IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Position Paper on

Mental Health Services

November 2010

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2

Tel: (01) 6767 273
Fax: (01) 6612 758
Email: imo@imo.ie
Website: www.imo.ie

IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Mission Statement

The role of the IMO is to **represent** doctors

in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,

efficient and effective Health Service.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Position Paper on

Mental Health Services

November 2010

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2

Tel: (01) 6767 273
Fax: (01) 6612 758
Email: imo@imo.ie
Website: www.imo.ie

Mental Health Services Overview

Mental health disorders affect one in four people each year[1] and have a profound impact on individuals, families and society. The cost to the economy in terms of lost output, healthcare and other costs, is estimated at over €3billion[2], yet just 5.2%[3] of the health budget in 2010 is allocated to Mental Health Services. In 2006, *A Vision for Change* set out policy for Mental Health Care including the transfer of services to the community setting, yet change has remained just that - "a vision". Doctors are frustrated that patients continue to be treated in antiquated institutions inappropriate to their needs and community mental health teams remain inadequately staffed for the provision of holistic multidisciplinary care. With the current economic crisis and rising unemployment, the value of good mental health and good Mental Health Services must be recognised. Members of the IMO are now urgently calling for the Minister for Health and Children to replace rhetoric with action and implement effective, sustainable Mental Health Policy.

Prevalence of Mental Health Disorders

While most people have a reasonably high level of positive mental health, psychological distress and mental health disorders are common[4] and are the leading cause of disability worldwide.

Mental health disorders range from emotional and psychological mental health problems which cause distress and interfere with everyday life, to severe and debilitating mental disorders that affect cognitive and emotional functioning, including mood disorders (e.g. depression) and psychotic disorders (e.g. schizophrenia).[5]

While different studies suggest different rates, it is thought that 27% of adults experience at least one mental disorder in one year.[6] Worldwide neuropsychiatric conditions, including unipolar depressive orders, alcohol use disorders, schizophrenia and bipolar disorders, accounts for one third of YLD (years lost due to disability) among adults. [7]

The most frequent disorders in Europe are anxiety disorders, depressive, somatoform and substance dependence disorders.[8] In Ireland 6% of adults are classified as having a major depressive disorder and 3% as having generalised anxiety disorder. [9] 25% of people (approximately 19,400 people) in receipt of illness benefit in 2009 cited mental health issues as the reason they were unfit for work - depression and anxiety accounting for almost 10,000 claims and stress for a further 4,500.[10] Women are three to four times more likely to suffer from depression than men,[11] although four times more men die from suicide than women with highest suicide rates amongst males aged 20-24.[12]

Child and adolescent mental disorders encompass a broad range from psychosis, depression and eating disorders, through anxiety and attachment disorders to autism and pervasive developmental disorders.[13] Overall 1 in 5 children under 18 have a mental or behavioural disorder at any one time, and 1 in 10 will have a disorder severe enough to cause impairment. In Child and Adolescent Mental Health Units depressive orders are the leading cause of admissions followed by eating disorders and neuroses.[14]

---

[1] Wittchen HU, Jacobi F. Size and Burden of Mental Disorders in Europe – a critical Review and Appraisal of 27 Studies, *European Neuropsychopharmacology* 2005: 15 :357-376
[2] O'Shea E. Kennelly B. The Economics of Mental Health Care in Ireland, *Mental Health Commission* 2008 : 89
[3] HSE National Service Plan 2010
[4] Barry, M.M., Van Lente, E., Molcho. M., Morgan, K., McGee, H., Conroy, R.M., Watson, D., Shelley, E. and Perry, I. (2009) *SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Mental Health and Social Well-being Report,* Department of Health and Children. Dublin: The Stationery Office.
[5] European Commission, Mental Health in the EU – Key Facts, Figures, and Activities: A Background Paper provided by the Support Project, *Luxembourg* 2008: 6
[6] Wittchen HU, Jacobi F. 2005
[7] World Health Organisation, The Global Burden of Disease 2004 Update, *Geneva: WHO* 2008 : 36:37
[8] Wittchen HU, Jacobi F. 2005
[9] Barry, M.M., Van Lente, E., Molcho. M., Morgan, K., McGee, H., Conroy, R.M., Watson, D., Shelley, E. and Perry, I. (2009) *SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Mental Health and Social Well-being Report,* Department of Health and Children. Dublin: The Stationery Office.
[10] Minihan M. 25% of Sick Claims Cite Mental Health *The Irish Times* 27 January 2010 p9
[11] Aware leaflet 2008 *A Better Understanding of Depression* http://www.aware.ie/information.php
[12] National Suicide Research Foundation (NSRF), *National Registry of Deliberate Self Harm – Annual Report 2008.* 2009: 12-15
[13] Irish College of Psychiatrists, A Better Future Now, Dublin 2004
[14] HSE Child and Adolescent Mental Health Services First Annual Report 2008, 2009 : 3

