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St Patrick's
Mental Health Services

Submission to the Oireachtas Joint Committee on the Future of Mental Health Care

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Contents

1.	Executive Summary	2
2.	Summary Recommendations	3
3.	An Overview of Mental Health Care in Ireland	5
4.	Status of Mental Health Care in Ireland	6
5.	Future Outlook	10
6.	Recommendations	11
7.	Key Performance Indicators	17
8.	References	18

Executive Summary

St. Patrick's Mental Health Services' vision is a society where all citizens are given the opportunity to live mentally healthy lives. St. Patrick's Mental Health Services (SPMHS) works to provide the highest quality mental health care, to promote mentally healthy living and mental health awareness, to advocate for the rights of those experiencing mental health difficulties, to support the investigation into and the enhancement of evidence-based knowledge and to develop the competencies of those committing to work in mental health and the organisations providing mental health care.

This submission outlines key guiding principles for the mental health care system. It examines the requirement for a rights-based strategy which adequately reflects the needs and views of all stakeholders including service users and the independent sector. It also identifies some of the key challenges in mental health care provision and provides recommendations on addressing these challenges.

Recommendations Summary

1. Adopt a rights-based approach into a new mental health strategy encompassing the four essential elements of availability, accessibility, acceptability and quality.

2. Enshrine the right to good mental health care in law. Everyone should have access to basic mental healthcare services as a right. The exact services to which people are entitled access should be set out in law, so that it is clear to both service providers and service users that legal obligations exist and that a right of remedy exists where these are not provided.

3. Develop and implement a comprehensive new rights-based national mental health strategy in consultation with key stakeholders outlining clear lines of accountability.

4. Provide adequate resourcing to develop mental health services. The mental health budget should represent at least 8.24% of the overall health budget.

5. Ensure access to services for disadvantaged groups and provide training for staff on awareness of and expertise in meeting the mental health needs of vulnerable and disadvantaged groups.

6. Introduce formal supports for those caring for a person with mental health difficulties.

7. Develop and progress the full range of Child and Adolescent mental health services. Ensure all children under 18 have access to age-appropriate services in a timely manner.

8. Continue to educate young people on mental health issues to reduce stigma, support mental health, and raise awareness of available services.

9. Harness new technologies by researching and developing a range of evidence-based treatments that are efficient and cost-effective that could be used in the Irish context. Develop a range of e-mental health preventive, direct access services and a 24-hour centralised e-mental health referral and assessment service.

10. Develop advocacy and information services for children. A national specialist independent advocacy service for all children under 18 years who are engaging with mental health services should also be developed.

11. Develop a methodology to meet the mental health needs of an ageing population.

12. Address the human resources needs of services. Based on the new strategy a ten-year human resources and recruitment strategy should be developed for mental health services, outlining the current and future staffing required and a methodology for securing these staff.

13. Develop an integrated primary, secondary and community mental health care model grounded in evidence-based best practice principles

14. Introduce a comprehensive 10- year stigma reduction programme.

15. Consult mental health service staff in relation to any proposed changes and ensure sufficient support is provided to carry out their roles.

16. Introduce a value-based system of mental health care focusing on health outcomes per euro spent. This system could be achieved by the introduction of a bundled payment model.

17. Introduce an incentive programme for the introduction of electronic mental health records.

18. Establish Key Performance Indicators as measures of effectiveness and performance.

An Overview of Mental Health Care in Ireland

The mental health of a population significantly influences the economic and social health of a country. Mental Health care is not only an investment in an individual's quality of life but is also an investment in creating a vibrant and robust Society. Creating a mentally healthy society involves building a comprehensive system of awareness raising and education and providing accessible and effective mental health care services.

The WHO, in a report published in 2017[1] indicates that in 2015 the proportion of the global population with depression was estimated to be 4.4%, an increase of 18.4% over the ten years from 2005-2015. The proportion with anxiety was estimated to be 3.6%, an increase of 14.9% over the ten-year period. Irish research indicates that 22% of Irish adults' report having or having had a mental health problem[2]. One in three Irish children under 13 will experience a mental health difficulty and this increases to one in two for Irish young people under 23.[3]

In Ireland, as in other developed countries, the mental health care system is determined by political ideology, economic conditions, international and national legislative obligations and societal beliefs and expectations.

