Mental Health Reform
Promoting Improved Mental Health Services

Mental Health Reform Pre-Budget Submission 2019

July 2018

Pre-budget recommendations

Recommendation 1: Ring-fence additional revenue funding of €105M in 2019 for primary, secondary and tertiary mental health services, including €55M for the development of new mental health services, and €50M to maintain existing levels of service in the face of increased demand. This must occur in accordance with an overall increase in the mental health budget towards 10% of the total health budget within the next 10 years.

Specifically, in 2019 development funding should be used in part to:

- Continue building staffing levels to ensure that all service users have timely access to comprehensive mental health care
- Develop 7/7 crisis intervention mental health services for children and young people in every community across the country
- Increase the capacity of the Counselling in Primary Care service to meet growing demand and extend access to people on low incomes
- Invest in primary care psychology services through the recruitment of additional psychologists at staff grade level and above to meet the needs of both children and adults.
- Increase capacity of independent national advocacy services for both children and adults with mental health difficulties in hospital and in the community

Recommendation 2: Dedicated funding should be allocated for the capital costs of providing social housing for people with severe and enduring mental health difficulties

Recommendation 3: Allocate funding for 'mental health advisors' and other necessary resources to implement a nationwide schools programme on mental health promotion and well-being which encapsulates the 'whole school approach' for both primary and post primary schools. In particular, mental health and wellbeing should be included in a revised SPHE curriculum at primary and senior cycle. This will require adequate resourcing, including training and ongoing professional development for teachers, principals and other staff members

Recommendation 4: Allocate funding to implement the recommendations of the Porporino report on the development of mental health supports within the prison system.

Introduction

The prevalence of mental health difficulties in Ireland is significant. The most recent census data (2016) shows that the percentage of people with a psychological or emotional condition increased by almost 30%, between 2011 and 2016. The Healthy Ireland survey reports that almost 10% of the Irish population over age 15 has a 'probable mental health problem' (PMHP) at any one time. The situation is more severe for children and young people, with almost 20% of young people aged 19-24 years having had a mental health disorder and 15% of children aged 11-13 years also having experienced a mental health disorder.[1]

Despite growing demand for mental health supports, at all levels of the system, services continue to struggle to operate within existing resources. Between 2012 and 2016 there has been a 26% increase in the number of referrals to child and adolescent mental health services (CAMHS).[2] In December 2017 there were almost 8,000 people on the waiting list for primary care psychology, of which almost 30% were waiting more than 12 months to be seen.

The lack of availability of direct mental health services for adults and children has far reaching consequences across all domains of society. The Healthy Ireland Framework estimates that mental health difficulties cost the Irish economy €11 billion each year, much of which is related to lost productivity in the labour market. To put this in context, the costs of overweight and obesity in Ireland in 2009 were estimated at €1.13 billion.

National and international research clearly shows the economic returns on investing in mental health supports, including early interventions. Funding allocated to mental health, should therefore be seen as an investment, rather than a cost. It is imperative that investment in mental health support occurs at all levels of the system (primary to specialist services) and across Government departments, including health, education, employment, housing and so on.

Below Mental Health Reform sets out each of its recommendations for investment in mental health in Budget 2019 for the Departments of Health, Housing, Education and Skills and Justice.

Department of Health

Recommendation 1: Ring-fence additional revenue funding of €105M in 2019 for primary, secondary and tertiary mental health services, including €55M for the development of new mental health services, and €50M to maintain existing levels of service in the face of increased demand. This must occur in accordance with an overall increase in the mental health budget towards 10% of the total health budget within the next 10 years.

In 2018, Minister for Health Simon Harris and Minister for Mental Health Jim Daly made a commitment to allocate €55M for new developments in mental health in Budget 2019. Mental Health Reform seeks that this commitment be fully upheld by Government.

[1] Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I (2013) The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group Dublin: Royal College of Surgeons in Ireland.
[2] HSE (2017) HSE Mental Health Division Delivering Specialist Mental Health Services 2016. Dublin: HSE.

Between 2012 and 2018 €210M in Programme for Government funding has been allocated to the development of new mental health services. While a substantial proportion has gone to building up community teams in line with *A Vision for Change*, these resources have not kept pace with increasing demand. In November, 2017 there were still fewer staff in the mental health services than there were before the recession, in 2008, despite an increase in Ireland's population of 7.6% between 2008 and 2016.

Delay in spending development funding over the years (so-called 'time related savings') has been used to cover an underlying deficit in core mental health services, including:

- maintaining existing levels of service in the face of increased demand
- expenditure on out of area placements, and
- agency staff cover for unfilled posts

Furthermore, a significant proportion of development funding has been spent on new initiatives that were not costed as part of *A Vision for Change*, including:

- the National Office for Suicide Prevention
- Counselling in Primary Care
- Clinical Care Programmes for self-harm, early intervention in psychosis, etc.

