the need to understand the impact of policy decisions on access, equity and treatment outcomes.

4. **Research on the economics of mental health services** – to provide information to support choice of interventions and rational planning, it is important that there is local information on the costs of mental illness and local economic evaluations of treatment, prevention and promotion programmes. There is a paucity of up-to-date local data on costs in Irish mental health services, or on the costs of mental illness in Ireland.

RECOMMENDATION 19.8: Research should focus on mental health services – outcomes, policy and service, and economics – creating an evidence base for mental health care.

19.10 ISSUES IN MENTAL HEALTH RESEARCH

A brief discussion of the policy context for mental health research is to be found in Annex 19. This brief examination of some of the national and international policy on mental health research highlights many of the gaps in mental health service research in Ireland, both structural gaps and gaps in knowledge.

Structural gaps include the lack of a national mental health research strategy, poorly developed mental health research infrastructure, paucity of personnel with the training, experience and interest in mental health service research, lack of funding to support this research and a low level of service user involvement in mental health service research[210,211]. Knowledge gaps include the absence of studies on the economics of mental health services and mental health, information on outcomes, and how best mental health services should be organised and structured to deliver the most effective mental health care.

RECOMMENDATION 19.9: The recommendations of the Health Research Strategy should be fully implemented as the first step in creating a health research infrastructure in mental health services.

RECOMMENDATION 19.10: A national mental health services research strategy should be prepared.

19.10.1 FUNDING FOR MENTAL HEALTH RESEARCH

The Department of Health and Children supports the research programme of the Mental Health Research Division of the Health Research Board. The MHRD receives limited annual funding to carry out mental health services research.

Much valuable and influential work which has fed into policy has been carried out based on these limited resources, for example studies of acute bed usage[180], day hospital and day centre provision and utilisation[85] and the need for care provision in severe psychiatric illness[23]. The wider research programme of the division is also funded by national and international sources.

The funding departments of the HRB are the main source of support for health research in Ireland. Thus the HRB provides the majority of funds for health services research. Mental health service research however, receives a relatively small proportion of these funds, especially considering the burden of mental ill health on the population.

The other major source of funding in the area of mental health research and education is from pharmaceutical companies.

The business of pharmaceutical companies is to develop and test new drugs and to bring them to the marketplace. They conduct research into their products, and they engage in a variety of activities to promote their products.

There have been concerns expressed however, at the involvement of pharmaceutical companies in research and in the promotion of 'educational initiatives' for mental health professionals, particularly doctors and nurses.

One of the greatest concerns is that the influence of the pharmaceutical industry results in undue weight being put on a narrow biological/medical approach to mental health problems and treatments, resulting in the relative neglect of other approaches to mental health and other interventions[212].

It must be acknowledged that this heavy involvement of pharmaceutical companies in research, training and educational activities in mental health services, has come about because of the scarcity of funds from other sources. The funds of the HRB are limited and mental health services research is not a major beneficiary of these funds.

In many other health areas there are a number of charities, that provide funding for research, for example the Imperial Cancer Research Fund. This type of funding does not exist in mental health research in Ireland. There has been little central funding of mental health service research. This difficulty in attracting research funds to mental health has been recognised in the UK where a decision was made to provide ring-fenced central government funds for mental health research. Mental health is the only one of the NHS research and development programme priorities to be funded in this way. A similar approach to funding is proposed for this country.

The increased funding for health research in the UK has been driven by the 'value-for-money' agenda of the Treasury and the need to evaluate services to determine what outcomes were being achieved for the investment made. This is mental health service research in action: seeking answers to questions that will improve services for those who are using them.

RECOMMENDATION 19.11: Dedicated funding should be provided by the Government for mental health service research.

19.10.2 INVOLVING SERVICE USERS IN MENTAL HEALTH RESEARCH

Consultation with users and carers in the preparation of this policy, highlighted the need for the development of a National Mental Health Research Strategy involving

all mental health stakeholders, to promote ethical, progressive mental health research that will impact through policy, service and societal change on the lived experience of service users, carers and the public. It was an expressed concern of service users that such a research strategy would be underpinned by a social and human rights model of mental health and would promote the fundamental principles of participation and empowerment of people with experience of mental health difficulties and carers. It should use existing good practice guidance such as the NDA's *Guidelines for the Inclusion of People with Disabilities in Research* and the NDA's *Ethics in Disability Research*[213,214].

The strategy should adopt an emancipatory research approach to mental health research in Ireland, i.e. it should involve people with experience of mental health difficulties at every stage of the research process, including the development of research agendas, commissioning, overseeing, conducting and evaluating research as well as supporting the use of the emerging evidence base in policy and practice.

RECOMMENDATION 19.12: People with experience of mental health difficulties should be involved at every stage of the research process including the development of research agendas, commissioning, overseeing, conducting and evaluating research as well as supporting the use of the emerging evidence base in policy and practice.

19.10.3 TRAINING AND EDUCATION

The culture of the mental health services is not very supportive to mental health services research or to the collection of information. These activities need to be part of the everyday pattern in the mental health services. The benefits of data collection and research conducted also need to be made more immediately visible. The education and training of all those involved in the delivery of mental health services should ensure that the importance and benefits of information and research are conveyed and reinforced on an ongoing basis. This will require support from employers in terms of time for training and time to carry out research.

RECOMMENDATION 19.13: Mental health research should be part of the training of all mental health professionals and mental health services should be structured to support the ongoing development of these skills.

19.11 RECOMMENDATIONS

1. Service users and carers should have ready access to a wide variety of information. This information should be general (e.g. on mental health services in their area) and individualised (e.g. information on their medication).

2. The HIQA should put mechanisms in place to carry out systematic evaluations on all forms of interventions in mental health and this information should be widely disseminated.

3. Measures should be put in place to collect data on community-based mental health services.

4. In accordance with the recommendation in the National Health Information Strategy, an electronic patient record (EPR) should be introduced with a unique identifier for every individual in the state.

5. A national mental health minimum data set should be prepared, in consultation with relevant stakeholders.

6. Mental health services should implement mental health information systems locally that can provide the national minimum mental health data set to a central mental health information system.

7. A national morbidity survey should be carried out to determine the prevalence of mental health problems in the population.

8. Research should focus on mental health services – outcomes, policy and service, and economics – creating an evidence base for mental health care.

9. The recommendations of the Health Research Strategy should be fully implemented as the first step in creating a health research infrastructure in the health services.

10. A national mental health services research strategy should be prepared.

11. Dedicated funding should be provided by the Government for mental health service research.

12. People with experience of mental health difficulties should be involved at every stage of the research process including the development of research agendas, commissioning, overseeing, conducting and evaluating research as well as supporting the use of the emerging evidence base in policy and practice.

13. Mental health research should be part of the training of all mental health professionals and mental health services should be structured to support the ongoing development of these skills.

CHAPTER TWENTY

Transition and transformation: Making it happen

20.1 INTRODUCTION

This document has described a vision for changing how we think about mental health and how we can work effectively to bring greater mental health to every corner of our society. But producing a policy document is only one step in the process of achieving change in the mental health services. To make the proposed vision a reality, to produce real benefits for individuals, families and service providers, the recommendations of this policy must be implemented. This will involve a challenging process of transition and transformation which will depend on willingness to change and the cooperation of all those involved in the mental health system.

Change

20.2 FUNDING

If this policy is adopted by government, a funding programme over the next seven to ten years will need to be put in place to support its implementation. It will be the responsibility of the HSE to ensure that the recommendations outlined in this document become a reality. It is crucial to the effective implementation of the 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. The interdependence of the key recommendations in this policy is such that a failure to implement all of these recommendations in appropriate sequence, will result in a less then effective mental health system.

RECOMMENDATION 20.1: It will be the responsibility of the HSE to ensure the implementation of this mental health policy. The key recommendations of the policy must be seen as inter-related and interdependent and should be implemented as a complete plan.

To ensure the implementation of these recommendations, considerable additional investment in the mental health services will be required. There has been much public comment in recent times about the fact that the overall share of the health budget allocated to mental health services has declined from 12% to 7% in the last twenty years. It is recommended that there be a commitment to progressively increase over the next seven to ten years

the proportion of funding given to mental health services. If the recommendations of this policy are implemented, this will increase the percentage total health fund spend on mental health to 8.24%.

The Expert Group also believes that the value of the very considerable land banks and other assets associated with the mental hospitals needs to be harnessed to enable the capital investment required by this policy to take place. This could be achieved in the short term by means of exchequer loans, equivalent to the value of the lands in question, being extended to the HSE and National Mental Health Service Directorate to build community mental health facilities. The loans would then be repaid when the hospitals were sold. It is recommended that the potential for this type of arrangement be explored as a matter of priority by the Department of Health and Children and the Directorate when the latter is established.

20.3 CHANGE PROCESS

It must be acknowledged that the new mental health system described in this policy involves significant change on the part of everybody involved in providing, managing, planning and funding mental health activities in the broadest sense, and mental health services in particular. It will be necessary to engage all stakeholders in this vision and motivate and incentivise those involved to ensure that both the spirit and the substance of this policy are implemented. Change is also required on the part of service users and carers, as a role of much greater involvement and responsibility is envisaged for these groups.

The change process should be characterised by support, sensitivity and listening. All stakeholders should be actively engaged in this process, which is as much about changing hearts and minds as it is about changing mental health service structures. It should be a function of the National Mental Health Service Directorate, in conjunction with the HSE, to put in place advisory, facilitatory and support capacity to assist the change process and ensure the complete implementation of this policy.

RECOMMENDATION 20.2: The National Mental Health Service Directorate, in conjunction with the HSE, should put in place advisory, facilitatory and support capacity to assist the change process.

Action is required immediately on adoption of this policy by government, and the first steps that might be taken are outlined below.

20.4 FIRST STEPS

A series of changes need to occur in parallel to ensure the effective implementation of this policy. The management and reorganisation changes need to occur in parallel with the closure of mental hospitals, which needs to occur in parallel with the provision of funding. These steps are described here.

20.4.1 MANAGEMENT AND ORGANISATION

The first step that should be taken is the reorganisation and restructuring of mental health services. This should involve:

- the appointment of the National Mental Health Service Directorate
- the reorganisation of Mental Health Catchment Areas into the larger catchments proposed in this policy
- the appointment of local Catchment Area Management Teams in these catchment areas.

These steps are largely resource-neutral and should be implemented immediately on adoption of this policy. Both the National Directorate and the local Catchment Area Management Teams would then lead the implementation of this policy.

20.4.2 THE FORMATION OF MENTAL HEALTH CATCHMENT AREAS

The new catchment areas proposed in this document will require planning and implementation at the local and HSE level. Each Mental Health Catchment Area should contain within it the full range of mental health services, with the exception of services that require provision on a regional or national basis. There should be flexibility regarding catchment area size and composition, taking factors such as population structure, distribution, and deprivation into account and also considering the location of facilities such as acute in-patient units. The formation of Mental Health Catchment areas has been described in detail in Chapters Eight and Sixteen.

20.4.3 HUMAN RESOURCES

One of the first actions of the local Catchment Area Management Teams should be to identify local leaders to drive the change process. It will also be necessary to identify the human resources and skills available to the catchment area mental health services to begin the process of re-orienting the delivery of mental health services into the community.

20.4.4 TRAINING AND SUPPORT FOR CHANGE

One of the major tasks from the very beginning of this process will be the provision of training in new skills for many of those currently involved in delivering mental health services. This will require careful planning and phased resourcing, and should be led by the National Mental Health Service Directorate. A 'Future Skills Group' might be useful to provide direction on this.

Appropriate training and education should also be provided for service users and carers, to equip them with the skills necessary to have a greater role in mental health services planning and delivery, and also to assist them in their changing role in this new model of mental health services.

20.4.5 OTHER RESOURCES

There are also other resources available to the mental health services, namely the buildings and facilities from which mental health services are currently provided. These assets will need to be audited in terms of capacity, location, services provided and staff associated with them so that the entire service within the larger Mental Health Catchment Area can be reorganised along the lines envisioned in this policy.

RECOMMENDATION 20.3: The first steps that should be taken to implement this policy include the management and organisational changes recommended in Chapter Sixteen and the provision of training and resources for change.

20.5 CLOSURE OF MENTAL HOSPITALS

Mental hospitals have been the mainstay of mental health services in Ireland for many years. However, the type of person-centred, recovery-oriented care recommended in this policy cannot be provided in institutions of this size or environment. For this reason, it is recommended that the process of closing mental hospitals, which was begun following the recommendations of *Planning for the Future*[75], be continued until all mental hospitals are closed.

In the process of auditing the physical resources available to mental health services, special attention should be given to the old mental hospitals that still exist in parts of the country. Many of the human resources required for the model of service provision detailed in this report are currently still attached to mental hospitals. In order to free up these resources and to provide community-based, multidisciplinary team-delivered mental health care for all, existing mental hospitals will be required to close.