From the founding of the State until the 1980's mental health care services in Ireland were mainly delivered through psychiatric hospital based in-patient care supported by community based psychiatric teams. In the 1980's a number of government policy papers outlined the need for reform of the system. This culminated in the launch, in 2006, of A Vision for Change (AVFC)[4], the mental health care policy that has underpinned mental health care delivery for the last eleven years.

AVFC is described as a framework for building and fostering positive mental health across the entire community and for providing accessible, community based, specialist services for people with mental illness. It outlines a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It proposes a person-centred treatment model provided through an integrated care plan, reflecting best practice, and involving agreement from service users and their carers'.

Up until 2007, the main legislation impacting on the delivery of mental health care in Ireland was the Mental Treatment Act 1945. This was replaced by the Mental Health Act 2001 [5] which was fully enacted in 2007. This Act is grounded in the best interests' principle stating that "in making a decision…concerning the care or treatment of a person…, the best interests of the person shall be the principle consideration". The Act provides for the involuntary admission to approved centres of persons suffering from mental disorders and for the independent review of these involuntary

admissions. It further provides for the establishment of the Mental Health Commission, the introduction of Mental Health Commission Tribunals and the appointment of the Inspector of Mental Health Services. Since its enactment a number of regulations and standards have been produced and placed on a statutory footing to support the Act. These form the basis of inspections of approved centres.

Ireland is a signatory to a number of UN conventions, two of which, the UN Convention on the Rights of the Child (UNCRC) and the UN Convention on the Rights of People with Disabilities (UNCRPD) are particularly important to the provision of mental health services. The latter, when ratified, will strengthen the rights of people who lack capacity and those that are the subject of involuntary detention. As part of the preparatory work for ratification new Assisted Decision Making and Capacity legislation was introduced in 2016. This legislation has yet to be implemented. The UNCRC combined with Irish constitutional provisions effectively places a statutory obligation on the Irish state to provide mental health care for children requiring such care and to protect their rights within this care system.

Current Status of Mental Health Care in Ireland

Mental health services in Ireland are provided by the Health Service Executive (HSE), independent organisations and voluntary organisations.

HSE Services: The HSE is the main provider of mental health care and delivers services through primary care, community teams, psychiatric units in general hospitals and psychiatric hospitals. At the end of 2013 only five psychiatric hospitals remained in service compared to fifteen in 2009 [6]. Some of these have been closed or have become only partially operational since then. Most of the hospitals in which psychiatric units are based are run by independent Boards or religious organisations with the largest proportion of their funding coming from the HSE, on whom, as a result, they are financially dependent.

The Mental Health Commission Annual Report 2016 [7] indicates that there are 2,791 adult in-patient beds in the country. The HSE provides 2,198 beds, St. Patrick's Mental Health Services provides 293 beds, St. John of God provides 183 beds and Highfield Healthcare provides 110 beds. Lois Bridges, a privately-run eating disorders service, provides 7 beds. The most recent Health Research Board Irish Psychiatric Units and Hospital Census 2016[8] indicates that there were 17,290 admissions to in-patient mental health care in 2016. 3,000 (17.4%) were to St. Patrick's Mental Health Services.

The HSE's Performance Report for July to September 2017[9] indicates that 74.3% of people referred to a community adult mental health team for an adult mental health appointment were seen within 12 weeks and that 95.5% of those referred to Mental Health Services for Older Persons were seen within 12 weeks. The report indicates that over 1,472 children and adolescents waited longer than three months for a first appointment and that over 300 had waited over a year.