While this investment has been welcome, there is no doubt that it has been vastly outstripped by other costs attributed to challenges in the operation of the mental health services. There is an ongoing shortfall of investment in mental healthcare creating a system that is at breaking point and in dire need of financial attention, in the context of significant increased demand since *A Vision for Change* was published in 2006.

In 2017, the HSE reported that it required an additional €98M to achieve the staffing for mental health services set out in *A Vision for Change.* This figure did not include investment in primary care and the voluntary sector. Thus, notwithstanding investment by successive Governments since publication of *AVFC,* the reality is that upwards of 10% more funding is needed, in today's terms and in light of today's demographics, simply to fulfil the mental health service programme published in 2006.

Furthermore, an increase in mental health expenditure is required not only for new developments, but to maintain 'existing level of service' ("ELS"). ELS costs increase each year due to a variety of factors, such as costs affiliated with out of area placements for services that are not available in Ireland, and agency staff to cover vacant posts. In 2017 the HSE Mental Health Division estimated that approx.€62M (inclusive of PfG funding) was required in 2018 for existing levels of service.

It is imperative that funding is allocated to ELS in 2019 to ensure that services continue to operate in line with increased demand. Before 2016, the HSE Mental Health Division did not receive any additional budget for existing level of service pressures and therefore such costs were drawn from the base mental health budget, including the full recurring development funding. This has resulted in new developments being stalled, while funding is swallowed up by ELS cost pressures.

Ring-fenced funding in mental health for new developments and existing level of service costs must be accompanied by an increase in public expenditure on mental healthcare towards 10% of the total health budget to fulfil Slaintecare, and in line with national and international standards.

In recent years, mental health as a proportion of the total health budget has amounted to approx. 6% each year. In a report, the Work Research Centre identified that "a comparative

positioning of Ireland internationally suggests that the percentage resource allocation today is…lower than in some of the countries with better developed and better performing mental healthcare systems". "The data available indicates levels of allocation of 10-13% in countries such as Sweden, Netherlands, Germany, France and the UK".[3]

These figures reveal that a step change in investment in mental healthcare in Ireland is needed. We must be much more ambitious than heretofore. We must think in terms of ensuring that everyone has speedy access to the mental health support that they need. If not, the costs will be felt everywhere else in our health and social system, from higher costs for physical healthcare to higher disability and illness benefit payments to higher supported housing costs and lost productivity for employers.

A report published by the London School of Economics (LSE) and Political Science identified that total expenditure on healthcare for 'mental illness' amounts to some £14 billion a year in the UK. In addition, 'untreated mental illness' amounts to over £10 billion in physical healthcare costs each year and the total non-NHS cost of adult mental illness to the Exchequer may be around £28 billion.[4]

A report by the Institute of Health Economics in Canada states that the indirect costs of lost productivity in the work place, in addition to the monetary losses due to reductions in a person's health-related quality of life (HRQOL) was estimated at approx. $44 billion in 2006. In Australia, a study carried out by KPMG estimated that "mental ill health" costs the economy almost $60 billion a year and that improvements in "mental ill health" rates could improve workforce participation rates by 30%.

The aforementioned report by WRC identifies that the "economic costs of 'mental health disorders' are enormous, with figures suggesting this may amount to as much as 4% or more of GDP in some countries. As identified in international studies "although substantial costs accrue to mental healthcare systems, the main economic costs are located in the labour market and social protection systems, not just for those experiencing poor mental health but also for other family members".[5]

Allocation of additional funding to mental health is not cost, it is good investment. The evidence based review on refresh of AVFC clearly identifies that

> "… studies have shown the substantial returns on investment that a broad range of prevention and treatment mental healthcare interventions can yield. This may include better outcomes for the mental health care sector and for the physical healthcare sector, cost-savings arising from prevention, and substantial cost-savings and other contributions across other areas of the public sector, economy and society."[6]

The London School of Economics states that "effective mental health treatment can generate large savings to the government, for example by increasing employment or improving the behaviour of children." For example - "the Improving Access to Psychological Therapies programme in the UK has almost certainly paid for itself through reduced disability benefits and extra tax receipts".[7]

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[3] Work Research Centre (2017) A wide-angle international review of evidence and developments in mental health policy and practice. Department of Health: Dublin.
[4] The Centre for Economic Performance Mental Health Policy Group (2012) How Mental Illness Loses Out in the NHS. The London School of Economics and Political Science: London.
[5] Work Research Centre (2017).
[6] Ibid.
[7] The Centre for Economic Performance Mental Health Policy Group (2012).

In addition, the WHO says that every US$1 invested in scaling up treatment for depression and anxiety leads to a return of US$4 in better health and ability to work.[8]

KPMG Australia identified a number of evidence based mental health interventions for the purposes of investment, including supporting people in work, minimising avoidable ED presentations and hospitalisations, in addition to mental health promotion, prevention and early intervention. KPMG estimated that on the basis of 10 identified interventions between $8.2 and $12.7 billion would be generated from an investment of under $4.4 billion.