This can be achieved through a four-stage process:

stage 1 – identification of measures required to enable admissions and transfers to mental hospitals to cease, and these measures to be put in place

stage 2 – no admissions or transfers to take place to mental hospitals and plans for the relocation of the existing patients to be drawn up

stage 3 – plans for the relocation of the existing patients to be implemented

stage 4 – closure or de-designation of hospitals.

The first stage should be put in place for each mental hospital as a matter of urgency. Closure should be on a phased basis with wards or sections of the hospital closed sequentially. This process will require funding for training and upskilling of staff, and for the CMHTs to be put in place. Liaison may also need to take place with local social and housing services to ensure appropriate continued placement of individuals who have been living in the community for some time and are under the care of the mental health services. In some areas there has been an expectation on the part of local housing and social services that when these people become older and need a higher level of nursing care they will be accommodated in the psychiatric hospital. This can no longer be the case.

RECOMMENDATION 20.4: Mental hospitals must be closed in order to free up resources to provide community-based, multidisciplinary team-delivered mental health care for all. A plan to achieve this should be put in place for each mental hospital.

20.6 MONITORING PROGRESS

It is recommended that an **independent monitoring group** be appointed by the Minister for Health and Children to oversee the implementation of this mental health policy. While other bodies are involved in the operation, management and inspection of mental health services, the sole function of this group will be to oversee the implementation of this mental health policy. This will help ensure a continuous focus on the implementation process. The Monitoring Group should have also a role in the annual assessment of the plans to close psychiatric hospitals.

This Monitoring Group should have an independent chairperson and 4–5 members, some of whom should be members of the Expert Group. The inclusion of members of the Expert Group will ensure continuity and clarity in this process. This Monitoring Group should be required to meet at least bi-annually and produce annual reports for the Minister for Health and Children, and these reports should be published. The implementation should be reviewed formally after seven years in the light of what has been implemented and the changing needs and priorities for service provision, and a final report issued. It is important that the Monitoring Group should engage with and listen to the stakeholder groups and support them throughout the change process. This independent Monitoring Group should be established as soon as this policy has been adopted by government.

RECOMMENDATION 20.5: An independent monitoring group should be appointed by the Minister for Health and Children to oversee the implementation of this mental health policy.

20.7 MAKING IT HAPPEN

The implementation of this policy will require substantial and significant change on the part of all those involved in mental health services. This degree of change is challenging to many and it is recognised that there will be a period of transition while services are reorganised and reoriented.

Change and transformation are intrinsic to positive mental health. To remain vital and creative in life requires that as human beings we continually adapt to the changing landscape of our experience. To retain their health and relevance, mental health services similarly need to grow and evolve. There is ample evidence of the willingness and capacity to embrace change within mental health services, as was demonstrated in the radical changes that were undertaken by many services to implement *Planning for the Future*[75]. The desire for a high-quality, modern mental health service as espoused in the

consultation process by so many service users and those providing mental health services, coupled with the skills, enthusiasm and motivation of all those involved will drive the successful implementation of this policy, aptly titled *A Vision for Change*.

20.8 RECOMMENDATIONS

1. It will be the responsibility of the HSE to ensure the implementation of this mental health policy. The key recommendations of the policy must be seen as inter-related and interdependent and should be implemented as a complete plan.

2. The National Mental Health Service Directorate, in conjunction with the HSE, should put in place advisory, facilitatory and support capacity to assist the change process.

3. The first steps that should be taken to implement this policy include the management and organisational changes recommended in Chapter Sixteen and the provision of training and resources for change.

4. Mental hospitals must be closed in order to free up resources to provide community-based, multidisciplinary team-delivered mental health care for all. A plan to achieve this should be put in place for each mental hospital.

5. An independent monitoring group should be appointed by the Minister for Health and Children to oversee the implementation of this mental health policy.

Acknowledgements

The Chair and the members of the Expert Group wish to extend sincere thanks to all those who were involved in preparing this policy document, including all those who made written submissions to the Expert Group, attended the consultation days, made presentations to the Group and worked on subgroups. These contributions have been invaluable to the development of this new mental health policy. The individuals, groups and organisations from whom submissions were received are listed in Appendix 1 and the members of the sub-groups are in Appendix 2.

Particular thanks to Dr. Fiona Keogh, Research Consultant, Ms. Marie Cuddy, secretary to the group and the secretariat in the Mental Health Section of the Department of Health and Children: Ms. Ailish Corr and Ms. Joan Byrne.

Appendic

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Appendix 1:

SUBMISSIONS TO THE EXPERT GROUP ON MENTAL HEALTH POLICY

Amnesty International (Irish Section)
Amnesty International/MHI/SI
Association for Psychoanalysis and Psychotherapy in Ireland
Association of Community Mental Health Nurses of Ireland (ACMHNI)
AWARE
Ballyfermot Mental Health Association
BODYWHYS
BSc Students Psychiatric Nurses (2002 intake), UCC
Child Psychiatry Services, Midland Health Board
Cluain Mhuire Service
College Lecturer in Psychiatric Nursing, UCC
Conference of Religious of Ireland (CORI)
Cooley Environmental & Health Group
Cork City Development Board
Crumlin and District Mental Health Association
Department of Health Promotion, National University of Ireland, Galway
Department of Justice, Equality & Law Reform
Department of Nursing and Health Sciences, Waterford Institute of Technology
Department of Psychiatry of Old Age, Northern Area Health Board, Dublin
Department of Psychology, Jonathan Swift Clinic, St. James's Hospital
Department of Strategy & Planning/Programme Manager's Office, Southern Health Board
Directors of Nursing – ERHA
Directors, Centre of Nurse Education –JCMH/Tallaght/St. Ita's
Disability Federation of Ireland
Dr. E. Keenan/Dr. B. Smyth, SWAHB Addiction Service
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East Coast Area Health Board
Eastern Regional Health Authority
ERHA- Occupational Therapy Submission
EVE – Eastern Vocational Enterprises
EVE – Eastern Vocational Enterprises – New Century House

Family Therapy Association of Ireland
Federation of Voluntary Bodies – Co, Monaghan
Fisherfolk Consulting – Social Services Consulting
GROW
H.Dip Psychiatric Nurses, University College Cork
HAIL – (Voluntary Housing Association)
Heads of Disciplines – OT, Social Work & Psychology Managers
Health Promotion Service, Midland Health Board
HPSI – Heads of Psychology Services Ireland, Brothers of Charity Service, Limerick
IMPERO
Irish Association for Counselling and Psychotherapy
Irish Association of Consultants in Psychiatry of Old Age
Irish Association of Creative Arts Therapists
Irish Council for Psychotherapy
Irish Nutrition and Dietetic Institute
Irish Prison Service, Dublin
Irish Psychiatric Association
Irish Psychiatric Training Committee
Irish Translators' and Interpreters' Association
Living Life Voluntary Counselling Centre Ltd
Lucena Clinic Child and Adolescent Mental Health Services
Mental Health Association- Bray/Wicklow
Mental Health Commission
Mental Health Ireland
Mental Health Managers Group
Mental Health Nurse Advisory Forum
Mental Health Nurse Managers Ireland
Mental Health Review Group – South Eastern Health Board
Mental Health Service User Research, Training and Policy Consultant
Mental Health Services for Older People, Limerick
Midland Health Board
Midland Health Board Consultant Psychiatrists
Mr. K. Crowe, R.I.P.
Mr. A. Leonard, Dublin
Mr. D. McMahon, Co. Dublin
Mr. D. Milner, Dublin
Mr. G. White, Co. Cork
Mr. G. Ryan, Dublin
Mr. Hugh Ryan MPSI, O'Briens Pharmacy, Co. Tipperary
Mr. J. Killilea, Dublin
Mr. M. Lennon, Limerick

Mr. M. McGing, Mayo Mental Health Services
Mr. Martin McMahon, North Eastern Health Board
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Mr. S. Madigan, Tús Nua, Ballymun
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Mr. T. Hayes, Co. Waterford
Mrs. I. Cassidy, Dublin
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STEER Mental Health
The Alzheimer Society of Ireland
The Department of Systemic Psychotherapy- Carlow/Kilkenny Adult Mental Service
The Drug Treatment Centre Board, Dublin
The Federation of Irish Complementary Therapy Associations (FICTA)
The Hospital Pharmacists Association, Ireland
The Institute of Public Health in Ireland
The Irish College of Psychiatrists – Child & Adolescent Psychiatry Section
The Irish College of Psychiatrists – Faculty of Adult Psychiatry
The Irish College of Psychiatrists – Forensic Psychiatry Section
The Irish College of Psychiatrists – Learning Disability Section
The Irish College of Psychiatrists - Psychotherapy Services
The Irish College of Psychiatrists – Section for the Psychiatry of Old Age
The Irish College of Psychiatrists – Substance Misuse Section
The Irish National Council of ADHD support Groups (INCADDS)
The National Forensic Mental Health Service (CMH)
The National Group of Health Promotion Managers & Mental Health Promotion and Suicide Prevention NAHB
The Psychiatric Nurses' Association of Ireland
The Psychological Society of Ireland
The Women's Health Council
Transgender Equity Network (Gender Identity Disorder)
TRUST
West Galway Mental Health Service
Western Society for Autism
Women's Aid

Appendix 2

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Annexes to the Report

INTRODUCTION

These annexes contain additional material from various chapters in the report. A decision was made to put material such as detailed figures and further discussion of complex issues that would detract from the flow of the main report into an annex, rather than discard valuable information. The annexes also contain some illustrative examples of practice from around the country. The numbering of the annexes associates them with the chapters, so material relevant to Chapter One is in Annex 1, and so on.

Annex 1: The consultation process

A1.1 THE VALUES TO ACTION PROGRAMME

The values inherent in the principle 'respect for persons' are communicated in and through relationships and in the way one treats people. The following is an example of how values can be brought into the everyday delivery of care, to the benefit of service users and those providing the service.

Self-image is often a function of how one is valued by others. The service providers in this example were aware that many of the individuals using their mental health services were dependent on the staff to develop their sense of self-worth and value, as these were the people they had most contact with. A staff awareness and training programme called *Values to Action* was implemented, to facilitate the transmission of these values to service users.

Values to Action was concerned with the principle of normalisation and how values inherent in that principle could be generalised in the service user's experience. This principle is concerned with minimising difference, enabling people to do more, not less, with their lives and with facilitating a more socially valued and culturally valued role for these individuals in the community.

The principle of normalisation was operationalised using a number of valued life experiences (dignity, choice, relationships, independence, contribution and participation) which are valued by all individuals and by society. The approach taken examined the extent to which these values were available in the service user's experience and in the process called attention to two aspects of a mental health service:

- what the service does (activities, physical settings etc.)
- what the service actually achieves for those who use it.

Values to Action was concerned not just with learning, but with opening minds and changing attitudes. The approach engaged staff and service users in a collaborative and respectful way. Staff felt their role was being enriched by this experience, and the positive impact of this approach was also evident in the service user's experience, as illustrated by many comments, for example:

> 'I never thought that I would be treated with such respect and that I would ever regain my own self-respect after all these years as a psychiatric patient.'

A1.2 HUMAN RIGHTS AND MENTAL HEALTH

Human rights treaties recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. At the core of Ireland's human rights treaty commitments is a range of principles that underpin the fulfilment of all civil and political, social and economic rights of mental health service users[215,216,217,218]. The right to dignity is the 'anchor norm' of human rights and places the individual at the centre stage. All mental health policies and strategies should promote the following overarching human rights principles that apply also to service user's and carers:

- the right to equality and non-discrimination
- the right to privacy and autonomy

- the right to physical and mental integrity
- the right to participation
- the right to reciprocity
- the right to information
- the right to the least restrictive alternative
- the right to freedom of association
- the right to proportionality in all restrictions imposed on rights.

But there are other international human rights that relate to these overarching principles such as:

- the right to freedom from inhumane and degrading treatment
- the right to respect for family life
- the right to education
- the right to procedural safeguards and accountability mechanisms.

International human rights standards explain that the right to health requires the adequate provision of quality health and related services. The right to health should be understood as 'a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.'[219]

Human rights in the field of economic and social rights are essential to day-to-day quality of life and embrace rights already mentioned. The provision of good-quality mental health care services is essential to the creation of an environment of equality and participation in society. It is also the most powerful and effective means of reducing stigma and isolation.

Everyone with a mental illness should have the right to live and work in their own community as far as possible. Where in-patient facilities are needed, people should have the right to appropriate treatment near home and to return to the community as quickly as possible.

The right to treatment should be suited to the person's own cultural background, age and needs and include training of personnel for this purpose. The recognition of the role of carers and their needs must be given appropriate consideration and respect.

Children and adolescents are entitled to mental health care that embraces all of the relevant human rights principles in order that they can achieve full social integration and personal development.

Children should enjoy conditions that ensure dignity, and promote self reliance. They need specific safeguards and should not be placed for mental health care in an inappropriate environment with no benefit to them. Their right to continue with their education in the mainstream while receiving mental health care must be ensured as far as possible.

