Mental Health Reform
Promoting Improved Mental Health Services

Mental Health Reform Pre-Budget Submission 2020

July 2019

Pre-budget recommendations

Recommendation 1: Ring-fence additional revenue funding of €100M in 2020 for primary, secondary and tertiary mental health services, including €50M 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 by 2023.

Specifically, in 2020 development funding should be used in part to:

- Continue building staffing levels to ensure that all service users have timely access to appropriate 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 the capacity of national advocacy services for both children and adults with mental health difficulties in hospital and in the community

Recommendation 2: Invest in community and voluntary organisations that provide mental health services and supports across the country. The C&V sector should be appropriately recognised and supported to build their capacity to improve the mental health outcomes of their client groups.

Recommendation 3: The Departments of Health and Housing should jointly provide a national sustainable funding stream for tenancy sustainment supports, where required, for individuals with severe and enduring mental health difficulties (including those transitioning from HSE supported accommodation and for mental health service users living in other types of accommodation in the community) in order to prevent homelessness and promote recovery.

Recommendation 4: Dedicated funding should be allocated for the capital costs of providing social housing for people with severe and enduring mental health difficulties. More specifically, Mental Health Reform recommends that Government invest €12M in Budget 2020 to contribute towards funding 100 (one bed) housing units for people with severe and enduring mental health difficulties with a housing need.

Recommendation 5: 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.

Recommendation 6: Allocate funding to implement the recommendations of the Porporino (New Connections) 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]

In July 2019, a report published by Eurofound showed that young Irish women are suffering the highest levels of moderate to severe symptoms of depression among their counterparts in the EU. Some 17% of this age group of women in Ireland report being moderately or severely depressed compared to an EU average of 9%.[2]

Despite growing demand for mental health supports, at all levels of the system, services continue to struggle to operate within existing resources. The number of referrals to child and adolescent mental health services (CAMHS) increased by over 40% from approx. 12,800 in 2011 to 18,100 in 2019.[3] Moreover, as of December 2018, the total number of children and young people on the CAMHS waiting list was 2,517, of which 314 were waiting more than a year for an appointment.[4] At the end of last year, the number of people on the waiting list for Psychology in Primary Care amounted to 8,087, almost a quarter of whom had been waiting more than 12 months to be seen.[5] Waiting lists for primary care psychology are rising, with an increase of 5% between 2017 and 2018 alone.

The lack of availability of direct mental health services for adults and children has far reaching consequences across all domains of society. The cost of mental health difficulties is enormous, with figures suggesting this may amount to as much as 4% or more of GDP in some countries. This would equate to approximately €12.4B every year based on Irish figures. To put this in context, a research study on the cost of childhood overweight and obesity estimated the total lifetime cost in the Republic of Ireland to be €4.6B per annum. This equates to approximately 1.4% of GDP.

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 supports occurs at all levels of the system (primary to specialist services as well as the community and voluntary sector) and across Government departments, including health, education, employment, social protection, housing and criminal justice.

Below Mental Health Reform sets out its recommendations for investment in mental health in Budget 2020 for the Department of Health.

---

[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 Epidemology Research across the Lifespan (PERL) Group. Dublin: Royal College of Surgeons in Ireland.

[2] Eurofound (2019), Inequalities in the access of young people to information and support services, Publications Office of the European Union, Luxembourg.

[3] Houses of the Oierachtas. (13th March 2019). Child and Adolescents Mental Health Services. Dáil Éireann Debate.

[4] HSE. (2019). Performance Profile October-December 2018 Quarterly Report. HSE: Dublin

[5] Ibid.

Department of Health

Recommendation 1: Ring-fence additional revenue funding of €100M in 2020 for primary, secondary and tertiary mental health services, including €50M 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 by 2023.

Between 2012 and 2019 €270M 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 December 2018 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 9% between this ten-year period.

The HSE's Workforce Planning document, published in October 2018, reports that the mental health workforce is at just 76% of the recommended levels in AVFC.[6] It identifies that an additional €177M is required simply to achieve the staffing levels as set out in the national mental health policy. Of note, this figure does not include investment in primary care or the community and voluntary sector.