While dementia and Alzheimer's disease are a main cause of disability among the elderly,[15] depression is the most common mental health illness affecting up to one in seven people over 65 years old.[16]

Despite the fact that many mental health disorders can be successfully treated, relatively few sufferers receive even the most basic treatment.[17] In a recent survey on *Mental Health and Associated Service Use on the Island of Ireland*[18] found that less than half (43%) of people in the State who reported mental health problems attended a GP.

Factors Affecting Mental Health

A wide range of factors affect mental health including genetics, biology, individual experiences, family situation, social circumstances, and economic and environmental conditions.[19] At the same time long-term mental illness can have a significant impact on physical health, family relationships and on an individual's social and economic circumstances.

Physical Health and Mental Health

The interaction between mental and physical illness is complex and it is often difficult to determine the causal direction.[20] People with mental health problems may present to their GP complaining of physical symptoms that have no medical cause, leading to missed or delayed detection. Mental health disorders are also associated with higher rates of chronic disease[21] which particularly affect older people. Approximately, 30% of individuals with cancer, cardiovascular disease or diabetes have major depression as a co-morbidity.[22] Mental Health disorders are also linked to a wide range of risk behaviours, such as misuse of alcohol and drugs and sexual risk behaviour, [23] which tend to further compound problems.

Family Relationships, Social Isolation and Mental Health

Family relationships and social isolation can have a significant impact on mental health and vice-versa. Reported levels of depression are higher among divorced/separated people. [24] Poor levels of social support and experiencing loneliness are also strongly associated with higher levels of psychological distress. Looking after a family member or friend with mental illness can also cause a significant amount of stress to the carer, impacting on relationships as well as loss of income.[25]

Children of parents with depression have a higher risk of developing a similar disorder. [26] Parental relations, home-life and social support all impact on the psychological well-being of children and adolescents. Mental health disorders in children and young people can damage self-esteem and relationships with their peers, undermine school performance, and impact on quality of life for the child or young person as well as their parents or carers and families. Mental health problems in childhood are a strong predictor of mental health problems in adulthood. [27]

Poverty/Social Exclusion and Mental Health

Poverty is both a cause of poor mental health and a consequence. Whether defined by low income, socio economic status, living conditions or education, poverty is an important determinant of mental disability. Higher levels of psychological distress, depression and anxiety disorders are found among medical card holders, lower income groups, those with lower levels of education and those who are not in paid employment.[28] Stigma and discrimination associated with mental illness can further limit housing, education and employment opportunities, leading to further poverty and social exclusion.[29] The EU Support Project identified the following key groups whose social and economic