KPMG say that while there is a requirement for "upfront investment from Government and industry the positive returns provide a compelling case for investment". The authors argue the "significant and powerful return on investment figures for mental health that have comparatively high impact when compared to other areas of health investment such as heart disease.

> "Without this investment, Governments will be left to face a broad range of mental health costs – ranging from avoidable emergency department presentations, hospital beds, homelessness support, drug and alcohol treatments, [income supports] to the absenteeism and presenteeism and workforce participation rates affecting the broader economy."[9]

Going forward, it is imperative that mental health is afforded financial parity of esteem within the wider health budget to reflect its significance in contributing to the burden of disease in Ireland. This will require a substantial increase in mental health funding.

Mental Health Reform believes that effective investment can be made by targeting additional funding at specific initiatives that can be tracked in terms of their implementation and performance. For the purposes of Budget 2019, Mental Health Reform recommends investment in the following areas.

Recommendation 1.1: Continue building staffing levels to ensure that all service users have timely access to comprehensive mental health care

Despite the difficulties in the recruitment of professionals to mental health services in recent years, additional investment is required to increase, at a minimum, the number of staff in post to staffing levels recommended in *A Vision for Change* (i.e. 12,778).

As of October 2017, there were 9,767 WTE staff in post in the mental health services.[10] This equates to just 76% of staffing levels required as per *A Vision for Change.* As mentioned above, there have been significant reductions in the number of staff in post since 2008 despite recommendations by the Expert Group for increases in mental health staffing.

The situation is more severe in child and adolescent mental health services. As of December 2017 there were 589 WTE clinical staff in post in child and adolescent community mental health services. This equates to just 56.2% of staffing levels required as per AVFC. Despite concerted efforts by the HSE to improve staffing levels in CAMHS over the last couple of

[8] World Health Organisation (WHO) "Investing in treatment for anxiety and depression leads to fourfold return", media release, 13th April 2016 available at http://www.who.int/mediacentre/news/releases/2016/depressionanxietytreatment/en/.

[9] KPMG Australia (2018) Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform, Australia: Mental Health Australia.

[10] See HSE Performance Assurance Report October – December 2017.

years, there has been an increase of just 68 clinical staff across the country since December 2015.

Mental Health Reform considers that it is possible to increase investment through recruitment by broadening the scope of roles within mental health services, reserving scarce clinicians for roles they can uniquely perform.

MHR has consistently recommended that there be a shift of focus in recruitment of staff from primarily medical professionals to allied health and social care professionals, including psychologists, occupational therapists, social workers, etc. AVFC sets out a model of modern mental health care that relies on multidisciplinary teams to support the recovery and social inclusion of people with severe mental health difficulties. Its recommendations entail a significant increase in number and involvement of allied health professionals. Yet the total number of such professionals is still well below *A Vision for Change* recommended levels.

Currently in CAMHS, there are less than 40% of the required number of clinical psychologists in post, less than 50% of social workers and less than 60% of occupational therapists. In general adult services, there is less than 70% of the required clinical psychologists in post, less than 70- 45% of occupational therapists and less than 45- 25% of addiction counsellors.

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

No doubt, the impact of staffing shortfalls is significant, including the continued absence or lack of specialist services for particular groups of individuals, e.g. people with a dual diagnosis of addiction and mental health difficulties, long waiting times to access supports, in addition to a reduction in quality of care.

Furthermore, while there is a fundamental requirement to invest in specialist mental health services, there is also substantial scope to develop mental health services elsewhere in the system, including in primary care and across the community and voluntary sector.

Recommendation 1.2: Develop 7/7 crisis intervention mental health services for children and young people in every community across the country

The announcement by Minister for Mental Health, Jim Daly in January 2018 on the roll out of a seven day a week service across all general adult mental health teams through the allocation of €4.5M / 47 WTE staff is a welcome commitment. As of July 2018, 24 of these posts have been offered, with 23 positions yet to be filled.

Despite such progress, there is a requirement to continue to develop out of hours services to ensure a 24/7 response to people experiencing a mental health crisis, and as a first step, to expand seven day a week services across all child and adolescent mental health teams.

This recommendation is consistent with national policy and guidance, including *A Vision for Change*, the suicide prevention framework Connecting for Life, in addition to the Mental Health Commission's Quality Framework and HSE Mental Health Operational Plans.

The urgent requirement for crisis services can be demonstrated by the prevalence of children and young people presenting to emergency departments with mental health

difficulties and the continued admission of children to adult inpatient units, due to a lack of out of hours services. In the absence of community-based supports, EDs are often the only option for children and young people in crisis, even for those already known to the mental health services. However, those who use mental health services and their family members consistently raise to Mental Health Reform their dissatisfaction at having to access crisis supports through EDs.