The realisation of many of these human rights in mental health care requires that these principles should be embedded in legal and policy documents. Mental health legislation is essential to underpin the right to respect for the dignity of individuals and the protection of their human rights.

Annex 3: Partnership in care: Service users and carers

A3.1 QUALITY OF LIFE ISSUES IDENTIFIED BY SERVICE USERS AND CARERS

This section deals with specific issues that affect users and their families when engaging with mental health care services. They include matters that impact on the quality of life of the service user or of members of the service user's family.

From the perspective of mental health care service providers, some of these issues may not be seen to be very important and sometimes they may be overlooked in the attempt to provide a comprehensive service.

Issues of medication

The prescribing of medication is a dominant feature of Irish mental health care services. The vast majority of people who receive mental health care either at primary level or at secondary specialist level will at some point receive a prescription for medication. The ideal mental health service model should be one where there is a balanced range of options provided that includes medical, psychological and social interventions. The range of specific interventions will vary from individual to individual but all three interventions should have equal importance in the lives of service users. Specifically the following issues arise:

- **Use of polypharmacy:** Research carried out in 2002 indicates that over 65% of respondents were on two or more medications, over 30% were on three or more and that 13% were on four or more medications for mental health problems[220]. The inappropriate use of multiple psychotropic drugs is an issue of concern to many, not just service users but others such as the Inspector of Mental Health Services[79]. There can be serious problems associated with polypharmacy, these include confusion between therapeutic efficacy and side effects. Polypharmacy also heightens the risk of a drug interaction developing.

- **Side effects:** Many medications have unwanted side effects and each has its own side-effect profile. Side effects may vary and some are potentially more harmful than others. Typical anti-psychotics can cause severe side effects. These include extra pyramidal side effects, typified by movement dysfunction. Other drugs, including atypical psychotics, mood stabilisers and anti-depressants may cause a range of side effects including sexual dysfunction, excessive weight gain and sedation.

Attendance at clinical reviews

Many mental health care service users report that they attend clinical reviews on either a three-monthly or six-monthly basis. In some cases, they may meet a different doctor for the first time at each of these appointments. This means that they often have to explain or repeat information about their condition to a new person. This gives rise to issues and problems in terms of continuity of care relationships and a perception that individuals are not receiving individualised care. It is most disconcerting and gives rise to a poor quality service.

This problem arises primarily because junior hospital doctors, senior house officers (SHOs) undergo a rotation system during their psychiatric training. In addition, there are often situations where non-national doctors are in rotation and this may give rise to communication

problems, due to language and cultural differences. This is an issue that needs to be addressed in terms of medical education and manpower. The appropriateness of these reviews is also questioned. It may be more appropriate for regular reviews to be carried out by the other members of the CMHT.

Physical environment

Some people who have been residents or users of residential units, day activity centres, day hospitals and acute units report that the physical environment leaves much to be desired. Many mental health service premises are inadequate in terms of space and design, are badly maintained and can present a stigmatising and negative image. Such an environment is not conducive to either treatment or recovery. The Inspector of Mental Hospitals has highlighted the lack of appropriate physical environment on many occasions[221] and this is an issue that needs to be addressed urgently within the mental health services.

Discharge planning

Some mental health services have poor discharge planning[221]. The perception from the service user or family point of view is that little effort is being put into proper planning for discharge prior to the event and that users and carers do not have a central involvement in the development of any plans. Families often complain that the first sign that discharge is imminent is a phone call from the hospital or residential centre saying their family member will be discharged within the next 48 hours. Service users also often complain that in hindsight they feel discharge may have been premature and often cite this as the cause for relapse later. There is a general perception that discharge from hospital may be decided, not from the point of view of the interest of the patient, but from the need to create space for the admission of new individuals to a unit. Service users often complain that while they may have a reduction in symptoms at time of discharge they have not made a significant enough recovery at that point to be able to move to a lower level of support.

Segregated same sex units

There has been much anecdotal information provided about the problems of the two sexes sharing some mental health facilities. From the perspective of females this may result in an environment that is perceived to be aggressive and male-dominated. It is imperative that in units where the two sexes share facilities; that every attempt is made to provide a service that meets the individual needs of either sex.

Rehabilitation services

Few Irish mental health care services have provided appropriate services for individuals who have enduring mental illness and who need a range of rehabilitation supports. Traditionally people who have been considered to have an enduring mental illness have been relegated to long-stay wards, have been given places in group homes or hostels or have been assigned to sheltered employment or training centres. The policy towards these people has been one of maintenance, rather than one of assertive intervention to maximise recovery and independence. Many people live in unsatisfactory physical environments, whether in hospital or group homes and are often in 'permanent training' in sheltered employment, with little or no intellectual or physical stimulation.

Involuntary detention

There are a number of issues around the process of involuntary detention that give concern to both service users and family, specifically the involvement of gardaí. Many families report that where gardaí have been asked to intervene in the case of an involuntary detention, gardaí may often be uniformed and use marked police cars to escort their family members to mental health care services.

Privacy and personal possessions

Many service users and family members report that in residential services, i.e. in hospital, hostels or group homes, there is a lack of privacy and ability to maintain personal possessions due in part to the numbers and to the physical layout.

Respite beds and long-term beds

Some group homes, hostels and residential services have residential units with respite care beds. The provision of respite care beds can be very disturbing for people in long term placement. Respite beds may be used by people who are by definition going through a difficult crisis time and it may not be appropriate that they should share the same environment with those people who are not in crisis.

Physical health

It has long been acknowledged that the physical health and well-being of people with mental health problems is of lower quality than in the general population[222]. Specific problems that arise are obesity, smoking, diabetes, dental health and general body hygiene. In the person-centred new mental health service model it is proposed that specific attention be given to ensure that the service users' physical health is addressed in the same way as their mental health.

Annex 4: Belonging and participating: Social inclusion

A4.1 A FRAMEWORK FOR INTER-AGENCY ACTION

The *National Action Plan against Poverty and Social Exclusion* (NAPS/incl)[45] represents an important policy document in addressing social exclusion and describes a number of **institutional arrangements** that provide a useful framework for action in this area, particularly as responsibility for action in many of these areas is in departments other than the Department of Health and Children. These include:

- **Cabinet Committee on Social Inclusion, Drugs and Rural Development** – chaired by the Taoiseach, this committee brings a strategic focus to tackling problems of social exclusion, disadvantage and alienation. Its work therefore ranges across the responsibilities of a number of ministers. The committee receives regular updates on the implementation of the NAPS/incl.

- **Senior Officials Group on Social Inclusion** – chaired by the Department of the Taoiseach, the group includes senior officials from relevant government departments.

- **Social Inclusion Consultative Group** – co-chaired by the Department of the Taoiseach and the Department of Social and Family Affairs, this group comprises representatives of the relevant government departments, the social partners, and certain statutory agencies, e.g. the Combat Poverty Agency, the Equality Authority and the Economic and Social Research Institute. The group meets twice a year to offer advice and observations on the NAPS/incl. and related programmes.

- **Office for Social Inclusion** – based in the Department of Social and Family Affairs, the OSI has overall responsibility for coordinating the preparation and implementation of the NAPS/incl. and for the monitoring and evaluation of progress on meeting the objectives.

- **The Management Group of Assistant Secretaries** comprises senior officials from the relevant government departments and oversees the work of the Office for Social Inclusion.

- **Social Inclusion Units** – established in key government departments to coordinate their department's contribution to the NAPS/incl. and its implementation.

Inter-agency work is key to much of the action around mental health, both at the population level, in improving mental well-being, and also at the individual level, where the social needs of a service user in the area of housing and employment may need to be addressed. This well developed structure represents a key network to facilitate this type of cross-cutting work.

Annex 5: Fostering wellbeing: Mental health promotion

A5.1 MENTAL HEALTH PREVENTION AND PROMOTION

Box A5.1 Prevention and promotion

Mental health promotion involves any action to enhance the mental well-being of individuals, families, organisations or communities.

Primary prevention refers to interventions designed to prevent a disorder or problem occurring.

Prevention may be:
- **universal** – targeted to the whole population, e.g. pre-school day care
- **selective** – targeted to individuals or groups at increased risk, e.g. home visits for low income mothers
- **indicated** – targeted to individuals with early symptoms, e.g. cognitive therapy for children with behavioural problems.

Secondary prevention is concerned with reducing prevalence through early interventions and **tertiary prevention** with reducing disability resulting from a disorder.

Early interventions target individuals developing or experiencing a first episode of a mental health problem.

The distinction between prevention and promotion is not clear cut:
- some promotion programs, e.g. initiatives to promote employee participation, may reduce stress-related illness, and result in a range of broader outcomes such as increased job satisfaction and higher productivity
- interventions designed to prevent specific problems, e.g. post-natal depression, may also have a wide range of socio-economic benefits, extending well beyond the impact of the intervention on the mother.

World Mental Health Day initiatives to reduce negative media coverage of mental health issues have the same goals as tertiary prevention: to reduce the problems experienced by people with a diagnosis.

From Mrazek and Haggerty[223], Caplan[224].

A5.2 POLICY CONTEXT

The World Health Organisation has advocated the promotion of positive mental health as an integral part of improving overall health and well-being, and the World Health Reports 2001[10] and 2002[11] were devoted exclusively to the issues of mental health and health promotion.

The WHO estimates that in any given year 33.4 million people from the European Region suffer from major depression and that this carries an undefined economic and social burden for families, communities and countries[8].

Nationally, there has also been recognition of the importance of promoting positive mental health with the National Health Strategy *Quality and Fairness*[1] calling for the development of a new action programme for mental health including mental health promotion and stigma-reduction components.

One of the strategic aims of the National Health Promotion Strategy 2000–05[225] is to promote positive mental health and to contribute to a reduction in the percentage of the population experiencing poor mental health through identifying models of best practice and initiating research into the development of a national positive mental health strategy.

The Report of the National Task Force on Suicide[226] also makes several recommendations to promote positive mental health as the risk factors for suicide prevention are best addressed within a broader approach to mental and emotional health.

A5.3 IRISH DEVELOPMENTS IN MENTAL HEALTH PROMOTION

The strategic aim regarding mental health in the current National Health Promotion Strategy 2000–05[225] is:

'to promote positive mental health and to contribute to a reduction in the percentage of the population experiencing poor mental health.'

The objectives under this strategic aim are:

- to initiate research into models of best practice in mental health promotion
- to initiate research into the development of a positive mental health strategy
- to work in partnership to support the implementation of the recommendations of the Report of the National Task Force on Suicide[226].

A5.4 CORE PRINCIPLES OF MENTAL HEALTH PROMOTION

Health Promotion is defined in the WHO Ottawa Charter[65] as 'a process of enabling people to take control over, and to improve their health'. The Charter calls for health promotion action in five key areas:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personnel skills
- re-orienting health services.

Mental health promotion is concerned with enhancing positive mental health and quality of life at a population level. To be consistent with the approach set out in the Ottawa Charter, core principles of mental health promotion practice therefore must:

- focus on enhancement of wellbeing rather than illness
- identify the whole population as a target group
- focus on improving the social, physical and economic environments that determine the mental health of populations and individuals
- build on competencies and resources of individuals and communities
- involve health and social policy as well as medical services

To enhance the value and visibility of mental health, the WHO state that;

> National mental health policies should not be solely concerned with mental illness but recognise the broader issues affecting the mental health of all sectors of society…including the social integration of severely marginalised groups[11].

The key messages from WHO[65] on mental health state:

Key Messages from the World Health Organisation

- mental health is more than the absence of mental illness: it is vital to individuals, families and societies
- mental health is determined by biological, socio-economic and environmental factors
- mental health is linked to behaviour
- mental health can be enhanced by effective public health interventions
- collective action depends on shared values as much as the quality of scientific evidence
- a climate that respects and promotes basic civil, political, economic, social and cultural rights is fundamental to the promotion of mental health
- intersectoral linkage is the key for mental health promotion
- mental health is everybody's business

Annex 6: Mental health in Ireland: Where we are now

A6.1 THE RELIANCE ON INSTITUTIONAL CARE

The history of mental health services in Ireland has been well documented by several authors[70,71,72,73]. These accounts remind us that most people with mental illness have usually been cared for by their family and community. Ireland was perhaps unique in the protection that was offered to the mentally ill in pre-Christian and early Christian times by the Brehon laws. These provided a variety of protections for people with mental disorders, protecting them and their property from abuse and exploitation.

St. Patrick's Hospital, the first mental hospital in Ireland, received its charter in 1746 and opened to the first patients in 1757, and the first district lunatic asylum, the Richmond, was opened in 1815. The asylum-building programme continued in Ireland throughout the nineteenth century.