Furthermore, an increase in mental health expenditure is required not only for new developments, but to maintain 'existing levels 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 was required in 2018 for existing levels of service. It is imperative that funding is allocated for ELS in 2020 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 comply with other 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".*[7]

These figures reveal that a step change in investment in mental healthcare in Ireland is needed. 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

[6] HSE. (2018). Workforce Planning – Mental Health Assessing Supply and Demand. Dublin: HSE
[7] Work Research Centre. (2017). A wide-angle international review of evidence and developments in mental health policy and practice. Evidence review to inform the parameters for a refresh of A Vision for Change (AVFC).

supported housing costs and lost productivity for employers. As previously noted the costs of mental health difficulties are enormous - 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. 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 £14B a year in the UK. In addition, 'untreated mental illness' amounts to over £10B in physical healthcare costs each year and the total non-NHS cost of adult mental illness to the Exchequer may be around £28B.[8]

The 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."[9]

KPMG Australia has 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 (double) and $12B (triple) would be generated from an investment of under $4B. Such findings have been reflected in work carried out by the London School of Economics and the World Health Organisation. The WHO reports 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.[10]

There is a general consensus that while there is a requirement for "upfront investment from Government and industry, the positive returns provide a compelling case for investment [in mental health]". KPMG Australia have argued 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 presentism and workforce participation rates affecting the broader economy."*[11]

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.

---

[8] 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.
[9] Ibid.
[10] 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/.
[11] KPMG Australia (2018). Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform, Australia: Mental Health Australia.

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 2020, Mental Health Reform recommends investment in the following areas.

Recommendation 1.1: Continue building staffing levels in line with the HSE's Workforce Planning document, 2018, to ensure that all service users have timely access to appropriate 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. 12,725 according to population growth by 2021)[12]

As of December 2018, there were 9,446 WTE staff in post in the mental health services, which equates to just three quarters of the staffing levels required in line with national mental health policy. As mentioned above, there have been significant reductions in the number of staff in post since 2008 despite recommendations by the Expert Group on AVFC for increases in mental health staffing. The situation is more severe in child and adolescent mental health services with just over half of the staff required in post.

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.

In its 2017 Operational Plan, the Mental Health Division stated 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.

However, in 2018, there was less than 40% of the required number of clinical psychologists in post in CAMHS, less than 50% of social workers and less than 60% of occupational therapists. In general adult services, there was 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.

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.

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.

There is a fundamental requirement to invest in staffing in specialist mental health services, with a greater focus on recruitment of allied health and social care professionals. There is

[12] HSE. (2018). Workforce Planning – Mental Health Assessing Supply and Demand. Dublin: HSE

also significant scope to invest in peer support workers. In its Workforce Planning document, the HSE identified peer support workers as one of the top three disciplines that will be required in mental health service delivery going forward. It is imperative that there is a continued focus to recruit and sustain these positions in mental health services across the country.

Finally, 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: Establish 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 / 48 WTE staff is a welcome commitment. As of April 2019 recruitment was complete for 36 out of the 48 vacancies.[13]

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 next 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. Of a total of 408 child admissions in 2018, 20% (84 admissions) were to adult mental health inpatient services.[14]

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. 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!".*

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 in one CHO to full cover in others. 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".[15]

[13] HSE. 8th April 2019. Response to Parliamentary Question 10789/19.
[14] MHC (2019). Mental Health Commission Annual Report 2018. Dublin: MHC
[15] Ombudsman for Children Office. (2018) Annual Report 2017. Dublin: OCO.

The OCO expressed concern about the lack of out-of-hours services for children, and recommended that Government prioritise the development of its inpatient mental health services and out-of-hours facilities across all CHO's.[16] The Seanad Consultative Committee on Child and Adolescent Mental Health Services has also recommended that "as a priority 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".[17]

At an international level, 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 of April 2019, the HSE had no planned date for completion of a costed implementation plan for providing 7/7 CAMHS. This is in contrast to the HSE's commitment to develop a seven day per week service for CAMHS to ensure appropriate support for children and young people, as set out in the HSE National Service Plan 2019.

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.

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 doubt, there are models of good practice at both national and international level, that could 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. The out of hours service provided by Galway child and adolescent mental health services is often looked to as a model of good practice.

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

[16] Ombudsman for Children Office. (2018). "Take My Hand" Young People's Experiences of Mental Health Services, Dublin: OCO

[17] See Seanad Public Consultation Committee Report on Children's Mental Health Services October 2017.

Care Concordat is implemented, including the provision of an out-of-hours mental health services. 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 referred to 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.[18] 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 more.