Furthermore, access to specialist CAMHS consultants out of hours varies considerably across the country. In his recent annual report, the Ombudsman for Children reported that 'out of hours' services range from no such cover at all in CHO5 (South Tipperary, Carlow/Kilkenny, Waterford and Wexford) to full cover in CHO2 (Galway, Roscommon and Mayo) and CHO3 (Clare, Limerick, North Tipperary/East Limerick). Overall, 70 consultants provide out-of-hours cover nationally while 25 do not, with an additional 13 posts vacant around the country. The report further states that "at times there is no CAMHS consultant available to assess children in the area when they [go to] hospital with suicidal behaviour. Some children had to be admitted and stay in hospital for several days until a CAMHS consultant was available".[11]

The Seanad Consultative Committee on Child and Adolescent Mental Health Services acknowledged the "recurring problem of lack of out-of-hours emergency care at weekends and night time". As of October 2017, "there are 15 counties in Ireland without out-of-hours services for children". "Parents gave evidence of waiting in excess of two weeks for crisis emergency treatment and report a consistent absence of emergency response services for crisis intervention". In its report the Committee recommend "as a priority that out-of-hours CAMHS be provided across all CHO areas on a 24/7 basis for acute presentations. In the absence of this service, children are required to rely on local Accident and Emergency Departments which do not have child-appropriate staff, let alone psychiatric staff to deal with the presentations".[12]

There is broad based consensus across the mental health community that accessing supports through hospital EDs is inappropriate and distressing to an individual and in particular for a child or young person experiencing a mental health crisis. A quote from the CAMHS Independent Survey of Parents' Views, July 2017, captures this sentiment

> *"children should NEVER EVER have to go through A&E for non-medical referral to CAMHS out of hours!".*

Clear, accessible routes to 'out of hours' and 'crisis' CAMHS is described in Irish and international guidance as essential to facilitating access to CAMHS. However, the documented views of children, young people and family members indicate that the lack of 'out of hours' crisis CAMHS services is among one of the key factors affecting both equity and accessibility of mental health services for children and young people in Ireland.

The UN Committee on the Rights of the Child raised concerns in its concluding observations on Ireland in 2016 about "children being admitted to adult psychiatric wards due to inadequate availability of mental health facilities for children, long waiting lists for access to mental health support and insufficient out-of-hours services for children and adolescents with mental health needs….".

As previously recommended by the Children's Mental Health Coalition, it is imperative that all CAMHS provide a specialist out of hours and crisis service that is well publicised, fully staffed and resourced to provide a rapid response to children and families in need. No

[11] Ombudsman for Children Office (2018) Annual Report 2017, Dublin: OCO.
[12] See Seanad Public Consultation Committee Report on Children's Mental Health Services October 2017.

doubt, there are models of good practice at both national and international level, that should be considered in the national roll out of 7 day a week responses across CAMHS.

A small number of mental health teams across Ireland have already begun offering a more appropriate, responsive way in to urgent support, including the provision of 7-day-week day hospitals alongside home treatment and assertive outreach teams and 24/7 telephone support from specialist mental health staff. There are other models of out-of-hours mental health supports across the country that could inform the development of 7-day-week and subsequently 24/7 community mental health service provision, including the out of hours service provided by Galway child and adolescent mental health services. Furthermore, there is a dedicated phone line for listening support and signposting, operating in Bantry mental health services, in addition to home-based treatment and assertive outreach teams in areas such as Cavan/Monaghan and Clare.

In the UK, the Government has taken significant steps to improve access to crisis mental health supports for both adults and children. This is largely reflected in the publication of the Crisis Care Concordat, which commits to ensuring that every local area develop its services so that people experiencing a mental health crisis can avail of supports 24 hours a day, seven days a week. The Care Quality Commission has endorsed the Concordat and has made specific recommendations to improve crisis supports across the UK in line with the principles of the agreement. In its review of crisis services, the Commission has identified that there are some local areas in the UK which are effectively meeting the needs of people in mental health crisis.

Future in Mind, a report in the UK on improving mental health services for young people identifies that "the litmus test of any local mental health system is how it responds in a crisis". It specifically recommends that the support and intervention as outlined in the Crisis Care Concordat is implemented, including the provision of an out-of-hours mental health service. The report also refers to the provision of home treatment teams and appropriate and timely psychiatric liaison from specialist mental health services.

Good practice guidelines on the provision of 'crisis' CAMHS have also been developed by the Quality Network for Community CAMHS Standards (2011, UK) and are offered here as sample good practice.

Recommendation 1.3: Increase the capacity of the Counselling in Primary Care service to meet growing demand and extend access to people on low incomes

The Counselling in Primary Care (CIPC) service, although a positive initiative, is limited in that it only accepts referrals from people in receipt of medical cards, has a limitation of eight counselling sessions and is currently only available to individuals over the age of 18 years.