Throughout this period, the numbers of mentally ill in asylums increased dramatically. As each new asylum was built it quickly became filled and eventually overcrowded. In the 14-year period 1900 to 1914 the number of insane in care in the 32 counties increased from 21,169 patients to 25,180 *(64th Report of the Inspector of Lunatics in Ireland)*.

In his exploration of the asylum system, Scull[227] suggested an explanation for this inexorable rise in the 'mentally ill':

> Beyond the initial hard core of easily recognisable behavioural and/or mental disturbance, the boundary between the normal and the pathological was left extraordinarily vague and indeterminate … the range of behaviour it (insanity) could be stretched to encompass was almost infinite (p. 238).

Scull was describing what were in effect, very broad admission policies whereby the aged, infirm, unruly children, homeless individuals, those with physical illness and individuals with an intellectual disability could gain admission to an asylum. They became, in many cases homes for those who had 'nowhere else to go'. These broad admission policies were still in place quite recently in Ireland, at least into the middle of the twentieth century. In 1963, 41% of the 19,800 patients in mental hospitals had been resident there for 18 years or more. Eleven per cent had been there for over 28 years[228].

Ireland was, and to some extent still is, what Robins described as 'hospital prone'. In 1961, the rate of psychiatric beds per 1,000 population of 7.3 was believed to be among the highest in the world[74]. Robins' explanation for this is that for a 'considerable period of time' those in need of treatment or care for any disability in Ireland had little choice but to seek it within an institution. In contrast, the poor law provisions in Britain established a system of parochial charity which had a significant element of non-institutional care for the sick and infirm. This established a tradition which was maintained through various legislative changes and eventually led to the post-World War II 'welfare state'. This type of social care system was lacking in Ireland. In fact, there were few statutory provisions at all for social care in Ireland until the latter part of the twentieth century. The dispensary system established under poor law legislation in 1851 could only care for the acutely ill.

This lack of social care provision resulted in the workhouses and asylums of the nineteenth century becoming 'receptacles for a whole range of human infirmity and deprivation'[71]. Although there was considerable stigma attached to these institutions, they were for many the only place they had.

From a societal perspective, the institutions represented an economic way of dealing with a whole range of social problems. This resulted in a lack of social service infrastructure, the effects of which are still seen today.

Services for disturbed children have only been provided in the past few years; previously many such children would have been placed in mental hospitals. The Republic is still catching up in the provision of services for individuals with an intellectual disability; in the past these individuals were admitted to mental hospitals.

It was not a question of whether a mental hospital was the most suitable place for these individuals. Rather, faced with someone who had nowhere else to go because of a lack of social care provision, they more often than not ended up in an institution, usually a mental hospital. As Robins[71] has stated;

> the institution as a means of dealing with illness or infirmity in any form became a deeply rooted Irish practice which still leaves its influence despite the modern development of alternative methods of care. (p 203).

The institution was also an important part of the local economy, providing employment for many individuals from the hinterland. This economic importance of the local institution can be a significant barrier to the complete closure of these institutions, thus hindering the provision of alternative methods of care[71].

A further important consequence of the ready availability of beds and liberal admission procedures was the expectation created among individuals and families that admission could be gained at any time, for any 'mental health' problem, the definition of which, as described by Scull, could be very broad. Most of these institutions are still in use today and admissions to these psychiatric hospitals constituted over 50% of all psychiatric admissions in 2004.

These influences have shaped today's mental health services; an historically generous provision of institutional places with poorly defined admission policies; a lack of comprehensive social care services for children, adults with social problems, individuals with an intellectual disability and others; the importance of the institution to the local economy; and the expectation of individuals and families, in spite of stigma, that admission to institutions could be gained whenever it was felt to be necessary.

Annex 7: Mental health in primary care

A7.1 EXAMPLE OF AN EVIDENCE-BASED PSYCHO-SOCIAL INTERVENTION IN PRIMARY CARE

An example of this kind of intervention is problem-solving treatment. This has been shown to be useful for individuals with anxiety and minor emotional disorders[229] and for individuals with depression[230]. Other trials found that problem solving was as effective as anti-depressant medication in the treatment of major depression when provided by experienced GPs or practice nurses[231]. The thinking behind this approach is that emotional symptoms are often induced by problems in living. The process usually involves six sessions with a therapist (a member of the primary care team) and has a total contact time of less than four hours. This approach can be taught easily and quickly to a range of health professionals[231]. Box A7.1 gives an outline of the approach.

Box A7.1 Problem solving handout for primary care patients.
(Mynors-Wallis et al., 1995) [231]

Depression is very common. It is often induced by problems of living. Depressed people can learn ways of dealing with these problems. Using problem solving, they can learn to cope better and reduce their depressive symptoms.

Problem solving is a systematic, common sense way of sorting out problems and difficulties. If you learn how to do problem-solving, you can lessen your depressive symptoms without having to take pills. In problem solving, the therapist explains the details of the treatment and provides encouragement and support, but the ideas and plans come from you. Problem solving will be useful to you not only now, but also in the future if problems arise.

There are five important stages:

1. Write down a clear description of the *main problem*. What is the nature of the problem? When does the problem occur? Where does the problem occur? Try to break up complicated problems into several smaller problems and consider each separately.
2. Decide on your *goals*. Choose achievable and definite goals.
3. List as many *alternative solutions* as you can, before considering the pros and cons for each one.
4. Choose your *best* solution.
5. Set out clear steps to achieve the solution: specify exactly what you are going to do and when.

Problem solving concentrates on the here and now rather than mistakes in the past. You should focus on improving the future rather than regretting the past.

Problem solving may not solve all your difficulties, but it can help you to start dealing with your problems. As your symptoms improve you will feel more in control of the problems.

Table A7.1: Some models of providing mental health care in primary care

Model	Description	Purpose	Comment
1. Shifted outpatient clinics	CMHT moves its outpatient service to a primary care setting. Can include psychiatric outpatient, psychologist and CPN clinics.	To promote ease of access To reduce stigma To improve communication between CMHT and GP To transfer management of patient back to GP in longer term	Contact between CMHT and GP may be very limited – operating in parallel. Benefits may lie more in the informal contacts which evolve within primary care setting[232]
2. Mental health professionals as part of primary care team	Mental health professionals (e.g. counsellors, CPNs, psychologists) employed by the practice	To provide direct patient care To reduce stigma To provide on-site mental health referral point for GPs	This model is changing in the UK with a move towards equity of provision and access across primary care groups
3. Consultation model	CMHT acts in consultative capacity to GP, who presents cases for advice and support	To supplement and enhance GP skills in the detection and management of mental illness	The CMHT does not see the patient – treatment remains within primary care
4. Liaison-attachment model	CMHT develops close relationship with PHCT CMHT may have designated liaison worker per practice. This worker may screen cases	To train PHCT in assessment and management of people with mental health problems To enable PHCT staff to screen and refer more effectively to secondary care To promote effective communication and where appropriate, co-working	

Adapted from Gask & Croft[102], Gask et al.,[101]; Onyett and Peck[232]; SDCMHS[233]

Annex 10: Child and adolescent mental health services

A10.1 CHILDREN WITH AUTISM

Autism is now internationally recognised as a spectrum disorder which may present at different stages of development, with differing levels of severity, and differing levels of intelligence. It is increasingly recognised as a neuro-developmental disorder with considerable genetic contribution to its aetiology. It has a considerable amount of overlap with other conditions, such as learning disability, language disorder, dyspraxia, ADHD, obsessive compulsive disorder, and schizoid personality disorder.

Many children with the milder forms of 'autism' are labelled as suffering from Aspergers Syndrome, which is associated with many emotional, behavioural, social and communication difficulties and carries with it the risk of serious psycho-pathology in adulthood. The increasing recognition of autism as a spectrum of disorders has led to a significant increase in estimated prevalence levels.

The needs of children with autism are diverse and require significant inputs from the educational system, in addition to health care. Education provision varies from placement in special classes to mainstream education with special support, to special class provision for children with autistic spectrum disorders, to special school provision. A complete and comprehensive review of the educational needs of children with autism is beyond the scope of this review. Special education interventions that are evidenced-based should be available and provided to children with autism.

Autism is no longer considered to be primarily a mental disorder, so all children who have a diagnosis of autism do not require the ongoing care of a consultant child psychiatrist. The main needs of these children are in the area of language and communication programmes, social skills and self-care training programmes, specific education interventions, vocational advice and training, family support, access to respite care, support and education for siblings. These needs are similar to those attending learning disability services, where these models already exist.

Teams of professionals are required to provide these developmental interventions on an ongoing basis. The professionals required for this type of work are:

- speech and language therapists with expertise in pragmatic therapy
- occupational therapists
- clinical psychologists
- social workers with family counselling skills
- counselling nurses
- educational psychologists.

These teams already exist in many intellectual disability services and community care services. In some cases individual therapies are being offered in a uni-disciplinary fashion. Because of the multiple difficulties that these children have multidisciplinary coordination is essential.

Annex 11: General adult mental health services

A11.1 PSYCHOLOGICAL INTERVENTIONS

The term 'psychological therapies' is employed as an umbrella term, to encompass all the main, established approaches to helping individuals cope with personal or interpersonal difficulties[234]. A consistent theme in the consultation process with service users and providers was for greater access to psychological therapies – or 'talk' therapies. The popularity of these approaches and the evidence for their effectiveness has been growing in recent years[235, 236]. The emerging consensus is that they should be regarded as fundamental to basic mental health services, rather than viewed as merely options that are available in a very uneven way. Psychological therapies have been shown to be effective treatments for people with a range of mental health problems, including those with severe and enduring mental illness[234].

Although access to 'talk' therapies is often rated most highly by users in terms of improvements they want to see in the mental health services, there is very limited understanding among either service users or service providers of what this implies[237]. In developing services and in informing users of the range of options available to them, it is important to have an appreciation of the range of interventions that these therapies cover and some idea of what constitutes an effective, appropriate, intervention for people at different levels of crisis and recovery.

Effective psychotherapy and counselling offer a range of interventions – within the context of a safe, confidential respectful relationship with a therapist – that are designed to empower the service user to understand, transform and cope with those vulnerabilities and problems that give rise to their mental health difficulties.

Different forms of counselling and psychotherapy can be distinguished according to the focus, complexity and duration of the psychological intervention. Counselling is often the preferred term for a brief intervention with an individual who presents with a circumscribed difficulty, precipitated by some specific challenging event in their life, such as a career crisis, a sudden bereavement or a medical illness.

In practice, the terms 'counselling' and 'psychotherapy' are used inter-changeably. These different forms of counselling and psychotherapy are generally categorised in three groups, according to complexity and duration of the interventions they offer.

These distinct categories offer a way of understanding different levels of psychological intervention, but in practice many service users will require a combination of all three levels during the course of recovery:

Type A – Counselling, formal and informal, which can be part of every interpersonal engagement with the user. Every health care provider, and service users themselves, can become skilled to provide this category of psychological therapy.

Type B – Structured psychological therapies which are distinguished by their unique formulation of an individual's problems, or symptoms, and which are delivered by trained personnel, in a structured way. Accredited therapists, or those working under supervision, provide this category of psychological therapy.

Type C – Therapies that constitute specialist programmes, often delivered over an extended period of time, aimed at historical conflicts that continually aggravate the client's mental health problems. These conflicts may well arise from experiences of trauma, sexual abuse or long-standing personality disorders. This category of intervention is distinguished by the intensity and duration of its focus, and requires significant commitment and motivation on the part of the service user. This level of psychotherapeutic expertise requires high-level training, supervision and skill on the part of the practitioner.

A11.1.1 COST EFFECTIVENESS OF PSYCHOLOGICAL THERAPIES

Research on the cost benefits of psychological interventions is relatively recent but there is growing evidence that supports their cost-effectiveness[238, 239]. There is increasing evidence that psychological therapy is a good investment as significant savings are made through reduced costs to the health service – shown in shorter hospital stays, lower use of prescriptions and better outcomes – than treatments that do not include a psychological therapy component[240].

A review of the impact of counselling in primary care settings concluded that counselling intervention lead to indirect resource savings – shown by a reduction in referral to NHS outpatient services and fewer patient consultations with their GP in the year following counselling[241].

Psychological interventions can also be more cost effective than optimal drug treatment, for example, cognitive-behavioural treatment for depression has been estimated to cost approximately a third less than pharmacological treatment[242]. Whilst not the sole form of intervention, psychological therapy also contributes to cost savings when offered to patients with mental illness such as schizophrenia and bipolar affective disorder, by reducing hospitalisations, medical expenses and work disability[243]. This contrasts with the traditionally held view that psychotherapy is least effective for patients with the most serious psychiatric disorders.

A11.2 SOCIAL THERAPIES

Social therapies offer a number of pathways for individuals that promote capacity to fully engage in community life in line with their own aspirations and preferences.

Education/health literacy: The population with enduring mental illness have to date been marginalised in the educational system due to illness and hospitalisation throughout their lives. There is a need to ensure that individuals are facilitated to access and participate in the educational system commensurate with their ability and potential for new learning. Such educational initiatives must take place in mainstream settings and operate optimally where there is a partnership approach between health and educational services.