Sláintecare includes a specific commitment to extending counselling in primary care beyond medical card holders through a funding allocation of €6.6 million over three years. The rationale of the Committee is that "if people get the right intervention at the right time, they may not need to access other more acute/crisis mental health services. Extending counselling in primary care is a way of addressing mental health needs at a lower level of complexity, providing universal access to 6-8 counselling sessions for those whom their GP determines is in need of the service."

The Joint Committee for the Future of Mental Health Care also expressed concern over a lack of accessible counselling services and the insufficient funding allocated by the State in this area compared to psychotropic medication. In line with this, the Committee recommended that the Government increase investment in counselling and talk therapies.

Mental Health Reform also 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 these commitments translate into practice and are carefully aligned with the presenting need of each particular CHO. Data from 2018 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 the service 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.

[18] Information provided by CIPC.

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.[19]

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 sanctioning of the recruitment of 114 assistant psychologists for primary care teams across Ireland. The addition of these posts is a positive step towards providing earlier access to mental health 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. At the end of August 2018 there were 6,340 children on a waiting list for a primary care psychology appointment, a quarter of which had been waiting more than a year to be seen.

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.

This estimate is simply 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.

[19] HSE. (2018). Counselling in Primary Care Service National Evaluation Study Report of Phase 1, Dublin: HSE.

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.

A recent small scale study[20] 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[21] for people with mental health difficulties and very few individuals have accessed such services.[22] 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 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.

[20] Mental Health Reform. (2017). Advocacy Needs of Mental Health Service Users Living in the Community: A Pilot Study 2017, Dublin: MHR.
[21] 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).
[22] 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.

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.

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".[23] 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 the opportunity to 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.

Recommendation 2: Invest in community and voluntary organisations that provide mental health services and supports across the country. The C&V sector should be appropriately recognised and supported to build their capacity to improve the mental health outcomes of their client groups.

Government and its agencies, including the HSE must sufficiently recognise and support the valuable, essential and complementary role of the community and voluntary sector in supporting the mental health needs of the population. Community and voluntary (C&V) organisations provide wide-ranging support for individuals experiencing mental health difficulties, including capacity-building and training programmes, information and sign-posting, resource centres, peer support groups, talking therapies, and crisis supports such as helplines and 'out of hours' services. C&V organisations also engage in the prevention of mental health difficulties including awareness raising, mental health promotion and stigma reduction programmes in communities around the country.

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

In recent years, demand on community and voluntary organisations' services has grown considerably. For example, MyMind, Centre for Mental Wellbeing, reported an increase of 55% in counselling and psychotherapy appointments between 2018 and 2019.

The work of the C&V sector has shown to positively impact on the mental health outcomes of people using its services. For example, in a study of the Life Skills Group programme, facilitated by Aware, it was found that there were statistically significant reductions in terms of scores of depression and anxiety seen in participants on completion of the programme and these differences were maintained at 12-month follow-up. The programme had an uptake of 2,174 individuals across the country in 2014.[24] Other successful examples from the C&V sector include the positive outcomes of Jigsaw's early intervention services and Suicide or Survive's suicide prevention programmes.

Peer-led local community projects such as Gateway and Áras Folláin have also proved successful. A survey conducted with their clients showed that over half of participants reported some or a significant reduction in the symptoms of their mental health difficulties (53.8%). Furthermore, just over two-fifths reported some or a significant reduction in hospital admission (43.9%) and attendance at mental health services (43.9%). Moreover, participants reported positive impacts on their recovery, management of mental health, and self-empowerment.[25]

The valuable role community and voluntary organisations have to play in supporting the mental health of individuals and communities is evident. However, adequate resourcing of the sector should be ensured to support new and existing mental health initiatives across the country. Financial instability and uncertainty is commonly cited as a risk among C&V organisations. As stated by Gateway, "significant project resources are directed towards continuously identifying funding sources and fundraising, which diverts personnel from consolidating and further developing the projects and financial uncertainty hinders the capacity to plan for the future."[26]

During the economic crisis many of MHR's member organisations received substantial cuts to their public funding. In the context of mental health NGOs, many of whom are relatively small, these cuts hit disproportionately badly as there was little scope for efficiencies. The Government should ensure that funding for mental health NGOs that have demonstrated promising innovations and/or provide valuable, community supports is protected from cuts that would reduce their services in future.