Furthermore, the demand for CIPC is steadily growing and the number of referrals to the service has increased by almost 5% between 2016 and 2017 alone. The waiting lists for access to a first appointment also demonstrate increasing pressures on the service.

Of the 3,094 clients waiting for counselling nationally at the end of June 2018, 19% (593) of clients were waiting between 0–1 month, 48% (1,496) of clients between one and three months, 24% (745) between three and six months and 8% (260) of clients were waiting over 6 months.[13] There has been an increase of 9% in the numbers of people waiting between three and six months on the previous year and a 3% increase on those waiting six months or

[13] Information provided by CIPC.

more. Under the UK's Increasing Access to Psychological Therapies (IAPT) service, the target is that 75% of referrals would be seen within six weeks and 95% within 18 weeks.

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

The existing limitations of the Counselling in Primary Care service, in addition to the increasing demand on the service, demonstrate the pressing need to adequately resource CIPC so that it can respond in a timely manner to individuals in need of such supports. The CIPC service has the potential to reduce the number of individuals referred on to specialist mental health services, as well as to increase the number of individuals returning to work who may be absent due to mental or emotional distress.

The international literature highlights the benefits, including the economic returns of counselling in primary care. As already stated above, the WHO has estimated that every $1 invested in scaling up treatment for depression and anxiety leads to a return of US$4 in better health and ability to work.

Furthermore, the recent evaluation of CIPC, phase 1, highlights a number of positive outcomes for participants, including:

- a reduction in symptoms for 97% of clients
- 77% of clients were deemed to have recovered at the end of counselling i.e. they showed a significant reduction in their CORE scores and were no longer in the clinical range for psychological distress
- 57% of participants reported an improvement in their general health
- participants reported a 78% increase in the number of "mentally healthy days" between the beginning and end of counselling[14]

The IAPT programme in the UK has been proven to be cost-effective and has increased the number of individuals with mental/emotional distress returning to work. Over a three year period it has supported over 45,000 people to move off sick pay and benefits. Economic gains are also expected in terms of people retaining employment, and to employers, who benefit from a reduction in sick days.[15] It has been identified that the programme will enable savings to the NHS in the areas of:

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

[14] HSE (2018) Counselling in Primary Care Service National Evaluation Study Report of Phase 1, Dublin: HSE.
[15] Department of Health (2012) IAPT Three Year Report: The First Million Patients.Department of Health: UK.

Recommendation 1.4: Invest in primary care psychology services through the recruitment of additional psychologists at staff grade level and above to meet the needs of both children and adults

Mental Health Reform has previously welcomed the recent sanctioning of the recruitment of 114 assistant psychologists for primary care teams across Ireland (of which 111 posts have been placed). The addition of these posts is a positive step towards providing earlier access to mental health supports for children and adolescents. It is imperative, however, that such efforts by Government to increase capacity in mental health in primary care continue for both children and adults. Moreover, it is necessary that the further recruitment of posts is focussed at the level of staff grade or higher. This will ensure that individuals accessing services are receiving mental health support from fully qualified professionals.

The 2001 primary care strategy sought to promote a team-based, multidisciplinary approach to care that included "psychological expertise". It was acknowledged that providing mental health support through primary care, including the provision of psychological supports, would make mental health support accessible to more people. This sentiment has also been reflected in national mental health policy.

The current system of primary care psychology requires significant investment to address the increasingly high demand on existing services. In December 2017 there were 7,750 people on the waiting list for primary care psychology, of which 2,160 (28%) were waiting more than 12 months to be seen. The majority of individuals on the list for primary care psychology are children and young people under the age of 18 years. In March 2018, there were 6,584 children on the waiting list for primary care psychology, of which 1,794 (27%) were waiting more than a year.

Sources operating in primary care psychology in Ireland recommend 1 primary care psychologist per 10,000 population. This ratio would require 477 psychologists in primary care, aligning one psychologist per large primary care team, or roughly one psychologist to every six GPs. The most recent figures provided to Mental Health Reform indicate there were just 282 psychologists operating in primary care services across the country in 2015.

This estimate is intended to indicate at national level the order of magnitude of the change required. As set out in the workforce planning document for psychologists in Scotland "needs-based approaches to developing the workforce to meet local requirements should be encouraged". It is imperative that the HSE develops and publishes a workforce planning document which sets out the required number of primary care psychologists. Furthermore "reliable and up to date workforce intelligence is essential to the planning process" with a census of primary care psychologists being updated annually and forecast for increased demand being conducted biennially.