Leisure: There is evidence of a relationship between satisfaction with leisure and the absence of anxiety and depression, and that those involved in physical activity decrease their risk for depression. This finding has led to an increasing trend among doctors in the USA to prescribe exercise for people with depression and anxiety.

Employment: Traditional methods of offering individuals opportunities in sheltered workshops and day centres have provided care to people who have had very few options for gainful occupation, but they been largely unsuccessful in placing people in full employment. Vocational training courses often don't have the flexibility to meet the changing needs of service users[244]. A recent Cochrane review of randomised controlled trails in the area suggests the need to look at alternative methods. Thornicroft[245] argues that there is growing evidence to support the 'place and train model' where individuals are placed in real jobs first and offered support to help them succeed in their work. The Clubhouse model, a

service run by peers within the mental health system, has recently opened up additional options for community support for service users and should be utilised by the CMHT (see A11.3 below).

A11.3 CLUBHOUSE MODEL

A *clubhouse* is first and foremost a community of people. Much more than a simple employment or social service, the focus is on a community of people with mental health difficulties working together towards the common goal of recovery. As with all clubhouses, participants are known as 'members', as opposed to 'patients' or 'clients'. Members are unique individuals who possess valuable talents, strengths and abilities which when combined, assist in making the clubhouse come alive. This sense of membership, support and belonging are at the very heart of the clubhouse way of working.

Clubhouses originated in 1948, when former patients of a New York psychiatric hospital began to meet together informally, in response to the lack of mental health services available. It was organised to be a support system for people living with mental illness, rather than as a service or treatment programme. Today there are over 400 clubhouses worldwide who have modelled themselves on this premise and embraced the Clubhouse ethos.

E.V.E. Ltd has established four clubhouses, in Newbridge, Co. Kildare, and in Clondalkin, Blanchardstown and Coolock in Dublin. In February 2002, the Kildare clubhouse achieved International Centre for Clubhouse Development (ICCD) accreditation. All clubhouses have had both members and staff trained in the clubhouse model at a certified training base in the United States.

The daily activity of the clubhouse is organised around a structured system known as the work-ordered day. The work-ordered day mirrors normal business hours and focuses on activities required to run the clubhouse. While participation in the clubhouse is voluntary, each member is invited and encouraged to participate in the work of the clubhouse which includes administration duties, reception, catering, outreach, maintenance, employment and education programmes, orientation, recruitment of staff, and evaluating clubhouse effectiveness.

A11.4 DIFFICULT TO MANAGE BEHAVIOURS (DMB): CURRENT SERVICE PROVISION

There has been no survey of the prevalence of difficult to manage behaviour units in Irish mental health services. In the past, the matter was dealt with by keeping many wards in psychiatric hospitals locked, with many patients being needlessly confined.

Some wards were identified as 'refractory' and specially designated for the care of DMB. With the passage of time and more openness in psychiatric in-patient settings, the locked ward became the exception. In certain hospitals, however, locked wards continued to be used exclusively for DMB. In the absence of survey information, the unsatisfactory mechanism of determining the extent of the problem by assessing current locked provision and equating this with need has been adopted.

There are in addition a small number of locked wards remaining in psychiatric hospitals around the country. In some instances there are two such wards, one for each gender, but these are in the process of being amalgamated into one. Some locked wards accommodate intellectually disabled persons. Administratively and therapeutically these units generally function quite poorly.

Annex 13: Mental health services for older people

A13.1 PREVALENCE OF MENTAL HEALTH DISORDERS AMONG OLDER ADULTS IN IRELAND

In a sample of 1,232 persons aged over 65 years identified from GP lists in Dublin, 10.3% were categorised as being depressed[246]. These figures were corroborated in another Dublin study[247], and European studies have shown a figure of 12.3% of depression syndrome in older people[248].

A follow-up of the 1,232 persons three years later reported that only 10.4% were completely recovered; a further third of these older persons had mild depressive symptoms or other mental health problems[249].

Much depression in older people is covert, masquerading as physical complaint and therefore is unrecognised and untreated in primary care, in general hospitals and in other forms of institutional care such as nursing homes.

The importance of recognising and treating depression in the elderly is exemplified by the finding that 30 people aged over 65 died by suicide in Ireland in 2003[250]. These considerations call for greater educational inputs for general practitioners, hospital-based medical personnel and staff of nursing homes together with the provision of liaison consultation to these locations by specialist staff of MHSOP.

It is generally recognised that 5% of those over 65 suffer from some degree of dementia and that over age 80 this figure rises to 20%. The *Eurodem* study, embracing many European centres found a dementia prevalence of 6.4%[251].

The prevalence of dementia in residential and nursing homes is generally estimated at 60–75% while 31% of older people in acute hospital beds have cognitive impairment. In addition a significant proportion of those with dementia will suffer from behavioural or psychological disorders necessitating specialist intervention.

There is much still to be learned before service needs can be accurately assessed. For instance, in the absence of accurate outcome and survival data for various conditions, it is difficult to determine the extent of provision needed for continuing care. Similarly there are gaps in knowledge as to need in relation to acute provision because of lack of an accurate database.

Annex 14: Mental health services for people with intellectual disability

A14.1 LEGISLATIVE CONCERNS

The Mental Health Act, 2001[82] enshrines the general principle that the consent of a patient[1] is required for treatment. Sections 56-61 of the Act provide definitions and guidance on consent, treatment without consent, psychosurgery, electro-convulsive therapy (ECT) and consent where medication has been given for a continuous period of three months.

Consent

There is concern regarding the capacity of people with intellectual disabilities to give informed consent to treatment and the protection of their rights[146]. Under the Mental Health Act, 2001, consent in relation to a patient means consent obtained freely, without threats or inducements, where the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is *capable of understanding* the nature, purpose and likely effects of the proposed treatment **and** the consultant psychiatrist has given the patient *adequate information* in a form and language that the *patient can understand*, on the nature, purpose and likely effects of the proposed treatments (Section 56).

On the provision of adequate information, factors for consideration include the capacity to comprehend and decide, risks involved, patient's wishes to be informed, the nature of the procedure and the effects of information on the patient. The assessment of decision-making capacity is a matter of clinical judgement guided by professional practice.

To demonstrate capacity the patient should be able to understand in simple language what the proposed treatment is, its purpose, and nature and why it is being proposed, **and** be able to understand the main benefits, risks and possible alternatives and the consequences of not receiving the proposed treatment. The patient should also be able to retain the information for a sufficient period of time in order to consider it and arrive at a decision, and be able to communicate the decision. To fulfil the concept of voluntarism, there should be an authentic choice in the absence of coercion and the patient's decision should be made freely.

Consent on the grounds of incapacity may never be dispensed with in relation to the performance of psychosurgery (S. 58), ECT (S. 59) or the administration of medicine for a mental disorder (S. 60 & 61). Specific rules are laid down in the Mental Health Act, 2001. For example, where it is proposed to administer medicine to a patient* for the purpose of ameliorating their mental condition, after a continuous period of 3 months the patient must consent in writing. If a patient is unwilling or unable to give consent, the medication may only be given where the consultant psychiatrist approves the administration and refers the matter to a second consultant psychiatrist who authorises it. They must complete a form stating that they have examined the patient and are of the opinion that the patient would benefit from the continued administration of the medicine and give reasons for their opinions. This is valid for three months.

1 *In the Mental Health Act, 2001, the term 'patient' is used to describe someone who is involuntarily admitted. Patient does not therefore refer to all individuals in an approved centre.*

* *This refers to a 'patient' under the Mental Health Act, 2001.*

Annex 15: Special categories of service provision

ANNEX 15.1.1 THE CENTRAL MENTAL HOSPITAL (CMH) DUNDRUM

The CMH was legislated for by an Act of 1845, built shortly thereafter and received its first patient in 1850. With the exception of a small separate single-storey block erected some 20 years ago it remains essentially unchanged since it was built.

At present it accommodates approximately 80 patients, of whom on average five or six are female. Patients comprise three main groups, long-stay persons from the courts or prisons who, have been adjudged under existing legislation to be either 'unfit to plead' or 'guilty but insane', persons transferred from the prisons under hospital or treatment orders for treatment for mental illness and who are mainly of short-stay duration in the hospital and, finally, patients transferred from mental health units or hospitals under the provisions of sections 207 or 208 of the Mental Treatment Act, 1945.

The number of prisoners transferred to the CMH during 2004 was about 130, but, it is believed, this should have been 300, the actual number requiring treatment in the hospital, so that almost 200 were denied transfer because of lack of capacity. However a service level agreement was concluded recently between the former East Coast Area Health Board (which had responsibility for CMH) and the Department of Justice, Equality and Law Reform (which has responsibility for the prison service) to increase bed and staff capacity in the CMH and this will go some way to improving this situation and result in the rapid transfer of seriously ill prisoners to the CMH. The hospital itself, physically quite unsuited to modern therapeutic purpose, is due be replaced or rebuilt in a radical programme of reform.

There are perceived to be a number of misuses of current capacity in the CMH. First, a number of long-stay, older patients are resident for whom the security provided in the CMH is unnecessary and who should be, clinically and as a matter of civil right, repatriated to local mental health services. The constraining factor in this matter is the unwillingness of local services to accept them. This should be overcome.

Secondly, there has been historically a tendency to transfer persons from the prisons to the CMH unselectively without regard to need and priority. This issue is now being attended to.

Thirdly, many mentally ill persons who commit minor offences are charged, convicted, sentenced, imprisoned and, being mentally ill, transferred to the CMH when, if rapprochement between the gardaí and local services were better than it is, the person could be diverted to local services without taking up capacity in the CMH.

Fourthly, patients from generic in-patient services are transferred to the CMH under the provision of Section 208 of the Mental Treatment Act, 1945[80] because of perceived 'unmanageability' in their own services. In part this arises because of the absence of safe acute observation areas in in-patient units and lack of intensive care rehabilitation units. Some people transferred in this way have become long-stay in the CMH.

Finally, as with prisoners in need of hospital treatment for physical illness, suitable prisoners with mental illness could be granted temporary release from prison to receive treatment in their local in-patient mental health unit, instead of being transferred to the CMH.

ANNEX 15.1.2 THE GARDAÍ AND MENTAL ILLNESS

The gardaí are primary community agents. They are in constant contact with, and working with, the community. They encounter community mental illness almost on a daily basis, yet they have no formal training in how to recognise it or how to deal with it when it has been encountered. Despite this, they have statutory powers to take mentally ill persons into custody (Section 12 of the Mental Health Act, 2001[82]) and deal with them as deemed appropriate. A further piece of legislation which, when it becomes law, will have a bearing on the matter is the Garda Síochána Bill, 2004, the general provisions of which will make it possible to give emphasis and direction to mental health issues as they arise in day-to-day policing.

As matters stand, the majority of mentally ill persons who encounter gardaí are charged with minor offences and pose no security threat. They are needlessly processed by the criminal law, up to being charged, court appearance and prison committal and, in some instances, transfer to the Central Mental Hospital when the preferred and better option would be to divert them immediately to their local mental health services where they could effectively be dealt with, for the most part, in community-based settings.

This procedure requires, following the taking into custody of a mentally ill person by a garda under Section 12, examination by a Garda doctor and effective communication with local services, based on established relationships between the Garda doctor and the local mental health personnel.

A15.2 MENTAL HEALTH SERVICES FOR PEOPLE WHO ARE HOMELESS

Most of the information relating to the extent of homelessness in Ireland comes from studies carried out in the Dublin area, which has the highest concentration of homeless persons. Homeless persons as defined by the 1988 Homeless Act are to be found in a number of locations. These include people in hostel accommodation dedicated to the homeless, which constitute the largest group; people in refuges, people in bed and breakfast facilities, people living with relatives and friends, people in crisis accommodation, people in long-term institutional care and people sleeping rough.

It should be borne in mind that for many people in long-term hostel or institutional care (e.g. in psychiatric hospitals), this accommodation has de facto become their home.

A15.2.1 THE CAUSES AND CONSEQUENCES OF HOMELESSNESS

People are 'at risk' of homelessness when they have lost security of tenure in any residential setting. Socially embarrassing or disruptive behaviour exhibited by a mentally ill person may lead to eviction. Long periods of hospitalisation for treatment of mental illness may also compromise tenancy arrangements. Those discharged from mental health care and who lack resources and community ties are particularly vulnerable to homelessness.

Gaps in statutory service provision for people with mental illness, increase the risk of homelessness for some. Inflexible regimes and intolerance of certain behaviours, in some residential services, make it difficult for some mentally ill persons to live there, particularly younger people. While the 1988 Act is generally seen as a major step forward in improving homeless people's access to housing, it has been criticised by organisations working with the homeless for not going far enough in obliging local authorities to house the homeless.