Finally, in the context of mental health care, community supports can often provide value for money by reducing relapse and preventing individuals from requiring costly specialist mental health services and hospitalisation. For example, with regard to peer support, a study by the Centre for Mental Health showed that "the financial benefits of employing peer support workers do indeed exceed the costs, in some cases by a substantial margin."[27] An evaluation of the FRIENDS PROJECT in Ireland has "highlighted the benefits of peer support as a method of service provision for the family members of those with mental health

[24] Aware. (2015). 2014 Annual Report and Accounts, Dublin: Aware
[25] Murphy, R., Lindenau, A., Corrigan, C., Downes, C., and Higgins, A. (2016). Development and impact of peer-led mental health support in the community: A review of Áras Folláin and Gateway. Dublin: Mental Health Ireland.
[26] Ibid.
[27] Trachtenburg, M., Parsonage, M., Shepherd, G. & Boardman, J. (2013) Peer Support in Mental Healthcare: Is it good value for money? Centre for Mental Health, UK.

difficulties. Not only does peer support empower family members with crucial life experience, it also represents value for money".[28]

Considering the role of the community and voluntary sector, the much needed supports and services they provide, and the proven benefits of these services, the Government should prioritise the funding of C&V organisations working in the area of mental health as a way of promoting mental health in communities, fostering recovery and social inclusion of people with mental health difficulties and in effect improving the mental health outcomes of people living in Ireland.

Departments of Health and Housing

Recommendation 3: The Departments of Health and Housing should jointly provide a national sustainable funding stream for tenancy sustainment supports, where required, for individuals with severe and enduring mental health difficulties (including those transitioning from HSE supported accommodation and for mental health service users living in other types of accommodation in the community) in order to prevent homelessness and promote recovery.

Specifically, Government should allocate €180,000 in Budget 2020 to fund three dedicated support workers to provide tenancy sustainment support (low, medium and high support) for 100 individuals with severe and enduring mental health difficulties.[29] These posts should be funded on an ongoing, basis, year on year, and should account for any increased costs such as PRSI, etc.

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

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

At a national level, the Expert Group on *A Vision for Change* recommended that "opportunities for independent housing should be provided by appropriate authorities, with flexible tenancy agreements being drawn up in accordance with each service user's needs". "Arrangements that best enable service users to move from high-support to low-support and independent accommodation need to be considered".[30]

More recently, there has been a commitment within the Programme for Government to "establish dedicated funding supports for tenancy sustainment for people transitioning from

[28] Brennan, A. (2016) FRIENDS PROJECT EVALUATION, Dublin: FRIENDS project.
[29] These figures are based on estimates provided by HAIL, in line with current demand.
[30] AVFC (2006) p. 110.

HSE supported accommodation and for clients in mental health services living in other types of accommodation in the community".[31] Furthermore, the Oireachtas Committee on Housing and Homelessness has recommended the provision of "funding for visiting tenancy sustainment and support services to help prevent homelessness by working with those with mental health difficulties in their own homes".[32] Similar commitments have been made in Rebuilding Ireland, the Government's action plan on housing and homelessness.

As part of implementation of the National Housing Strategy for People with Disabilities approximately 450 people residing in HSE medium and low support accommodation are being supported to transition to independent living through joint funding between the Department of Housing and the Department of Health.

While this is a positive step, a national, sustainable funding stream is required to support other individuals living in the community who could benefit from such a tenancy sustainment programme. Currently, there are over 1,500 individuals residing in HSE supported accommodation, many of whom, could live in the community, given the right supports. A 2016 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 related need can access timely housing supports.

No doubt, tenancy sustainment supports extend beyond people in residential settings and in hospital, and include 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.

There are a number of non-governmental organisations that provide supports for independent living in the community for people with severe and enduring mental health difficulties, including Focus Ireland, Cork Mental Health Housing Association and HAIL Housing Association. A recent evaluation of Hail's Regional Visiting Support Service (RVSS), a homeless prevention service for people with mental health difficulties, highlights the effectiveness of tenancy sustainment supports. The study showed at 12 month follow up (on average) 80% of former clients of the service could be confirmed as remaining housed. 4% were deceased or had moved to a nursing home and 16% could not be traced. "These findings indicate that a large majority of those clients whose tenancies are successfully maintained at case closure, perhaps even almost all, are remaining in a tenancy at follow up".