---

[15] AGE, AGE Response to Green Paper: Improving Mental Health of the Population 2006
[16] SNIPH Healthy Ageing – A Challenge for Europe, *Stockholm* 2007 : 14
[17] WHO and Wonca Integrating Mental Health into Primary Care 2008
[18] Tedstone Doherty D, Moran R, Mental Health and Associated Service Use on the Island of Ireland: HRB Research Series 7 HRB 2009: 13
[19] European Commission, 2008: 18
[20] Lelliott P et al, Mental Health and Work, Royal College of Psychiatrists 2008: 2
[21] European Commission, 2008: 16
[22] Department of Health and Children *Tackling Chronic Disease: A Policy Framework for the Management of Chronic Disease* , 2008 : 9
[23] European Commission, 2008: 16
[24] Barry, MM et al, 2009
[25] The College of Psychiatry and The Carers Association of Ireland, *Carers of Ireland Who cares?*
[26] European Commission, 2008: 16
[27] HSE 2009 : 3
[28] Barry, MM et al, 2009
[29] McDaid D. 2005 : 2 and European Commission, 2008: 13

circumstances may put them at increased risk of mental health problems:[30]

- Those living in relative poverty and in financial insecurity
- Ethnic minority groups
- Recent migrants and refugees
- Those who are homeless
- People with a long term physical illness or disability
- Those who care for someone with a disability or long term illness (including young carers)
- People who have drug or alcohol problems
- Victims of violence or abuse
- Those undergoing significant life transitions, trauma, loss or change
- Prisoners and ex-prisoners.

Economic Burden

Estimates suggest the overall economic cost of poor mental health in Ireland is over €3 billion. [3] Health and social care costs account for less than a quarter of overall costs (23.4%). The majority of costs occur outside the health system, in terms of lost output (66.7%) due to unemployment, absenteeism, lost productivity, premature retirement and premature mortality. Other costs include informal care, hostel accommodation and prison costs (9.5%).[32] It is thought that only cardiovascular disease contributes more to the overall burden of illness in the State. Despite this, expenditure on Mental Health Services has fallen from almost 12% in 1990[33] to just 5.2% in 2010 of the total healthcare spend.[34]

The Development of Mental Health Policy in Ireland

International best-practice suggests that the majority of emotional and psychological problems, such as anxiety disorders and mild to moderate depression, can be adequately treated in primary care while more serious mental disorders such as schizophrenia, bipolar disorder, and severe depression and personality disorder require 'balanced care' with a mixture of community-based and hospital-based services.

Over the last few decades the trend in Mental Health care has shifted from the detention model of care, often in asylums, to the provision of care in the community. Although community care is not necessarily less expensive than institutional care,[35] it is associated with improved clinical outcomes and better quality of life for patients with greater liberty and dignity.[36]

Like elsewhere in Western Europe deinstitutionalisation and community-based care has been national policy in Ireland since the 1960s, however progress has been slow and the closure of institutions has not been accompanied by the adequate development of community-based services. In 2006 Mental Health policy in Ireland was laid out in *A Vision for Change*, the Report of the Expert Group on Mental Health. With over 160 recommendations *A Vision for Change* provides a broad framework for the transfer of Mental Health Services from an institutional to a community based setting over a 7 to 10 year period. An Independent Monitoring Group was set up to report annually on its progress.

In 2007 the full provisions of the Mental Health Act 2001 came into effect which aims to secure the rights of mentally ill patients who are involuntarily detained, in line with the European Convention on the Protection of Human Rights and Fundamental Freedoms.[37] The Mental Health Commission and Inspectorate of Mental Health Services was established under the Act to determine and maintain standards in the delivery of service and to protect the rights of those involuntarily detained.

---

[30] European Commission, 2008: 15
[31] O'Shea E. Kennelly B. T 2008 : 89
[32] O'Shea E. Kennelly B. 2008 : 22-43, 89
[33] O'Shea E. Kennelly B. 2008 : 4
[34] HSE National Service Plan 2010
[35] McDaid D, Thornicroft G. *Policy Brief Mental Health II Balancing Institutional and Community-Based Care* European Observatory on Health Systems and Policies WHO 2005
[36] Barry S, Brophy J, Walsh D. The Lie of the Land: Psychiatric Service Land Disposal & Failures and Delays in Capital Development of Community Based Mental Health Services, *Irish Psychiatric Association* 2008 : 3
[37] McDaid D, Wiley M, Maresso A, Mossialos E Ireland: Health System Review *European Observatory on Health Systems and Policies Health Systems in Transition* 2009:11:4 : 188-189

Since its publication in 2006, IMO members through motions and submissions have highlighted the slow progress implementing the Mental Health Strategy including the diversion of funding away from the Mental Health Services, the failure to set up a Mental Health Directorate, inadequate and incomplete multi-disciplinary community based teams and specialist services and the continued confinement of patients in antiquated institutions unfit for purpose.