Recommendation 1.5: Increase capacity of national advocacy services for both children and adults with mental health difficulties in hospital and in the community

Mental Health Reform has consistently highlighted that there are significant gaps in existing advocacy supports for people with mental health difficulties. There is currently no statutory right to advocacy, as recommended in *A Vision for Change* and envisaged in the Citizen's Information Act, 2007.

Existing advocacy services are limited in their remit. The National Advocacy Service (NAS) established under the Citizen's Information Board provides a non- statutory advocacy service to people with disabilities, including individuals with mental health disabilities.

However, it focuses primarily on individuals who reside in HSE supported accommodation. The Irish Advocacy Network (IAN) offers a peer advocacy service to individuals across the country, prioritising services to individuals in acute inpatient units. Both services are under-resourced.

In particular, there appears to be inadequate provision of advocacy services for people with mental health difficulties living in the community. *A Vision for Change* recommends that "all users of the mental health services – whether in hospitals, day centres, training centres, clinics, or elsewhere should have the right to use the services of a mental health advocate." This commitment has been reflected in more recent policy, including the National Disability Inclusion Strategy 2017-2021 and in the report of the National Taskforce on Youth Mental Health.

However, this right to advocacy has yet to be realised. While the advocacy needs of people living in the community is not fully known due to a lack of research in this area, small scale research indicates that there is significant unmet need, including a lack of awareness among people with mental health difficulties living in the community of existing advocacy and/or other supports. In addition there is ongoing reports to MHR of difficulties by people living in the community in making complaints about the mental health services, and reports by the Mental Health Inspectorate about a lack of support for people in supported accommodation to participate fully in community life.

A recent small scale study[16] carried out by MHR investigated the views of mental health service users on independent advocacy supports available in the community. The report identified that there is a very low level of awareness of existing advocacy services[17] for people with mental health difficulties and very few individuals have accessed such services.[18] Moreover, this group of participants were more likely to disagree than to agree that they are able to self-advocate. When asked "how confident you would be in making a complaint" about a range of different services, including housing, employment, education, mental health, a very small minority of participants stated that they would be fully confident in bringing such a complaint.

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

The Mental Health Commission's Quality Framework includes an obligation on mental health services to provide access to advocacy supports for both adults and children. The Children's Mental Health Coalition has also recommended the establishment of a dedicated advocacy service to ensure that the advocacy needs of children with mental health difficulties are met.

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[16] Mental Health Reform (2017) Advocacy Needs of Mental Health Service Users Living in the Community: A Pilot Study 2017, Dublin: MHR.

[17] Almost all participants indicated that they had heard of the Citizens Information Centre (97%), two thirds (67%) had heard of the Money Advice and Budgeting Service. 14% had heard of the Irish Advocacy Network and 11% had heard of the National Advocacy Service for People with Disabilities (NAS).

[18] A large majority of participants had used the Citizens Information Centre (92%), a quarter (25%) had used the Money Advice & Budgeting Service; 4% of participants had used the National Advocacy Service for People with Disabilities, and 2% had used the Irish Advocacy Network.

Furthermore, in a study with young people engaged in mental health services it was identified that a "a national advocacy service for young people with mental health difficulties in Ireland should be established as a matter of urgency as it will help young people to express their views about their treatment and help them advocate for better quality services".[19]

More recently, the National Taskforce on Youth Mental Health recommended that "an independent National Youth Mental Health Advocacy and Information Service should be established. ….".

The introduction of a pilot advocacy service in CAMHS, Galway is a welcome initiative, however, it is imperative that that such supports are rolled out on a national basis as a matter of priority to ensure that all children accessing child and adolescent mental health services have their voices heard.

The rights of children to participate in decisions that affect them is underpinned in both national and international legislation, including the Ombudsman for Children's Act, the national children's framework Better Outcomes, Brighter Futures, the National Strategy on Young People's Participation in Decision-Making and the National Youth Strategy. It is guaranteed in human rights legislation under the United Nations Convention on the Rights of the Child (UNCRC) and General Comment 12 and in other European and international policy and law.

In February 2016, the United Nations Committee on the Rights of the Child published its concluding observations on Ireland's compliance with the UNCRC. Among its recommendations were for Government to consider the establishment of a mental health advocacy and information service that is specifically for children [with mental health difficulties] and accordingly accessible and child-friendly. The Expert Group on the review of the Mental Health Act, 2001, has also recommended that advocacy services to children and to the families of children in the mental health services should be made available.

Department of Housing

Recommendation 2: Dedicated funding should be allocated for the capital costs of providing social housing for people with severe and enduring mental health difficulties

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

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

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

A recent study conducted in the Tallaght mental health services found that 98% of long-stay/delayed discharge patients had a housing-related need. In order to prevent inappropriate and costly long-term stays in acute mental health units, it is vital that people who are in inpatient care and who have a housing need can access social housing quickly.