In 2006 the Government established an Independent Monitoring Group to review the implementation of AVFC. This group produced six reports and was then disbanded by the Minister for Mental Health and Disabilities at that time, Kathleen Lynch. In its final report produced in 2012[10] the group state "It is clear that the implementation of

AVFC to date has been slow and inconsistent. There is a continued absence of a comprehensive, time lined and costed implementation plan and a lack of coherency in the planning and development of community based services. There is an absence of the ethos of recovery and poor development of recovery competencies in service delivery resulting in a reactive rather than a proactive approach to the needs of individuals and their families".

A report produced by Mental Health Reform in 2015[11] outlines that progress of implementation of AVFC continues to be hindered by shortfalls in staffing and the lack of a clear implementation plan. It identifies that throughout the last nine years there has been no information system that can report on inputs, outputs and outcomes of mental health service delivery. The report outlines how in the early years of AVFC, the restructuring within the new HSE slowed implementation and designated investment funds were lost to other parts of the health service and eventually stopped for a period. The report suggests that the economic crisis played a significant role in reducing mental health service resources, while at the same time, the demand for mental health supports increased "pushing a bleeding mental health service very hard".

Development of all areas of specialist mental health care delivery, old age care, intellectual disability and forensic care has been weaker than anticipated. This is particularly true of child and adolescent mental health care. The fifth and last HSE Child and Adolescent Mental Health Service (CAMHS) Report[12] published in 2014 indicates that over 100 children are admitted to adult in-patient units annually. These difficulties are confirmed by the Mental Health Reform Report which outlines that there are no CAMHS specific quality standards and guidelines and no quality and outcome monitoring system for CAMHS. The report identifies that in March 2015, the operational capacity of the Child & Adolescent Acute In-patient Units was 58 beds out of a total existing bed complement of 66. AVFC recommends 118 child and adolescent in-patient beds based on the 2011 census population data. The report further identifies a number of specific gaps in specialist services for children and young people and a lack of capacity in primary care services to effectively detect, treat and appropriately refer child and adolescent mental health difficulties. In addition, a small number of children are sent by the HSE to the UK and Canada annually for highly specialised in-patient treatment which is currently not available here.

<u>The Independent service providers</u>: Independent service providers in Ireland primarily deliver in-patient services. St. Patrick's Mental Health Services is an exception to this providing a range of community based Dean Clinics and a comprehensive Day Care Service. The waiting time for admission to independently run in-patient services is, by its nature, short. Access to these services is usually dependent on people having private health insurance and wait times can be less than a day. Waiting times for day services are also short while waiting times for SPMHS's Dean Clinics can be up to two months. All referrals to Dean Clinics are triaged to ensure urgent referrals are identified and addressed immediately.

<u>The voluntary service providers:</u> Voluntary organisations mainly concentrate on providing early intervention and prevention services such as helplines and support groups. Some provide one-to-one and group counselling. These organisations focus primarily on helping prevent people from developing acute mental health difficulties and on providing them with ongoing emotional support following acute episodes. One

focuses on helping people who self- harm within a model that sees self-harm as a sign of emotional distress and not necessarily an indication of a mental health difficulty while another is based on a brief counselling intervention model and has a number of centres around the country. There is also a community based counselling service for adults which operates a tiered payment for treatment system. It has a self-funding model but receives some HSE support. Some voluntary organisations have expanded their services over the last five years while others have contracted. Some have begun to focus on providing internet based support as a mechanism to replace costlier face-to-face and telephone based counselling. In the last five years a number of voluntary or commercially run internet based support services have been established.

Staffing: Within the HSE, staffing of specialist mental health services is a significant difficulty. The AVFC monitoring group identified that the effects of the recruitment embargo in 2010 and 2011 disproportionately and indiscriminately reduced the availability of professional mental health service staff. The Mental Health Reform report confirms that in 2015 staffing levels remained 11% below those of 2008. It outlines that of the 119-general adult community mental health teams and 77 child and adolescent mental health teams none have the full complement of staff recommended in AVFC. The HSE Mental Health Division Operational Plan for 2017 [13] identifies 1400 vacancies.