Homeless people are exposed to the same risk factors for physical illness as the general population but at higher levels, as well as to additional risk factors unique to homelessness. The homeless are an example of a disadvantaged group whose health is profoundly affected by their homelessness and by the factors that caused them to become homeless in the first place[161].

The living conditions of homeless people; either on the street or in hostels, exposes them to many additional health risk factors including trauma, inclement weather (causing sunburn, frostbite, dehydration, and hypothermia), violence, overcrowding and inadequate hygiene. Malnutrition is common among homeless people and may result from limited access to food, poor quality food, alcoholism, drug misuse or mental illness.

Action to avoid and reduce health risks amongst homeless populations is made more difficult by the poor quality and transient nature of the settings. Access to health care for homeless people is further hindered by both the nature of health services and the nature of homelessness.

As far as the health service is concerned, the first difficulty is that the appropriate service may not be readily geographically available. But more important may be the financial impediment to obtaining the service, absence of a medical card, lack of transport to the service or of means of paying transport costs.

The manner in which access to care is organised may itself be a powerful deterrent; making and keeping appointments may be beyond the capacity of some homeless people. Additionally health service staff attitudes to the homeless may constitute (and may be intended to be) a powerful disincentive to initiating and continuing care. Missing appointments, non-compliance with treatment regimes, physical co-morbidity and substance misuse frequently encountered in this group may make the homeless individual an unattractive service user to some service providers.

It should also be remembered that other perceived priorities may interfere with attendance at health service appointments such as attempting to find accommodation, the need to procure substances that are being misused and so on.

Barriers of access to health care mean that homeless people often present late or not at all for health service. The disorganisation and chaotic lifestyle of homeless people militates against adherence and compliance with health care treatments. Gate-keeping mechanisms designed to ration care may lead homeless people to further avoid seeking hospital care in the early stages of illness if the care-seeking process becomes more arduous or time consuming.

A15.2.2 PATIENTS LEAVING HOSPITAL AND MENTAL HEALTH CARE

In the specific area of preventing homelessness in the mentally ill it is important that people discharged from in-patient care should have a care programme agreed by the multidisciplinary team, a key worker and a detailed follow up plan. In addition there should be a check to ensure that the patient is registered on the housing or homeless list and that whoever is following them up checks to ensure that they remain on this list. Central to all, of course, is the necessity of providing residential accommodation. While mental health services provide over 3,000 community residential places for mentally ill persons, local authorities have been singularly remiss in accepting responsibility for housing mentally ill persons.

A checklist of best practice in risk assessment and prevention of homelessness in discharged patients should include:

- a documented discharge plan
- a check that the patient's housing conditions are satisfactory and that the next of kin is aware of the patient's pending discharge
- a link with the homeless service to obtain suitable accommodation
- a check to ensure patient has a current medical card
- a mutually agreed care plan and key worker.

Above all discharged service users should remain the responsibility of the service that treats them and, if against all the precautions, homelessness should ensue, they should return to receive care from their parent service. A care programme approach should be put in place for all

service users involving frequent service contact as a critical ingredient leading to positive compliance and adherence with treatment plan and better housing outcomes.

A15.2.4 EXISTING PROVISION FOR THE HOMELESS

A considerable number of agencies, statutory and voluntary, provide services of one sort or another for the homeless. It is estimated that they number over 100 in all. The range and diversity of services is wide: from hostels, bed and breakfast accommodation, emergency and crisis services, night shelters, womens' refuges, wet houses for persons with alcohol problems, and transitional housing to a long-stay unit for homeless mentally ill persons in St. Brendan's Hospital.

A directory of services dealing with homelessness is provided by the Homeless Agency. The Agency was established as part of the Government strategy on homelessness and is responsible for the management and coordination of services to people who are homeless in Dublin and for the continual improvement of those services. The agency operates a computer-based client recording system (Link) that allows organisations to input and monitor details of clients and the work done with them. Agencies in the field are using Link to improve service efficiency and to help exchange information to this end.

As far as specialised mental health services are concerned, two multidisciplinary teams are provided in the Dublin area. One serves the north inner city and is based in Usher's Island where a day service is provided. The same team also has responsibility at St. Brendan's Hospital for a long-established Programme for the Homeless that provides a 24-hour emergency service and a 16-place poor quality residential unit, mainly long-stay, for homeless people with mental health problems.

A day centre staffed by two nurses, one occupational therapist and one occupational therapy assistant provide care and therapy, seven days a week, for up to 125 service users at Usher's Island. Three hostels provide 37 places at medium and low support levels. The South-West Area Health Board established a psychiatric Service for Homeless People in its area based on a part-time consultant psychiatrist and team operating from a headquarters premises in the Homeless Agency facility. Finally, in Dún Laoghaire/Rathdown a limited out reach service has been put in place, operated by the Cluain Mhuire Family Service.

In Cork, there is a part time consultant and supporting team allocated to the hostels for the homeless in that city, and in Limerick and Galway the problem of mentally ill homeless people is catered for on a part-time sector basis without specialised inputs.

Elsewhere around the country, the local mental health services manage the homeless population within their existing resources. Because of data deficiencies it is not possible to even approximate the extent of activity of the Dublin-based services.

A15.5 EATING DISORDERS

A15.5.1 PREVALENCE OF EATING DISORDERS

A review of anorexia nervosa in Ireland from 1977–85, based on a psychiatric case register, reported a psychiatric first admission rate of 1.64/100,000 total population which was very similar to that of England and Wales and of Denmark; however when general hospital admission rates were included the Irish annual incidence rose to 4.18/100,000, in line with other international estimates[252].

Over 90 percent of the Irish admissions were females with the majority in the 15–24 age group. In addition, and also in line with international experience, the admission rate decreased over the period studied. However, this may be explained in part by an increase in treating anorexia nervosa in the community thus obviating hospital admission. Overall however, there is little sustainable evidence that anorexia nervosa is increasing but there is a perception that cases are presenting at younger ages – as early as 7 or 8 years.

In Ireland it has not been possible to derive deaths due to eating disorders from the Annual Reports on Vital Statistics, as these are not presented as a separate entity. However, given an incidence rate of 10 per 100,000 population or 400 new cases each year in Ireland, this represents 80 deaths annually. In addition to this 20 per cent mortality, it is estimated that 60 per cent of eating disorder patients recover while the remaining 20 per cent partially recover.

In 2003, there were 188 admissions to psychiatric units and hospitals with eating disorder diagnoses. Of those for whom a sub-category was recorded, 85 indicated an anorexia nervosa diagnosis and 40, one of bulimia nervosa. Of the 174 admissions, 82 were first admissions and 11 were to children's centres. Data from the Hospital In-patient Enquiry (HIPE) reporting from the majority of general hospitals revealed that 326 (anorexia nervosa 248; bulimia nervosa 78) discharges from general hospitals in 2002 were given either a first (84) or secondary (242) diagnosis of anorexia nervosa or bulimia nervosa. It is also highly likely that many hospital discharges with eating disorder conditions were given other diagnoses and that the accompanying co-morbid eating disorder diagnosis was not recorded. In addition, only the more serious, and often most advanced, cases come to the psychiatric services, with the majority of eating disorders presenting to general hospitals. Moreover, an unknown number of cases is likely to be in touch with voluntary agencies or a variety of private sources.

A15.5.2 COSTS OF EATING DISORDERS

The costs of eating disorders are personal, social and economic. Apart from the evident mortality, the relatively poor outcome – with only 20 percent completely recovered – and prolonged morbidity for many, there is the considerable family burden to be taken into account.

For the individual with an eating disorder, there is the disruption of education, vocational training, social isolation and loss of opportunity in so many spheres of human participation to be taken into account. The consequent economic loss both to the individual and family is evident.

A15.7 SUICIDE AND DELIBERATE SELF-HARM

A15.7.1 DELIBERATE SELF-HARM

The extent of self-harm behaviour, and its indication of a very high risk of later suicide make it a key area for concern in any suicide prevention policy. In excess of 10,000 cases of deliberate self-harm, some of which are the result of serious suicide attempts, present to Irish hospitals each year for assessment and treatment.

In 2003, the rate of deliberate self-harm for women was 241 per 100,000 and for men was 177 per 100,000[253]. Based on hospital-treated cases, deliberate self-harm rates are highest among the younger age groups, peaking for girls aged between 15 and 19 years and for young men aged between 20 and 24 years.

Drug overdose is more commonly used as a method of DSH by women (78%) than by men (64%). Self-cutting is significantly more often used as a method by men (23%) than by women (15%)[254]. This is in contrast with findings in most other countries, where self-cutting appears to be a method more typically used by women. Although alcohol as the primary method involved in DSH is rare, it is reportedly involved in nearly half of the male DSH episodes (47%) and in 39% of the female DSH episodes[254].

A substantial number of people are thought to harm themselves without coming to the attention of hospital services – perhaps in some cases being treated by a GP, or not receiving any medical attention. Indeed, in a recent Irish survey of almost 4,000 young people aged 15–17 years, 480 disclosed they had engaged in deliberate self-harm, but only 11% of this group engaged services beforehand and 15% after an act[255].

A systematic review found that within one year of a self-harm presentation to A&E, on average, 16% repeat the behaviour and 1.8% die by suicide[256]. Deliberate self-harm individuals in Ireland have a similar rate of repetition[255,257] but their risk of suicide or death by other causes is not known and may remain unknown unless a satisfactory mechanism of linking National Parasuicide Registry data and Central Statistics Office mortality data is established.

Assessing the risk of repeated suicidal behaviour, as well as the broader psychosocial needs of deliberate self-harm individuals attending A&E departments, is therefore an important task. The need for all deliberate self-harm individuals attending A&E departments to be given a comprehensive assessment by a suitably trained health professional followed by appropriate referral and follow-up has been recognised both nationally[258] and internationally[259].

A15.7.2 GUIDELINES FOR RESPONDING TO SUICIDAL BEHAVIOUR IN SPECIFIC HEALTH CARE SETTINGS

This section outlines some basic guidelines for responding to individuals and carers who present in different settings with suicidal behaviour. It is important to bear in mind that whilst the proposed guidelines are based on the best available agreed practices, a review of the suicide prevention literature highlights one finding repeatedly, that the key to preventing suicide is personal engagement with the service user, and the psychological and social circumstances of their particular predicament[176]. All assessment instruments, protocols and positive practices fall short of their aims, in the absence of genuine personal communication and listening between the individual at risk and the person who is engaged in assessing their pain.

Service providers need to become aware of attitudes and assumptions they hold in relation to suicidal behaviour and how these impact on their encounters with vulnerable individuals. Fear of engagement with individuals expressing suicidal ideation may arise from negative prejudices that such suicidal behaviour is 'selfish', 'manipulative' or represent a professional threat to the practitioner. If these assumptions remain fixed and unexamined, the danger is that they will shape and inform professional encounters in subtle but destructive ways.

Primary care and community settings

Primary care settings offer the possibility of contact with individuals in the early stages of an emotional crisis where they are not yet at high risk of suicidal behaviour, but where problems could escalate to a point where they find themselves in a suicidal crisis. Engaging with such an individual can help them to understand difficulties that seem overwhelming and enable them to consider resources that could resolve their predicament. Natural community supports may be available, or specialist help may be required. But where problems are not intensely distressing, the interest and concern of an intelligent listener can mobilise resources within the individual themselves to confront the source of the complaints that have lead them to seek help.

However, it is also true that patients with acute suicidal feelings and thoughts do present to primary care practitioners – GPs, student health counsellors, welfare officers – and don't find it easy to engage in an open conversation about the seriousness of their distress.

In a psychological autopsy study in Finland, in which a primary health practitioner had been consulted prior to the suicide, the issue of suicide had only been discussed in 11% of cases[260]. In this study, 18% of those who had completed suicide had consulted a primary health practitioner on the day they died by suicide, but the issue was only discussed in 22% of cases. Subsequent studies have established that an increase in contact with GPs prior to suicidal behaviour, suggesting also that the reasons for contact with the GP were related to distress which was not articulated[261,262].

Fear of stigmatisation, shame and lack of experience with articulating emotional conflicts may contribute to the reticence many patients have in expressing their difficulties. From the point of view of the physician, it may be important to consider the meaning that may underlie vague non-specific somatic complaints. Research has consistently concluded that questions about suicide do not trigger suicidal behaviour, but it does appear that not asking may confine a patient to the very prison from which they are desperately seeking relief.

The fear of engaging in a direct conversation with someone who is expressing very intense emotional pain needs to be acknowledged. Not only for those at the front line of care in the community, but for even experienced mental health practitioners. Underlying an aversion to engaging around the issue of suicide may be a fixed very negative perception of the individual who is expressing suicidality. Bancroft[263] found a striking disagreement between service users' explanations and those of psychiatrists for the service user's overdoses.