The planning mechanisms used by local authorities to estimate current and future housing need among individuals with severe mental health difficulties must be utilised to identify and allocate social housing stock. Of course, this extends beyond people in residential settings and in hospital, and includes people with mental health difficulties who are homeless or at risk of homelessness and those living in the community in family homes and/or in unsuitable accommodation. It is imperative that the Department of Health and the HSE work collaboratively with the relevant housing agencies throughout this process.

It is also important that individuals are provided with appropriate housing in order to support their recovery. Feedback from Mental Health Reform's Homeless Sector Advisory Group highlights that people with mental health difficulties are often placed in inappropriate accommodation, which can exacerbate existing mental health difficulties. Mental Health Reform's Grassroots Forum has recommended that people with mental health difficulties be housed in communities with infrastructure that supports improved living standards, including good transport links and community supports for the individuals' recovery. Members of the Forum expressed concern that placing people with mental health difficulties in areas where there is little community service provision may have an adverse effect on the person's mental health and recovery.

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

Department of Education & Skills

Recommendation 3: Allocate funding for 'mental health advisors' and other necessary resources to implement a nationwide schools programme on mental health promotion and well-being which encapsulates the 'whole school approach' for both primary and post primary schools. In particular, mental health and wellbeing should be included in a revised SPHE curriculum at primary and senior cycle. This will require adequate resourcing, including training and ongoing professional development for teachers, principals and other staff members

The introduction of a compulsory subject on 'wellbeing' for students starting first year of secondary school in September 2017 under the junior cycle reforms is a positive initiative that should be welcomed. However, it is imperative that a whole-school programme on mental health promotion and well-being is rolled out nationally and is available to all children and young people in both primary and post primary schools.

Despite publication of the national guidelines on mental health promotion and well-being for primary schools in 2015 and post primary schools in 2013, there has been a lack of implementation of these guidelines. The Children's Mental Health Coalition has consistently highlighted the absence of dedicated resources and supports for teachers and schools as a key contributing factor.

This shortfall in mental health in education is further compounded by additional pressures in the school system. Notwithstanding the phased restoration of 'posts of responsibility' in schools in the last budget, many schools still do not have enough resource to provide an adequate pastoral care service. Similarly, the Guidance Counselling service needs to be fully restored. Appendix 3 of DES Circular Letter 0007/2018 states that the service has reduced by 25% since 2012. Surveys by the Institute of Guidance Counsellors confirm that this reduction is most acutely felt in term of reduced opportunities for one-to-one meetings with students.

In a survey commissioned by Irish Second Level Student's Union (ISSU), respondents were asked if they "had Relationship and Sex Education (RSE) classes dealing with mental health and how would they rate them". The findings from this question highlight the disparity between students' experiences of mental health education in secondary school.

ISSU notes with concern that many students have not been supported in developing coping mechanisms to prevent and deal with mental health issues, nor provided with information on resources and supports available. ISSU is of the view that there should be mental health education as part of a revised RSE module which:

- enables students to recognise different types of mental health issues
- teaches students the coping mechanisms needed to deal with mental health issues or heavy periods of stress, including how to deal with the breakup of a relationship
- teaches students how to support a peer in a crisis situation and where to refer

More recently, the National Taskforce on Youth Mental Health included a specific recommendation on schools and youth mental health. In its report it acknowledges that "schools have an important role to play in supporting and fostering wellbeing and mental health. Training for existing teachers in mental health awareness and knowledge of local services and referral pathways is understood to be a key skill for staff".

It further highlights recommendations, as set out in the Department of Education and Skills (DES) Action Plan for Education 2016- 2019 including:

- The Department of Education and Skills should support teaching professionals in schools and centres for education with the knowledge and skills to understand their role in supporting young people with mental health issues and how to access information about services and supports available to them.
- Principals and teachers should be supported to implement the wellbeing junior cycle curriculum.

At an international level the WHO has identified that there is ample evidence that school based programmes can influence positive mental health and reduce risk factors and emotional and behavioural problems through social–emotional learning and ecological interventions. A number of outcomes have been identified from existing school based programmes, including "academic improvement, increased problem-solving skills and social competence as well as reductions in internalising and externalising problems such as depressive symptoms, anxiety, bullying, substance use and aggressive and delinquent behaviour".[20]

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

There is also compelling evidence on the value of a 'whole school' approach to social and emotional learning, which every level of education would benefit from.[21] In the context of mental health, the whole school approach builds the capacity of the school community to promote a sense of wellbeing, address the common emotional needs of young people and prevent the development of mental health difficulties. It seeks to make changes to the schools' social and learning environments, strengthen the structures within each school for addressing mental health promotion and promote links between the school and its community.

The implementation of the Incredible Years Programme in Ballymun has shown the benefits of implementing a whole school approach to social and emotional learning. Pre and post test monitoring data demonstrates significant improvements in children's social and emotional well-being (as measured by the Strengths and Difficulties Questionnaire) associated with participation in the programme. Such outcomes were also reflected in the parenting programme.[22] Parents who participated in the programme reported significantly reduced levels of stress (measured by Parental Stress Index) and depression (measured by the Beck Depression Index).