The independent sector is also experiencing difficulties recruiting although these organisations have the flexibility to develop innovative recruitment strategies and to offer competitive salary scales. Staffing levels in St. Patrick's Mental Health Services remain consistently between 95% and 100%. Staffing within the voluntary sector is less problematic given its flexibility to utilise more diversely qualified professionals and volunteers.

Quality Measurement: The quality of mental health services is assessed by the Mental Health Commission through its inspection process which focuses on measuring compliance with its statutory standards and regulations. Over the last number of years, the number of approved centres achieving full compliance with these standards and regulations has been limited. In 2015 the Mental Health Commission supplemented its inspection system, with the introduction of the Judgement Support Framework[14] SPMHS's three approved centres have had the most consistent track record of compliance. Some organisations, including St. Patrick's Mental Health Services participate in other quality and accreditation processes focused on specific services. These include the Quality Network for Inpatient CAMHS, the ECT Accreditation Service and POMH-UK.

Financing of services: In 2011 the statutory funding of mental health services had reduced to 5.3% of overall health expenditure, short of the 8.4 % believed to be needed to implement AVFC [4]. Since 2011 additional expenditure has been allocated to this budget, mainly earmarked for specific purposes. In 2017 the HSE budget for mental health care was €853.7m. In 2018 the HSE budget for mental health care increased by €35m. However, €20m of this relates to funding promised in 2017 resulting in a 1.76% increase in overall funding.[15] The substantial extra funding required for the delivery of AVFC has not been provided to date.

The funding of independent mental health service provision comes mainly from the payment of treatment fees, the majority of which is paid by private health insurers. These payments are primarily based on a per-diem rate and the amount of cover insurers are obliged to provide (100 days per annum) is governed by the Minimum Benefits Regulations contained in the Amended Health Insurance Act 1994. The per-diem rates paid by insurers are negotiated by each service provider separately. 46% of the Irish population has private health insurance up slightly on the number insured in 2015.[16] The per-diem rate paid to independent mental health providers includes payment for all care provided unlike the per-diem rate paid to general hospitals where consultant and procedural costs are billed separately. The funding of voluntary mental health services comes mainly from fundraised income, fees for service and grant aid from the HSE.

<u>Governance:</u> The HSE primary care, community services, child and adolescent in-patient services and psychiatric hospitals are governed and managed directly through the HSE management structures. The mental health management teams report to a Director. This Director reports to and is a member of the Board of the HSE. The HSE Board reports to the Minister for Health. Most of the HSE's adult in-patient services are run from psychiatric units based in general hospitals and these hospitals are governed and managed by independent Boards. The staff in these units are primarily HSE staff.

Independent service providers, including St. Patrick's Mental Health Services are governed and managed by independent Boards. Voluntary organisations are governed and managed by independent Boards with some containing HSE representatives. Most organisations receiving HSE funding do so through section 38 or 39 of the Health Act 2007 which enables the HSE to set certain conditions around usage of the funding.

<u>Electronic Health Records (EHR):</u> Unlike other countries, movement towards developing electronic health records in Ireland has been slow. Legislation regarding the establishment of a unique health identifier has only been recently introduced. St. Patrick's Mental Health Services introduced a new electronic mental health record system, eSwift, in 2017. St. John of God has developed its own bespoke EHR system while the HSE is now working to progress a generic electronic health record system across all of its services.

<u>Public Awareness and Advocacy:</u> There is general acknowledgement that mental health may be one of the most neglected public health issues across the world. In the book Mental Health Policy and Practice across Europe[17] the Director of the Open Society Institute states: "Stigma, prejudice and discrimination are widespread and deeply rooted. Many governments fail to see the treatment of people with mental health problems as an issue of human rights and there is little political momentum for reform". In the last ten years Ireland has seen a growing public focus on the issue of mental health. Driven by high levels of suicide and self-harm, high profile public figures declaring that they experience mental health difficulties and murder suicides attributed to mental health difficulties a number of awareness raising campaigns have been initiated by the HSE, voluntary organisations and SPMHS. The effects of these have yet to be determined. In 2005 the Government established the National Office for Suicide Prevention which aims to prevent suicide and monitor suicide rates. It runs

a number of suicide prevention programmes and funds a large number of suicide prevention voluntary organisations across the country.