The two reasons chosen most frequently by psychiatrists ('communicating hostility'; 'aiming to influence other people') were rarely chosen by the service users; on the other hand the two reasons most commonly chosen by service users 'to escape' and 'loss of control' were rarely chosen by psychiatrists. Training of all professionals likely to be engaged with people expressing suicidal behaviour needs to address assumptions and beliefs which are often carried unwittingly into the encounter.

A recent population based study reported that 96% of young men (sample aged between 18 and 34 years) believe that suicide is, 'at least sometimes', preventable[264]. Where suicidal ideation or any evidence of a likelihood of self-harm is identified, patients have rated as most important the sympathy and listening behaviour of the GP or nurse practitioner[265]. A visit from a community nurse for patients who did not attend follow-up appointments[266] and the use of a 'green card' with patients at risk were found to be helpful[181].

The 'green card' was an emergency card which indicated a professional who was available at all times. Should their condition become more unmanageable this could also be extended to indicate to patients and carers the services which they could access in their local community in the event of a emergency, e.g. suicide resource officer, A&E/crisis liaison service, local CMHTs. None of these act as a substitute for a consistent and trusting relationship with a health professional, or for a referral to specialist mental health services, but they increased the possibility of problems being identified and resolved before they escalated to a severe suicidal crisis or full blown depression.

The need for easy and effective access to a community mental health team is vital where there is evidence of high risk for suicide. GPs need to have a means of registering with the team their concern regarding the possibility of suicidal behaviour and the team needs to have a mechanism of responding quickly to these crises. Support and communication systems between primary care services and CMHTs are discussed elsewhere in this report (Chapters Seven, Nine and Sixteen).

Where referral or hospital admission is indicated, the primary care clinician needs to discuss this with the patient, their family or carers. Agreement should be sought with the patient as to how this will be accessed and also that any possible means to harming themselves be removed. Time may need to be taken to overcome the fear of stigmatisation that many patients may feel at the idea of referral to mental health services.

In most cases the wishes of the patient can be respected, particularly if they can agree to some alternative plan of action that is appropriate to their level of distress and need. If the patient flatly disagrees with accepting any kind of help and the judgement is that they are at a high risk of self-harm, involuntary admission may need to be considered and discussed openly with all concerned.

General hospital settings

Responding to the presentation of attempted suicide and the variety of behaviours that reflect a deliberate action to injure or harm oneself constitutes a significant part of the work in general hospital settings. Responding effectively encompasses treatment of physical emergencies, assessing seriousness of intent and continued risk, and negotiating a plan for referral and aftercare or hospital admission, where this is required.

Decisions about referral to specialist services are best made while the person is in hospital and access to a liaison mental health team, liaison nurse, or psychiatrist should be available, but it may also be important for the A&E staff to have basic training in engaging with patients and carrying out a basic assessment to inform their decision-making. Too often the severity of the injury that the patients have caused to themselves may be used as basis for making a referral or seeking consultation, whereas this may be a very unreliable basis for judging the seriousness of the situation. It is the intent of the patient rather than the objective danger of their self-harming behaviour that indicates the risk of suicide. The apparent physical danger of an overdose, for example, is a very unreliable measure of whether the patient wanted to die[267].

Mental health care settings (including acute in-patient care)

Clear procedures should be established for ensuring that people in serious crisis, who can be recognised as being at high risk, e.g. those with severe depression and psychosis, have easy access to services, appropriate care plans, and the necessary self-care skills and supports for living their lives outside the service. There is a wealth of information – highlighting risks of suicidal behaviour for every age group – that describes how services can best assist people through difficult times. There is no certainty that these strategies will prevent someone from making a choice to engage in suicidal behaviour, but for most people, their attitude towards suicide is intensely ambivalent, and the availability of someone who engages professionally and compassionately with them is enough to hold them while they work through a particular crisis.

Some of the highest estimates of risk relate to the first 1–12 months following discharge from an acute care setting, the highest risk being found among those most recently discharged. Reasons for this tendency to 'relapse' into suicidal behaviour include the following: their recovery may be incomplete and continuing care may be unavailable to them; the return of insight may produce a level of terror that they might ever again become so distressed; even a minor setback could trigger fear that this indeed could happen, and so they chose suicide to assuage future suffering, as much as to relieve them of current distress; discharge may confront people with problems that remain unresolved and which they are unprepared to deal with as they were when taken into acute care.

The implications for services is the duty of care to service users to provide continuity of care and some realistic 'survival plan' when they re-engage with predictable stresses in their life. Acute and community-based care needs careful integration so as to reduce risk of relapse and suicidal behaviour during the transition back to home life. Services need to monitor patients during these difficult transitions and be responsive to signs of distress and relapse, which may require additional supports be given on the short-term.

Members of teams who are responding to people in crisis may also require access and supervision to manage their own anxieties around caring for people who are at high risk.

Appleby[268] suggests that we should more accurately assess risk in terms of the balance between risk and protective factors in a person's life. According to his view individuals with many risk factors may not be at high risk if there are also protective factors working for them in their life. Similarly, a patient who appears to be stable may become a high risk when protective factors are removed, as may well be the case for many post-discharge suicides.

Annex 17: Investing in the future: Financing the mental health services

A17.1 ANALYSIS OF CURRENT MENTAL HEALTH FUNDING

Table A17.1 gives information on the secular trends in funding of mental health services in Ireland since the publication of the previous policy document *Planning for the Future*[75].

Table 17.1: Non-capital expenditure on mental health as a percentage of total health expenditure 1984 - 2004

Year	Total health Expenditure	Mental health expenditure	Mental health expenditure as % of total health expenditure
	€m	€m	
1984	1,413	184	13.0
1988	1,564	196	12.5
1989	1,318	158	11.9
1990	1,464	168	11.4
1991	1,631	183	10.3
1992	1,830	197	10.8
1993	2,016	209	10.4
1994	2,145	216	10.1
1995	2,299	228	9.9
1996	2,354	232	9.8
1997	3,443	326	9.5
1998	3,819	347	9.1
1999	4,573	393	8.6
2000	5,354	433	8.1
2001	6,739	497	7.4
2002	8,166	563	6.0
2003	9,087	619	6.82
2004	9,766	717	7.34

A17.2 STAFFING AND INFRASTRUCTURE REQUIREMENTS

Detail of the staffing requirements of all the teams and the infrastructure required is contained in the following tables.

TEAM/UNIT	Total Population per team or unit	Number of Teams Required	Team Co-Ordinator	Team Leader/Consultant	Practice Manager	Consultant	NCHD	Senior Nurse	Psychiatric Nurse	Occupational Therapist	Clinical Psychologist	Social Worker	Care Assistant	Team Secretary	Attendant	Cog Behaviour Therap	Family Therapist	Addiction Counsellor	Other Therapists	NOTES
General Adult CMHTs																				
General Adult Community Mental Health Team (CMHT)	50,000	78	78	78	78	78	78	156	468	195	156	156	195	156		117	78	78		
Adult Eating Disorders CMHT	1,000,000	4	4	4	4		4	8	24	10	8	8	10	8		6	4	4	4	
Rehabilitation CMHT	100,000	39	39	39	39		39	156	390	78	78	78	254	78		39		39	78	
Early Intervention CMHT	2 teams	2	2	2	2		2	4	12	6	4	4	6	4		4	2	2		
Adult Liaison Service	300,000	13	13	13	13		13	26	78	13	26	26	33	26		20	13	13		
Neuro-Psychiatry	2,000,000	2	2	2	2		2	4	12	4	4	2	5	4		4	2	2	4	1 based in Dublin 1 based in Cork
Perinatal Psychiatry						1		2												
Adult In-Patient and Residential Services																				
Acute In-Patient Units	300,000 : 50 beds	13 units x 50 beds						65	455						130					
Crisis Houses for Adult Services	300,000 : 1 unit x 10 beds	13 units						26	104				52		39					
Neuro-Psychiatry Unit	6 - 10 beds	1 unit						5	35						10					based in Beaumont Hosp
Staffed Residences	100,000 : 3 units x 10 places	117 units						117	468				351		351					

TEAM/UNIT	Total Population per team or unit	Number of Teams Required	Team Co-Ordinator	Team Leader/ Consultant	Practice Manager	Consultant	NCHD	Senior Nurse	Psychiatric Nurse	Occupational Therapist	Clinical Psychologist	Social Worker	Care Assistant	Team Secretary	Attendant	Cog Behaviour Therap	Family Therapist	Addiction Counsellor	Other Therapists	NOTES
Child & Adolescent CMHTs																				
Community Mental Health Teams	50,000	78	78	78	78		78		156	78	156	156	78	156					78	
Liaison Teams		7	7	7	7		7		7	7	14	14	7	14					7	
Eating Disorder Team		1	1	1	1		1		2	1	2	2	1	2					1	tertiary national service
In-Patient Service	20 beds per unit	5 units	5	5	5		5	10	80	10	20	15		15	25				20	
National High Secure Unit	10 beds							2	13						4					
Substance Misuse and Dependancy	1,000,000	4	4	4	4		4	8			4	4	8	8			8	12	8	team as recommended by substance misuse subgroup
Mental Health of Intellectual Disability CMHTs																				
Community Mental Health Teams - Adult	2 teams per 300,000	26	26	26	26		26	52		26	52	52	26	52					26	26 posts for various occasional therapies
Children & Adolescents	1 team per 300,000	13	13	13	13		13	26		13	26	26	13	26						
Mental Health Services for Older People																				
CMHT for older people	100,000	39	39	39	39		39	78	234	39	39	39	78	78					39	
Central Acute Day Hospitals	300,000 : 25 places	13 units						13	13				26		20					
Continuing Care Beds - Challenging Behaviour	300,000 : 30 beds	13 units x 30 beds						26	247						52					

TEAM/UNIT	Total Population per team or unit	Number of Teams Required	Team Co-Ordinator	Team Leader/Consultant	Practice Manager	Consultant	NCHD	Senior Nurse	Psychiatric Nurse	Occupational Therapist	Clinical Psychologist	Social Worker	Care Assistant	Team Secretary	Attendant	Cog Behaviour Therap	Family Therapist	Addiction Counsellor	Other Therapists	NOTES
Difficult to Manage Patients																				
Intensive Care Rehabilitation Teams	1,000,000	4	4	4	4		4			10	8	8	8	8		8	4	4		nursing input drawn from DMP service complement
Intensive Care Rehabilitation Units	1,000,000 : 30 beds	4 units x 30 beds						16	104						32					
High Support Intensive Care Residences	1,000,000 : 20 places	80 places						16	64						32					8 units x 10 places
Forensic Mental Health Services																				
Forensic Teams	1,000,000	4	4	4	4		4	4	8	10	10	8	12	8		12	12	12		
Forensic Teams - Child & Adolescent	2 teams	2	2	2	2	2	2	4	10	4	4	4	6	4		4	2	4		1 team based in C&A secure unit
Forensic Teams - Intellectual Disability	1 team	1	1	1	1	1	1	2	5	2	2	2	3	2		2	1	2		
Staff of Central Mental Hospital						5	11	20	95				11	13	12					
CMHTs for people with Co-morbid Mental Illness and Substance Abuse																				
CMHTs for People with Co-morbid Mental Illness and Substance Abuse	300,000	13	13	13	13		13		26	13	13	26		26				52		26 Psychiatric Nurses to operate as outreach workers

TEAM/UNIT	Total Population per team or unit	Number of Teams Required	Team Co-Ordinator	Team Leader/ Consultant	Practice Manager	Consultant	NCHD	Senior Nurse	Psychiatric Nurse	Occupational Therapist	Clinical Psychologist	Social Worker	Care Assistant	Team Secretary	Attendant	Cog Behaviour Therap	Family Therapist	Addiction Counsellor	Other Therapists	NOTES
Mental Health Services for Homeless People																				
Service Teams		2	2	2	2	2	2	2	16	4	2	2	4	2		2		4		
Crisis House		1 house of 10 beds											4		2					
Day Centres		2 units						2	6				4		4					7 day week
Day Hospital		1 unit						1	3				2	1	2					with further in-put from teams
TOTALS			**337**	**337**	**337**	**89**	**348**	**851**	**3135**	**523**	**628**	**632**	**1197**	**691**	**715**	**218**	**126**	**228**	**265**	**10,657**

Proposed Mental Health Service Units					
Service Accommodation	**Ratio Units/ Beds/Places : Population**	**Number of Units/Beds/ Places Needed**	**Number of existing suitable Units/ Beds/Places**	**Number of new Units/Beds/ Places Required**	**Notes**
Community Mental Health Teams (CMHT) - General Adult mental Health Services	1 unit per 50,000	78 units	none suitable	78 units	One unit of accomodation per team. One or a number of accomodation units will comprise a Community Mental Health Center (C.M.H.C.). Accessibility for service users and contact with PCCC services are important.
Adult Eating Disorders - CMHT	1 unit per 1,000,000	4 units	none suitable	4 units	1 per region
Early intervention CMHT - National Pilot	2 units	2 units	none suitable	2 units	
Acute In-Patient Units General Adult	50 beds per 300,000	13 units x 50 beds			To be located in major general hospitals. Existing general hospital beds exceed requirement. Location problems exist in some areas.
Adult Liaison CMHT	1 unit : 300,000	13 units	none suitable	13 units	Located at major general hospitals
Crisis Houses for Adult Services	1 per 300,000	13 houses x 10 beds	none suitable	13 houses	Located close to Community Mental Health Centres
Rehabilitation CMHT	1 unit per 100,000	39 units	none suitable	39 units	Would combine easily with General Adult and Psychiatry of Later Life
Staffed Community Residences	3 x 10 : 100,000	117 units	estimated 60 suitable	57 units	