In March 2010, the IMO surveyed GP and Consultant Psychiatrist members to find out the major issues affecting the treatment of patients with mental health illness. The issues most often raised by both groups are:

- Inadequate funding of Mental Health Services
- Lack of leadership and planning
- Deficient resources allocated to Primary Care
- Primary care access to public counsellors and psychotherapists
- Access to Mental Health Services
- Undeveloped Multi Disciplinary Community Mental Health Teams
- Bureaucracy and Expense of some provisions of the Mental Health Act 2001
- Outdated inpatient facilities
- Lack of Child and Adolescent Mental Health Services including inpatient beds
- Lack of Mental Health Services for Older People
- Underdevelopment of Specialist Services
- Stigma

Lack of Adequate Funding

Lack of funding for Mental Health Services is a major issue among IMO members. The allocation of resources to fund the Mental Health Strategy lacks transparency. A study of funding allocation carried out by the Irish Psychiatric Association in 2005 found huge regional disparities in the allocation of funding, no relationship between clinical resources and population size or socio economic need and no clear relationship between significant increases in budget allocation and the establishment of new clinical resources.[38]

Capital funding for Community-based services, including funds from the sale of psychiatric lands, has yet to be released or has been diverted to other services. In the current economic climate with falling property prices, the sale of psychiatric lands cannot be relied upon to fund *A Vision for Change* while rising unemployment is likely to increase demand for services.

Poor Leadership and Planning

Successive reports from the Independent Monitoring Group of *A Vision for Change* have highlighted the failure to develop a comprehensive implementation plan and the lack of leadership and responsibility for its progress. While the HSE last year adopted an implementation plan for 2009-2013 it has not been published in its final form. A report from the Mental Health Commission[39] stated that the necessary resources to implement the plan are not identified, plans for the reallocation of financial and human resources are not included nor are any links between outcome, timeframe and resources evident. In 2009 an Assistant National Director for Mental Health Services was appointed, however there is no leader with sole responsibility for the implementation of *A Vision for Change*, nor an implementation team in place with the necessary skills and expertise.

Mental Health Services in Primary Care

GPs are the first point of contact for most patients seeking help for mental health issues. The HRB study on *Mental Health and Associated Service Use on the Island of Ireland* [40] found that despite the fact that many people do not seek help for psychological distress, GPs are a preferred source of support and 10% of people in the Republic attended their GP for mental health problems within a 12 month period. The majority of psychological and emotional problems can be treated in Primary Care and the WHO and Wonca have stated that "*integrating Mental Health Services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need,*" [41]

---

[38] O'Keane V. Walsh D. Barry S. *"The Black Hole" The Funding Allocated to Mental Health Services Where is it Actually Going?* Irish Psychiatric Association 2005
[39] Mental Health Commission (MHC) From Vision to Action? An Analysis of the Implementation of A Vision for Change, *MHC* 2009 : 35
[40] Tedstone Doherty D, Moran R, 2009: 13

However few resources have been allocated to the treatment of patients at this level.

The IMO survey of GPs found that the issues most affecting the treatment of patients included access to public counselling and psychotherapists at Primary Care level, the cost of private psychotherapy services, communication with secondary Mental Health Services and time constraints.