Future Outlook

While the current programme for Government makes a recommitment to the implementation of A Vision for Change it is difficult to know if this will be delivered. There still appears to be a significant doubt regarding the future of the HSE and while the various mental health reports and service plans produced make reference to AVFC there are no clear goals or timelines outlined to implement the strategy. The substantial financial resources required for implementation are unlikely to be provided in the near future and any additional finances provided are being utilised to address existing shortfalls.

It is likely that the regulatory environment will continue to become more challenging and the staffing crisis facing the sector cannot be resolved in the short term. The state's obligations under the constitution and the United Nations Convention on the Rights of the Child are likely to place additional momentum behind addressing the shortfalls in child and adolescent mental health services. There are significant challenges and reform required to ensure full ratification and implementation of the UNCRPD.

There is no commitment to the development of a national electronic mental health record and it is likely that the HSE will immerse its mental health services records into a general electronic health record when such a system is developed. The effectiveness of ICT delivered mental health treatment services and the financial model underpinning them has still to be ascertained. While the companies developing such treatment models have had some commercial success it is still unclear whether these models provide gateways to traditional services or can be utilised as effective replacements for face-to face services. It is however likely that there will be significant development in this area in the next ten years.

The future for mental health care in Ireland is uncertain and challenging. Addressing the deficits created by years of underfunding will require substantial commitment and resources. Service users and their families are a disempowered group. Because of the stigma associated with having a mental health difficulty few will campaign for improved services.

Recommendations

1. Take a rights-based approach to the mental health care system and enshrine the right to good mental health care in law

The right to health, healthcare or mental health treatment is not clearly defined in Irish law. The Convention on the Constitution made a recommendation to enumerate a number of economic, social and cultural rights, including the right to essential healthcare, in the Constitution of Ireland.[18] However, the 2016 *Programme for a Partnership Government* commits only to refer the recommendation to the Housing Committee but does not address the recommendation in the context of the right to health, healthcare or mental health treatment.[19]

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health has been recognised in a number of international human rights treaties.[20] The goal of a human rights-based approach is that all health policies, strategies and programmes are designed with the objective of improving the enjoyment of all people to the right to health.[21]

There are four key elements for the introduction of a rights based mental health care system; availability, accessibility, acceptability and quality.

Recommendations

- A rights-based approach to mental health care should be adopted into any mental health strategy encompassing the four essential elements of availability, accessibility, acceptability and quality.
- The right to good mental health care should be enshrined in law. Everyone should have access to good mental health care services as a right. The exact services to which people should be entitled to access should be set out in law so that it is clear to both service providers and service users that legal obligations exist and that a right of remedy exists where these are not provided.

2. Develop and implement a comprehensive new rights-based national mental health strategy in consultation with key stakeholders outlining clear lines of accountability

Any new strategy should be rights-based and grounded in a recovery ethos. The Donabedian model of healthcare aligns with the recent approach adopted by the Office of the High Commissioner for Human Rights (OHCHR) in developing human rights indicators to measure progress on a particular rights issue.[22] Both models use structural, process and outcome indicators.

SPMHS supports the Mental Health Commission's vision of a "quality mental health service that is founded on the provision of recovery-based care, dignity and autonomy for service users".[23] To achieve this type of service and to ensure adequate accountability, stakeholders including staff, service users and representatives from the independent and voluntary sector need to be consulted in developing the strategy.

As part of the development of this strategy a comprehensive data base of all of the services currently being provided by the HSE, independent providers and voluntary organisations should be compiled and maintained. These should be used as a foundation on which to build a new fully inclusive, costed, innovative strategic plan for the delivery of the highest quality recovery based and human rights driven mental health care. The role each of the service providers can and should play in delivering this strategy should be outlined. Service users should have a key role in developing this strategy.