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

Case study, Islington, England

The Islington Mental Health and Resilience in Schools (iMHARS) framework began in 2014 (in a number of pilot schools in the London borough) and is supported by Public Health and the Clinical Commissioning Group (CCG). iMHARS helps schools to identify areas for improvement (in mental health in education) and plan steps that will best meet their needs, before putting measures in place. Once this audit has been complete schools are then encouraged to develop an action plan based on the findings and to think about measures to monitor impact. Action plans vary across schools, and recommendations could be anything from a whole-school review of the behaviour policy, to mental health training for staff, mapping of enrichment activities, reviewing pupil voice, incorporating more opportunities for problem-solving or improving peer support.

The iMHARS framework sets out the components of school practice and ethos that effectively develops resilience, promotes positive mental health and supports children at risk of, or experiencing, mental health difficulties. Each component is broken down further into supporting practices, to help schools build a detailed picture of what each one looks like in practice.

iMHARS was informed by guidance from the National Institute for Health and Care Excellence (NICE) on promoting social and emotional wellbeing in education, Carol

[21] Elias, M.J., Zins, J.E., Weissberg, R.P., & Greenberg, M.T. (2003) Promoting social and emotional learning: Guidelines for educators. Alexandria, VA: AFSP.
[22] Morgan, M. & K. Espey (2012) Whole-school implementation of Incredible Years: An Action Research Study, Dublin: Young Ballymun.

Dweck's research on growth mindset, boingboing's resilience framework, the Hands on Scotland toolkit and Young Minds work with schools.

Both Islington and Camden have a designated health improvement advisor for mental health who is available to support schools in implementing mental health health and well-being among students. The cost of an annual salary for an advisor equates to approximately €52,000. Mental Health Reform recommends that the Department of Education invest in the recruitment of such posts in Budget 2019.

Department of Justice

Recommendation 4: Allocate funding to implement the recommendations of the Porporino (New Connections) report on the development of mental health supports within the prison system.

In 2015 an independent evaluation of the psychological services within the Irish Prison Service was published.[23] At that time is was identified that the level of resourcing for psychology across the prison system was well below accepted international standards as well as international practice. In addition to the lack of resources assigned to psychology within the IPS, the review identified a number of additional areas where mental health supports required further development.

In response to the New Connections report, the IPS has developed a Psychology Service Strategy for 2016-2018 with the aim of developing psychological services for the prison population. Furthermore, actions have been progressed by the IPS in order to implement recommendations of the report and to enhance psychological supports in prisons across the country.

Mental Health Reform promotes the full implementation of the recommendations of the New Connections report in order to adequately meet the psychological needs of the prisoner population. In addition, it is of paramount importance that a range of talking therapies are developed and made available across the prison system.

The lack of psychological and other talking therapy supports can be seen in the over-reliance on medication to treat mental health difficulties among the prisoner population to date. In the latest reports of the European Committee for the Prevention of Torture and Degrading Treatment (CPT), serious concerns were highlighted over the prescription of medication in Irish prisons and the lack of adequate supervision or follow-up assessments. The CPT found that there was an over-reliance on pharmacological treatment and an underdevelopment of non-pharmacological interventions. The CPT highlighted that, contrary to World Health Organisation (WHO) standards, prisoners who had self-harmed or attempted suicide were not considered to require psychiatric assessment with rarely any psychological support provided.

The Irish Penal Reform Trust has strongly advocated that where prescribed medication is required, this should not be used in isolation, but should be administered in accordance with other therapeutic interventions such as one-to-one sessions with a psychiatrist or psychotherapist. IPRT recommends that the Irish Prison Service and mental health experts

[23] Porporino, J.F. (2015) "New Connections" Embedding Psychology Services and Practice in the Irish Prison Service, Dublin: Irish Prison Service.

work together towards the development of non-pharmacological interventions throughout the entire prison system.

The principle of equivalence of healthcare maintains that healthcare in the prison context should be equal to that in the community setting. As highlighted in previous empirical research, there is a need for better access to health services, including occupational therapy, psychology and other talking therapies in the prison environment.

The IPS Psychology Service has been working to implement "a more strategic, proactive model for service delivery along clear pathways of care that include a range of supports, including individual, short-term, group-based interventions and various motivational and self-help oriented approaches".[24] In order to support such efforts, it is imperative that the Porporino report, highlighted above is fully costed to ensure its implementation in full. This will require the allocation of the necessary resources.

About Us

Mental Health Reform is Ireland's leading national coalition on mental health. With over 60 member organisations, we drive progressive reform of mental health services and supports in Ireland. See www.mentalhealthreform.ie for more details.

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

[24] Ibid.