The value of psychological therapies, including counselling, cognitive behavioural therapy, psychotherapy and group therapy, is widely recognised in the treatment of patients with mental health issues and it is recommended in the Mental Health Strategy that "*All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist Mental Health Services.*" [42] However Primary Care access to HSE psychological services is limited.[43] While the Primary Care strategy[44] provides for the development of psychological services as part of the wider Primary Care network supporting Primary Care Teams, progress is slow. Less than half the number of teams in place and not even a quarter of teams at advanced functioning stage.[45] A range of counselling and psychotherapy services are available in the private sector, however the cost of private therapy is prohibitive for many patients, particularly Medical Card holders and patients on low incomes.

Lack of appropriate training combined with time constraints in busy surgeries limit a GP's ability to adequately treat patients with mental health problems themselves. Failure to provide psychotherapeutic services and support at Primary Care level can therefore lead to an over-reliance on drug therapy and/or unnecessary referral to equally under-resourced secondary Mental Health Services. Drug therapy again is prohibitive for individuals with low income who do not qualify for a medical card.

In many areas psychotropic medication is available free to a non-medical card patient who is prescribed the medication by secondary Mental Health Services but not to a patient prescribed the treatment by a GP. This is an anomaly that should be rectified so as to avoid inappropriate retention of patients in secondary care.

Community Multi-disciplinary Mental Health Teams

For patients requiring referral to secondary Psychiatric Services, GPs also raised the issue of access to both community and acute Mental Health Services particularly out-of-hours crisis management care. Equally, lack of developed Community Multi-disciplinary Mental Health Teams (CMHTS) was the most important issue affecting Mental Health Services raised by Consultant Psychiatrists affecting access to services and quality of care.

Central to the Mental Health Strategy was the closure of psychiatric institutions and the transfer of services to a more appropriate community setting, however four years on the 2nd Independent Monitoring Group for *A Vision for Change* was "*still not in a position to report accurately on the number of CMHTS that exist in the HSE structure*".[46]

CMHTS should comprise two consultant psychiatrists, two NCHDs, two psychologists, two psychiatric social workers, six to eight psychiatric nurses and two or three occupational therapists. While at the end of 2008 Indecon ascertained that 129 teams had been initiated, less than half the recommended numbers of staff were in place, with just one consultant per team and particular shortages of community mental health nurses, occupational therapists, psychologists and social workers.[47] Since the moratorium on recruitment in the HSE came into play in 2009, over 700 staff have left the Mental Health Services of which just 65 were replaced.[48] Failure to develop multidisciplinary teams and to replace staff has a profound effect on quality of service, limiting the ability of teams to provide social and psychological therapies and interrupting continuity of care. As mentioned above the allocation of resources and the development of services varies substantially between mental health catchment areas, and bares no relationship to populations size or socio economic need.[49] Mental health catchment areas do not correspond to Primary Care catchment areas, leading to substantial variation in services and limited choice both between and within catchment areas.

---

[41] WHO and Wonca 2008
[42] Expert Group on Mental Health Policy A Vision for Change 2006 : 61
[43] HSE, ICGP, Guidelines for the Management of Depression and Anxiety Disorders in Primary Care 2006
[44] DOHC Primary Care A New Direction Quality and Fairness Health System for You 2001
[45] Oireachtas Joint Committee on Health and Children, Second report on Primary Medical Care in the Community February 2010 : 6
[46] Independent Monitoring Group. A Vision for Change – the Report of the Expert Group on Mental Health Policy. June 2010 : 39
[47] Indecon 2009 : 37
[48] Independent Monitoring Group 2010 : 42

A Vision for Change also provided for a number of evidence-based intervention programmes to be provided by community teams including home-based services, crisis intervention and assertive outreach services to respond to the needs of people with acute illness in crisis on a 24/7 basis. However, again the establishment of these services varies between regions.

International evidence shows that early intervention services in mental health can reduce the duration of untreated psychosis, reduce the severity of symptoms, reduce suicidal behaviour and reduce the rate of relapse and hospitalisation.[50] While funding was provided for a pilot programme, early intervention services have yet to be rolled out on a national basis.

The Mental Health Act 2001

IMO Doctors have welcomed the introduction of the Mental Health Act 2001 to determine and maintain standards in care and to protect the rights of patients who are involuntarily detained however concerns have been raised about the high cost of operating Mental Health Tribunals, (approx. €10m per year), diverting funds from service provision.