Recommendation:

- Develop a new mental health strategy that is rights-based with a focus on recovery. Ensure it is informed by, and inclusive of, all stakeholders and be conducted in a way to ensure buy-in from service users and their families.[24]

3. Provide adequate resourcing to develop high quality mental health services

In 2015 mental health funding fell significantly below the recommended level contained in *A Vision for Change.*[25] Despite an allocation of €160 million between 2012 and 2016 to the development of community based mental health services and supports, development of services has been hindered by issues relating to staff recruitment, with less than a 7% increase in staff between 2012 and the beginning of 2016.[26]. Funding of mental health services remains insufficient.

Recommendation:

- Ensure the mental health budget is at least 8.24% of the overall health budget.

4. Ensure access to services for disadvantaged groups

In 2015, the UN Committee on Economic, Social and Cultural Rights (CESCR) noted its concern in the Irish context at the "overall deterioration in health-care services due to significant budget cuts in public health in recent years"[27] and notably the negative impact on access to health services by disadvantaged groups. *A Vision for Change* recognises the need for extra funding in certain geographical areas of social and economic disadvantage which have an associated high prevalence of mental ill health.[28] Access to services is also influenced by staff expertise and awareness. Training needs to be provided to staff to ensure they are aware of and can meet the mental health needs of disadvantaged and vulnerable groups e.g. training for trauma-informed care.

Recommendation:

- Ensure access to services for disadvantaged groups and provide training for staff on awareness and expertise in meeting the needs of disadvantaged and vulnerable groups.

5. Introduce formal supports for family members and those caring for a person with mental health difficulties.

A Vision for Change recognises the importance of supporting carers and children of service users[29] but does not make a specific recommendation on assessing and meeting their mental health support needs. Currently supports for families caring for a person with mental health difficulties are provided on an ad hoc basis around the country by

different voluntary groups which have developed useful guidelines underpinned by the principle of providing family support to help minimise the significant adverse effect of caring for a person with mental health difficulties.[30]

Recommendation:

- Introduce formal supports for family members and those caring for a person with mental health difficulties.

6. Develop and progress the full range of Child and Adolescent mental health services

SPMHS notes that in its 2016 Concluding Observations, the UN Committee on the Rights of the Child highlighted that the full range of Child and Adolescent Mental Health Services (CAMHS) needs to be further developed to ensure that children and young people receive age-appropriate supports and are not continually placed in adult facilities.[31] In April 2016, of the child and adolescent service users admitted to hospital, only 69.2% were admitted to dedicated child and adolescent inpatient units, despite this being considered a priority issue.[32]

Recommendation:

- Develop and progress the full range of Child and Adolescent mental health services and ensure that all children under 18 have access to age-appropriate services in a timely manner.

7. Continue to educate young people on mental health issues to reduce stigma, support mental health, and raise awareness of available services.

The 2013 *Guidelines for Mental Health Promotion and Suicide Prevention* for post-primary schools is a welcome step in addressing the need for education and awareness-raising of mental health issues amongst young people. However, it is also important to reduce the associated stigma around mental health services by taking practical steps to ensure that young people engage in the issue. For example, in this context SPMHS has developed a transition year programme which gives second-level students educational placements in its services.[33]

Recommendation:

- Continue to educate young people on mental health to reduce stigma, support mental health and to raise awareness of available services.

8. Harness new technology

In a 2014 report the OECD concluded that the "increased use of innovative evidence-based treatments, such as psychological treatments and eMental Health will help address the treatment gap for mild-to-moderate disorders"[34] Beating the Blues', a computerised Cognitive Behavioural Therapy (CBT) treatment used by the British National Health Service (NHS) to treat depression and anxiety, is a prime example of an evidence-based and effective technological intervention in mental health care with proven results in overcoming depression. Research demonstrates that patients report 'significantly higher treatment satisfaction' while the programme itself is also cost-effective.[35] It can be carried out through primary care services[36] while it also addresses 'the enormous requirement for evidence-based psychological treatment of common

mental health problems in the context of a severe shortage of trained therapists to meet that need.[37] As part of the new strategy a range of e-mental health preventive, direct access services should be provided and a twenty-four hour centralised mental health referral and assessment service should be established to provide access to more specialised services.