Service Accommodation	Ratio Units/ Beds/Places : Population	Number of Units/Beds/ Places Needed	Number of existing suitable Units/ Beds/Places	Number of new Units/Beds/ Places Required	Notes
Day Support Centres or equivalent - User Run	1 : 100,000	39 units	none suitable	39 units	
Neuro-Psychiatry CMHT	1 Centre per 2,000,000	2 centres	none suitable	2	Based in Beaumont Hospital and Cork University Hospital
Neuro-Psychiatry In-patient Unit	1 national Centre	8 beds	none suitable	8	based in Beaumont Hospital
CMHT for older people	1 unit per 100,000	39 units	none suitable	39 units	Would combine easily with general adult and rehabilitation services
Central Acute Day Hospitals for older people	25 places : 300,000	13 units x 25 places	none suitable	13 units	Located at major general hospitals
In-patient units for older people	These beds come within the bed complement of adult in-patient units				Located with acute beds in general hospitals - separate section - physically distinct
Continuing care beds - challenging behaviour - older people	30 beds : 300,000	13 units	1 unit	12 units x 30 beds	Located close to major general hospitals
Child & Adolescent CMHT	1 unit per 50,000	78 units	15 units	63 units	
Child & Adolescent Liaison Teams		7 units	current accommodation inadequate for full teams	7 units	
Child & Adolescent Eating Disorders Team		1 unit	none suitable	1 unit	

Service Accommodation	Ratio Units/ Beds/Places : Population	Number of Units/Beds/ Places Needed	Number of existing suitable Units/ Beds/Places	Number of new Units/Beds/ Places Required	Notes
Child & Adolescent Day Hospitals	1 unit per 300,000	13 units	none suitable	13 units	
C&A Substance Misuse and Dependancy Teams	1 unit per 1,000,000	4 units	none suitable	4 units	
Child & Adolescent In-patient Beds	including hq's for 5 in-patient teams	100 beds in 5 units	20 existing suitable beds	80 beds	Ideally located close to a general hospital with paediatric unit or adult psychiatry unit.
Adult Mental Health of Intellectual Disability CMHT	2 units per 300,000	26 units	none suitable	26 units	
C&A mental Health of Intellectual Disability CMHT	1 unit per 300,000	13 units	none suitable	13 units	
Specialist Intensive Care Rehabilitation Teams					Based in Intensive Care Rehabilitation Units
Intensive Care Rehabilitation Units	30 places : 1,000,000	4 units/120 places	none suitable	120 places	4 freestanding units. Nationally 8 x 15 beds in 4 locations, design and accommodation issues important
High Support Intensive Care Residences	20 places : 1,000,000	8 units/80 places	none suitable	80 places	Closely associated with Intensive Care Rehabilitation Units
CMHTs for Homeless People		2 units for Dublin	none suitable	2 units	

Service Accommodation	Ratio Units/ Beds/Places : Population	Number of Units/Beds/ Places Needed	Number of existing suitable Units/ Beds/Places	Number of new Units/Beds/ Places Required	Notes
Day Hospital for Homeless People		1 unit for Dublin	none	1 unit	Housing authorities should provide the required housing. Prevention would be better than elaborate specialist services.
Day Centres for Homeless People		2 units for Dublin	none suitable	2 units	
Crisis House for Homeless People		10 places for Dublin	1 unit	none	Use Weir Home - requires up-grading
Substance Misuse CMHT		13 units	none suitable	13 units	
Forensic CMHT		4 units	none suitable	4 units	
Forensic Teams C & A		1 unit	none suitable	1 unit	Second team to be based in C&A secure unit
Forensic Team Intellectual Disability					Based in the Intellectual Disability high secure in-patient unit
Child & Adolescent High Secure In-patient Unit	1 unit	10 beds	none suitable	10 beds	
Intellectual Disability High Secure In-patient Unit	1 unit	10 beds	none suitable	10 beds	
New Central Mental Hospital		New CMH			Site costs already agreed. Construction costs to be funded from sale of existing site. Not costed within this exercise

Summary of new infrastructure requirement bases for Community Mental Health Teams	No. Units
General Adult CMHTs	78
Early intervention teams	2
Adult liaison teams	13
Rehabilitation and recovery CMHTs	39
CMHTs for older people	39
Mental health of intellectual disability CMHTs	26
Child & adolescent CMHTs	63
C&A – Liaison teams	7
C&A – Eating disorder teams	1
C&A – Intellectual disability teams	13
C&A – Substance misuse teams	4
CMHTs for homeless people	2
Forensic – Adult	4
Forensic – C&A	1
CMHTs for people with co-morbid mental illness and substance misuse	13
Adult eating disorders	4
Neuro psychiatry	2
Total	**311**

Acute In-Patient Beds	**No. Beds**
■ General Adult Mental Health (50x13) – 35 for general adult (including rehabilitation and recovery mental health services, and co-morbid substance misuse) – 8 for mental health services for older people – 2 for people with eating disorders (may be pooled to 6 per region) – 5 for people with intellectual disability and mental illness	650
■ Child & Adolescent	80
■ Child & Adolescent High Secure	10
■ Intellectual Disability High Secure	10
■ Neuropsychiatry	8
Total *Note: Sufficient general hospital beds are in place but are not correctly located.*	**758**
Crisis (Respite) Houses	**No. Houses**
■ Homeless Persons	1 (Dublin)
■ Adult Services	13
Total	**14**
Continuing Care Beds	**No. Beds**
■ Mental Health Services for Older People (Challenging Behaviour)	360
Day Hospitals	**No. Units**
■ Mental Health Services for Older People (General Acute)	13
■ Child & Adolescent	13
■ Homeless Persons (Dublin)	1
Total	**27**
Day Centres	**No. Units**
■ Homeless Persons (Dublin)	2
Total	**2**
Service user provided support centres	**No. Units**
■ Support centres/social clubs	39
Total	**39**
Staffed Community Residences	**No. Units**
■ Rehabilitation	57x 10 places
■ Difficult to Manage Patients – High Support	8 x 10 places
Total	**65**
Intensive Care Rehabilitation Units	**No. Units**
■ Difficult to Manage Patients	4 x 30 places
Central Mental Hospital	**New Hospital**

Annex 19: Information and Research

A19.1 SOURCES OF INFORMATION FOR SERVICE USERS AND CARERS

Voluntary organisations currently play the largest role in the provision of information about specific mental health problems. Organisations such as Schizophrenia Ireland (SI) (information on schizophrenia), AWARE (information on depression and manic depression), Bodywhys (information on eating disorders) and the Out and About Association (OANDA – information on agoraphobia and social phobias) provide information on specific conditions and information on mental health and other services available for individuals and their carers. Other organisations such as Mental Health Ireland provide general information about mental health and related topics.

There is no single, readily available source of information on what mental health services are provided locally and nationally. However, the website of the Department of Health and Children – located at **http://www.doh**.ie – now provides a good deal of information on mental health. Topics covered include admission to a psychiatric hospital; a description of the *Mental Health Act, 2001*[82] and the Mental Health Commission; a detailed description of the roles of mental health professionals and services in broad terms and information on rights. The register of approved centres that will be maintained by the Mental Health Commission will provide some information on mental health services, but will be limited as it will cover mainly in-patient settings.

Box 1: A clinician's experience of adapting to the Electronic Patient Record

As a moderately sceptical clinician working within a multidisciplinary team the conversion was not easy for me. The medical, psychological and social needs of the patient are one aspect. But they exist within the context of the family and the environment where the care is provided and the record should reflect the complexity and uniqueness of this care and the interdisciplinary nature of the care. My first response was 'How on earth can anyone convert this into an EPR'?

There are several preconditions before starting the journey from paper to EPR. The first is a willingness of the patient to have their records held electronically. The second, is the management team commitment to the process. The third, a willingness by clinicians to examine their current work practice and define what exactly they want from the record. The fourth, a capacity to be open and work with colleagues from the IT department. The final precondition; an IT department who are willing to make the technology fit the clinical need. To do this our IT colleagues 'shadowed' clinicians to gain a greater insight into how we worked. Similarly, our IT Dept. sought a clinician to represent the views of those at the coalface. Representatives of each discipline were nominated and they formed a committee to provide continuous advice to colleagues in IT over the two year development process.

A19.2 ELECTRONIC PATIENT RECORD (EPR)

The following is an example of the process of developing and adopting an EPR from the point of view of a clinician.

Change provokes various personal and professional apprehensions. However, as long as the focus continues to be on improving care for patients they can, and in our institution were, allayed. Undoubtedly the road has been rocky – with the transition phase from paper to EPR leading to some temporary confusion while differing centres were co-ordinated and synchronised. The real payoff for clinicians is that now the record is current. It also allows us to review previous data easily and to follow progress over time. Also, it allows us to write prescriptions and to examine whether we have achieved a particular standard of care. We can now integrate with outside agencies to simplify transfers or discharges.

Is there a downside? Yes! Data entry into the record has to be efficient and effective and not detract from direct patient care by any interdisciplinary team member including psychiatrists. The overwhelming majority of clinicians cannot type as quickly as they write. This inevitably leads to much longer time being set aside for first assessments and slightly longer times for routine assessments. However, we find this time 'lost' is more than compensated for by the accessibility and quality of the record. A further possible problem is that while there is no resistance to adding worthwhile features to the system there is an increasing intolerance for any slow or cumbersome features. The IT Dept have completed the first phase of converting from paper to EPR in a multisite community based mental health service. They no longer try to persuade people of the benefits rather the opposite. They have to evaluate, organise and set priorities on the flow of new and innovative ideas from clinicians about what they can add to the patient record to further improve patient care. Most clinicians are not IT savvy and never will be, certainly not enough to keep such a system working. Therefore it is critical to have continuous 'on-site' IT support. Finally, clinicians who move to other centres in the country describe feeling a little lost and exasperated at having 'to go back to paper'. Having experienced the journey, seen the benefits to patient care this Luddite clinician does not wish to go back to paper.

A19.3 THE POLICY CONTEXT

Making Knowledge Work for Health – A Strategy for Health Research[210] is the national strategy for health research. The need for the establishment of a research and development function within the health services was acknowledged, and to achieve this it was recommended that:

- a research and development officer be appointed to the Department of Health and Children
- research and development officers be appointed in health boards and in specialist health agencies
- health boards and specialist agencies should prepare institutional research strategies that reflect health service priorities
- a Forum for Health and Social Care Research be set up to advise on agreed research agendas that address the main objectives of the health services.

Unfortunately, there has been very limited implementation of these recommendations and the research function in HSE areas is still seriously underdeveloped. For example, there is no research and development officer in the Department of Health and Children, and this leaves a critical vacuum at this level. Some of the recommendations of this strategy will need to be adapted following the restructuring of the health services. For example, the Heath Service Executive (HSE) is now responsible for the appointment of research and development officers in local or regional health offices.

The recommendations in the *Health Research Strategy*[210] apply equally well to mental health research. It could be argued that they have an even greater resonance for mental health research as the capacity for this type of research is so underdeveloped in Ireland, compared to other areas of health research which are more technologically based.

Two organisations in Ireland are active in producing and using mental health service research: the Health Research Board and the Mental Health Commission.

- The **Health Research Board** is a statutory body that promotes, funds, commissions and conducts medical, epidemiological and health services research in Ireland. The HRB encourages research that translates into improved diagnosis, understanding, treatment and prevention of disease and improves efficiency and effectiveness of the health services. The Mental Health Research Division of the HRB carries out national and international research, information-gathering and the dissemination of research outcomes on mental health and mental illness in Ireland. The Division administers the National Psychiatric In-Patient Reporting System (NPIRS) which informs policy and planning mental health nationally and regionally.
- The **Mental Health Commission** is an independent, statutory body and was established in April 2002 under the provisions of the Mental Health Act, 2001[82]. Under this Act, the Commission is mandated to undertake such activities as it deems appropriate to foster and promote high standards and good practices in the delivery of mental health services. One of the strategic priorities of the Commission is 'to promote and enhance knowledge and research on mental health services and treatment interventions'. Under this priority a mental health research strategy has been published[211]. This research strategy proposes an action plan which focuses on building capacity in mental health services research, providing facilities for recording and disseminating mental health services research, promoting partnership in this area and influencing the agenda for mental health research.

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