General Practitioners feel admissions procedures under the Mental Health Act 2001, which are complicated and time consuming and which delay timely access and act as a barrier to the treatment of patients with acute mental illness.

Services for People with Severe and Enduring Mental Illness

The Mental Health Strategy, set out the establishment of Rehabilitation and Recovery Services to treat long-stay patients currently in mental institutions, those discharged from long-stay services as well as new long-stay patients and patients with severe and complex mental problems. Recommendations include the establishment of specialist multi disciplinary teams, training of staff in recovery-oriented competencies, appropriate independent housing and services to facilitate re-establishing meaningful employment including mainstream and rehabilitation training.[51]

The Mental Health Commission[52] in their 2008 Annual Report stated that the failure to provide adequate rehabilitation services has meant that many individuals *"are left to live out cold, empty, colourless lives in old institutions, forgotten and neglected"* while others are *"warehoused"* in smaller community-based institutions called hostels, often with little in the way of gainful, productive day-time activities.

15 "Victorian-era" institutions remain open despite reports of substandard conditions from the Inspector of Mental Health Services. While the Minister of State with Responsibility for Mental Health has promised the closure of the remaining institutions by 2013, the IMO is concerned that adequate alternative rehabilitation services and community-based accommodation must be in place beforehand. While there has been progress in the establishment of Rehabilitation and Recovery teams from 5 in 2006 to 20 at the end of 2008, this amounts to less than half of the 41 teams required and again the teams in place are substantially understaffed. [53]

A HSE report in 2008 found a lack of a consistent understanding of, or approach to, rehabilitation evident in long-stay residential care. [54] 25% of individuals were inappropriately placed, the majority of activities in long-stay care are of a social nature and few individuals are engaged in therapeutic activities. Only a minority of individuals participate in rehabilitation training and even less are in paid employment.[55] The fourth report of the Independent Monitoring Group further found that within the Mental Health Services in general "*little progress has been made in embedding the Recovery Ethos"* with*" little or no evidence of in-service training or reconfiguration of services on the basis of the recovery paradigm".*[56]

---

[49] O'Keane V. Walsh D. Barry S. 2005
[50] Expert Group on Mental Health Policy 2006 : 100
[51] Expert Group on Mental Health Policy 2006 : 112
[52] Mental Health Commission Annual Report 2008
[53] Indecon 2009 : 35
[54] HSE *The Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services* 2008 : vii & 21
[55] The with less than 25% of individuals in high support community residence and only 6.7% of individuals on identified rehabilitation units, participating in rehabilitation training; Approximately 5.5% of individuals residing in high and medium support and 6.5% in low support community residences are in paid employment.
[56] Independent Monitoring Group 2010 : 43

The lack of appropriate Rehabilitation and Recovery services for people with severe and enduring mental illness can have major consequences on individuals and Mental Health Services, including an increased risk of homelessness, involvement in petty crime, inappropriate imprisonment, social isolation and dereliction and can lead to repeated involuntary detentions.[57]

Child and Adolescent Mental Health Services (CAMHS)

Child and Adolescent Mental Health Services is major area of concern for all IMO members. In 2006, the Expert Group on Mental Health Policy recommended that "*urgent attention*" be given to the completion of four 20-bed units in major hospital centres bringing the number of in-patient beds for children and adolescents to 100. While some progress has been made in 2009, with the opening of a six-bed adolescent unit at St. Vincent's Hospital in Fairview and an eight-bed interim unit at St. Stephen's Hospital, Cork, there are currently just 36 beds available. Concerns have been raised that due to staff shortages some units are not fully operational. Even with 20 permanent beds due to open in 2010 in Cork city and a further 20 to be commissioned in Galway, the number of beds falls short of the 100 beds which were required "*as a matter of urgency*" in 2006.