Recommendations:

- Research evidence-based treatments using new technologies that are efficient and cost-effective that could be used in the Irish context.
- Develop a range of e-mental health preventive, direct access services and a twenty-four-hour centralised e-mental health referral and assessment service.

9. Develop advocacy and information services for children

An independent advocacy and information service exists for adults with mental health difficulties,[38] but there is no equivalent national, independent service for those under 18 years, particularly those using in-patient services as recommended by the UN Committee on the Rights of the Child in its examination of Ireland in January 2016.[39] This is a violation of the child's right to access information,[40] to be heard in decision-making,[41] and to participate fully as service users in mental health service provision.[42]

Recommendation:

- Establish a national specialist independent, advocacy service for all children under 18 years who are engaging with mental health services.

10. Develop a methodology to meet the mental health needs of an ageing population

As the number of over-65s is set to almost treble by 2046,[43] the State will need to address the increasing mental health needs of older people and ensure that people can achieve healthy and successful ageing,[44] a concept reflected in the *National Positive Ageing Strategy*.[45]

Recommendation:

- Commission research into the types of services that may be required to address the mental health needs of an increased older population

11. Address the human resources needs of services

Recruiting and retaining motivated and skilled staff remains vital for the delivery of increasingly demanding and challenging mental health services to an expanding and varying demographic population".[46] However, a shortfall in staff remains a particular challenge to the delivery of mental health services.

Recommendation:

- Based on the data base of services and the new strategy a ten-year human resources and recruitment strategy should be developed for mental health

services, outlining the current and future staffing required and a methodology for securing these staff.

12. Develop an integrated primary, secondary and community mental health care model

There is no definitive model of an integrated mental health care system to ensure that service users will have access to a high-quality and efficient system,[47] however, research indicates that there are a number of principles associated with successful integration processes and models.[48] These include: "(i) Comprehensive services across the care continuum (ii) Patient focus (iii) Geographic coverage and rostering (iv) Standardised care delivery through inter-professional teams (v) Performance management (vi) Information systems (vii) Organizational culture and leadership (viii) Physician integration (ix) Governance structure (x) Financial management".[49]

In the experience of SPMHS, service users do not always want to receive treatment for mental health issues in the same place as they attend for treatment for physical complaints. However, the World Health Organisation has long recommended the integration of services as:

> "primary health care services are not associated with any specific health conditions, stigma is reduced when seeking mental health care from a primary health care provider… making this level of care far more acceptable - and therefore accessible - for most users and families."[50]

Despite recommendations to improve access to mental health services through primary care, GPs continue to find it difficult to communicate with specialist mental health services.[51] However, GPs and other primary care providers operate differently to community services, so this must be taken into consideration when planning for further integration.

Recommendation:

- Ensure that any proposals to integrate primary, secondary and community mental health care services are informed by the key principles above.

13. Introduce a comprehensive stigma reduction programme

Negative societal attitudes towards mental health issues persist with the SPMHS 2015 attitudes survey finding that 67% of respondents consider "that Irish people view being treated for a mental health difficulty as a sign of personal failure".[52] SPMHS welcomes the recognition in the *Programme for a Partnership Government* that tackling mental health stigma "will require a wider and more concerted effort across all aspects of society, not just focussed upon our health services".[53] However, a societal failure to understand the true nature of mental health difficulties clearly persists. See Change, the national stigma reduction partnership works to address and reduce stigma. SPMHS runs the very successful Walk in my Shoes anti stigma campaign. Initiatives such as these should be developed to become fully funded comprehensive national programmes. For example, the Scottish Government prioritised action to tackle stigma and the associated discrimination faced by people who suffer from mental ill health. In 2013 it allocated multi-annual funding of £4.5 million, in conjunction with Comic Relief, over three years to the See Me stigma reduction programme and reframed it to focus on impact and outcomes rather than outputs.[54]

Recommendation:

- A comprehensive stigma reduction programme needs to be introduced and sustained.