It is important that allocated funding for tenancy sustainment supports is provided for in Budget 2020, so that the Government's policy of deinstitutionalisation is not hindered by a gap in housing support in the community. Fundamentally, it is necessary for promoting the recovery of people with mental health difficulties, in ensuring their social inclusion within the community and upholding their human rights (including to choice, respect and dignity) on a par with individuals without mental health difficulties. Clear protocols must also be established between the two Departments and their relevant agencies on supporting the effective transition of individuals to community living, in addition to tenancy sustainment.

[31] Department of the Taoiseach (2016) Programme for a Partnership Government, Dublin: Department of the Taoiseach.
[32] Oireachtas Committee on Housing and Homelessness (2016) Report of the Committee on Housing and Homelessness, Dublin: Houses of the Oireachtas.

Department of Housing

Recommendation 4: Dedicated funding should be allocated for the capital costs of providing social housing for people with severe and enduring mental health difficulties.

More specifically, Mental Health Reform recommends that Government invest €12M in Budget 2020 to contribute towards funding 100 (one bed) housing units for people with service and enduring mental health difficulties with a housing need.

AVFC makes specific recommendations in terms of social housing for individuals suffering from mental health difficulties, namely

> *"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."*

In addition, 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".

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. As mentioned above, there are currently over 1,500 individuals residing in HSE supported accommodation, many of whom, could live in the community, given the right supports. There are many other individuals, including those in long-stay inpatient mental health units, or living in the community in family homes and/or in unsuitable accommodation that have an unmet housing need.

HAIL, the approved housing body, has estimated that at any given time there are approximately 100 individuals in need of housing, or 100 1 bed units required. The majority of these units are required in the Dublin City Council catchment areas. The average price of a 1bed unit is €187,000 resulting in a total cost of €18.7M to purchase 100 units.

There are different funding streams to cover the costs of these housing units. One option is for 50% of the costs to be funded by Government under the Capital Assistance Scheme (CAS) and 50% to be covered under the Capital Advance Leasing Facility (CALF) and Private Finance Scheme. This would require an investment of €12M by Government in 2020 and an allocation of €6.7M by the Approved Housing Bodies through Private Finance.

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 and Skills

Recommendation 5: 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.

MHR recommends the appointment of 10 mental health advisors across the country based on one advisor per 100,000 in first and second level education. This will require an investment of €520,000 in 2020, considering that the cost of an annual salary for a mental health advisor equates to approximately €52,000 based on UK figures.

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. Research on mental health provision in schools across Europe shows that staff capacity, school funding and lack of specialist expertise pose the biggest barrier in implementing mental health programmes in schools. [33]

There has been a strong commitment in national policy to fostering mental health and well-being through the school environment. The Department of Education and Skills has published the "Wellbeing Policy Statement and Framework for Practice 2018-2023", which aims to ensure that by 2023:

- "the promotion of wellbeing will be at the core of the ethos of every school and centre for education and

[33] Patalay, P., Giese, L., Stanković, M., Curtin, C., Moltrecht, B., & Gondek, D. (2016). Mental health provision in schools: priority, facilitators and barriers in 10 European countries. *Child and Adolescent Mental Health, 21*(3), 139-147.

- all schools and centres for education will provide evidence-informed approaches and support, appropriate to need, to promote the wellbeing of all their children and young people

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".

The Taskforce report 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".[34]

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.[35] 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. International and national[36] reviews of this approach continue to show evidence of its effectiveness and potential.[37]

[34] WHO. (2004). Prevention of mental disorders: effective interventions and policy options. Geneva: WHO.
[35] Elias, M.J., Zins, J.E., Weissberg, R.P., & Greenberg, M.T. (2003) Promoting social and emotional learning: Guidelines for educators. Alexandria, VA: AFSP.
[36] In Ireland, 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. 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).

[37] Barry, M. M., Canavan, R., Clarke, A., Dempsey, C., & O'Sullivan, M. (2009). *Review of evidence-based mental health promotion and primary/secondary prevention*. London: Department of Health.

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 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.

Department of Justice

Recommendation 5: 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.[38] 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 developed a Psychology Service Strategy for 2016-2018 with the aim of developing psychological services for the prison population. A revised strategy is due to be published shortly. 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.

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

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 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”. 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 70 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.