14. Ensure buy-in from mental health care professionals

In putting in place any plan to further integrate services, staff buy-in will be essential. According to the 2014 Health Services Employee Survey, while many employees across the Health Service indicated that they were fairly satisfied in their role, 40% of those working in the HSE did not feel their work performance was recognised, while a further 60% were dissatisfied with the extent to which the Health Services value their work.[55] There were also concerns about strategy and change management[56] which will need to be addressed and managed in order to ensure staff confidence at all levels. Exposure to risk is an area of concern for staff and they must feel supported in their roles to ensure that they have full confidence in their ability to carry out their job.

Recommendation:

- Consult with Mental Health Service staff in relation to any proposed changes and ensure that they are sufficiently supported to carry out their roles.

15. Introduce a value based system of healthcare

A value based system of health care focuses on increasing value for service users which involves moving away from volume and profitability of services provided[57] and shifting to measuring service user outcomes achieved per euro spent.[58] A value based system is an effective way to contain costs as the focus is on improving outcomes. In a value based model achieving and maintaining good mental health is less costly than dealing with poor mental health.[59] Outcomes are the ultimate measure of quality of mental health care, and measurement of value should focus on how well the care delivered meets the individual service user's needs. This requires following the service user through the entire process of care, looking at service users holistically, and recording all outcomes of treatment.[60]

The key components of a value based mental health care system are the creation of integrated practice units,[61] measuring outcomes[62]and costs[63] and moving towards a bundled payments system.[64] One of the fundamental drivers of escalating health care costs relates to not having a system for measuring service user's value of care.[65] Providers do not know how much it costs to deliver service user care, or how those costs relate to service user outcomes. Many participants in the health care system don't agree on what they mean by 'costs.' By standardising the measurement of mental health care costs, a determination of the value of a service user's care can be made.[66]

Bundled payments cover the entire cycle of care[67] for a service user with costs being aggregated over the full cycle of care.[68] By covering the entire cycle of care it will ensure that there is continuity of care for the service user.

For a bundled payment to maximise value it must; cover the overall care required to treat a condition, be contingent on delivering good outcomes, be adjusted for risk, provide a fair profit for effective and efficient care and should limit provider

responsibility for unrelated care or catastrophic cases.[69] Implementing a bundled payment system will reward providers for delivering better value, lead to greater integration of care, hold providers accountable for achieving outcomes and result in cost reduction[70] that occurs not at the expense of quality.[71]

Examples of the bundled payment systems for consideration by the Committee are:

- The OrthoChoice programme introduced in Stockholm, Sweden.[72]
- The Maternity Pathway Bundled Payment in the UK.[73]

Recommendation:

- Introduce a value based system of mental health care focusing on mental health outcomes per euro spent. This system should be achieved by the introduction of a bundled payment model.

16. Ensure all mental health services introduce an electronic mental health record, that meet HIMMS level 7 standards.

Electronic records improve efficiency, accountability and quality compliance. In the UK and across Europe electronic mental health records are being developed and implemented. The introduction of electronic mental health records which meet HIMMS level 7 standards needs to be incentivised in all mental health services.

Recommendation:

- Introduce an incentive programme for the introduction of electronic mental health records.

Key Performance Indicators.

The effectiveness of mental health services should be assessed by measuring and evaluating:

- Compliance with Mental Health Commission quality standards
- Real time feedback from service users and acting upon this feedback
- Clinical activity of services in real time
- Clinical outcomes data
- Research outputs
- Technology developments
- Public opinion research
- Attitudes to mental health
- Service user and carer participation initiatives
- Staff turnover and vacancy rates in real time
- Feedback from staff in real time
- The growth and impact of professional training
- Financial performance of each service in real time

END

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