In 2009, 155 children under the age of 18 were admitted to adult psychiatric units which the Mental Health Commission has described as a practice that is "*in-excusable, counter-therapeutic and almost purely custodial in that clinical supervision is provided by teams unqualified in child and adolescent psychiatry.*"[58] The provision of a sufficient number of child and adolescent units must be prioritised if this practice is to end by December 2011.[59]

The HSE Performance Report July 2010[60] reported 55 Community CAMH Teams now in place, however this amounts to just over half of the 99 CAMH Teams recommended and many teams are operating without the support of the full multidisciplinary compliment. Many CAMH specialists feel time is wasted on requests from other Departments, reducing the availability of teams to provide services to the acutely mentally ill. Despite the prevalence of eating disorders among young people, there are no specialist services outside the Dublin region.[61]

At the end of June 2010, 2779 children and adolescents were waiting on an appointment either for assessment or treatment with a CAMH team, with a 17% of these waiting over 1 year.[62]

Mental Health Services for Older People

A Vision for Change also recommended that mental illness affecting older people, including symptoms associated with dementia, should be treated in the community and that services should be home-based with appropriate recognition and support given to families and carers. This year the Independent Monitoring Group reported *"little or no progress in the restructuring of Mental Health Services for older people as envisaged in A Vision for Change".* Approximately half the recommended 42 Community Mental Health Teams for Older People are in place.[63] Some teams are operating with just a third of the recommended staff levels[64] while other areas have no specialised services at all.

Ireland's population is ageing. Currently 11% of the population are over 65, by 2036 25% of people living in Ireland will be over 65.[65] Service provision should be based on 1 team or 1 consultant per 10,000 older people rather than 1 per 100,000 general population as recommended in *A Vision for Change*.

Where hospitalisation is required older patients should be treated in specialised units instead patients are admitted to general adult acute psychiatric units where "*frail, elderly and demented individuals mingle in busy common rooms with psychotic, irritable, younger patients".* [66]

---

[57] Expert Group on Mental Health Policy, A Vision for Change 2006 : 105
[58] Mental Health Commission. Annual Report 2008 :
[59] Mental Health Commission. Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 – Addendum . July 2009
[60] HSE Performance Report September 2009
[61] Barnardos Recommendations for Mental Health Services for Children and Young People *Childlinks* 2007: 2 2-5
[62] HSE Performance Report July 2010
[63] Indecon 2009: 33
[64] Indecon 2009: 68
[65] HSE Health Forum Steering Group 2008 *Toward an Integrated Health Care System or More of the Same*
[66] MHC 2008: 64

Dementia is the most common reason for admission to long-term residential care yet few private nursing homes cater adequately for patients with severe dementia and waiting lists apply for public long-term beds.

Older people with longstanding psychiatric illnesses e.g. schizophrenia or recurrent mood disorders (graduates) should be cared for by Rehabilitation and Recovery Services.

Specialist Mental Health Services

The Mental Health Strategy also provided for a range of other specialist mental health teams including services for patients with intellectual disability, liaison services, forensic services and patients with dual diagnosis of addiction and mental health disorder.

Just 13 consultant posts exist in psychiatry for adults with intellectual disability and not one team exists with the full recommended complement of staff. [67]Meanwhile 300 patients reside inappropriately in general psychiatric hospitals[68] while others continue in placements outside the state.

While some liaison psychiatry services have been developed, many have less staff in 2009 then they did in 2006[69] and there has been no development in neuropsychiatry and perinatal psychiatry services.

Forensic services have been established in Dublin, Cork and Limerick, however demand on services would suggest a need for both extra intensive care rehabilitation units and specialist forensic teams.

Currently addiction services are totally removed from Mental Health Services despite the fact that evidence suggests a high prevalence of patients with dual diagnosis of addiction and mental health illness. A study by the UK Dept. of Health suggests that 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems, and 44% of mental health service users reported drug use.[70] *A Vision for Change* recommends that 13 adult teams and 2 child and adolescent teams should be developed to treat dual diagnosis, yet to date none have been initiated, instead patients rely on GPs or the voluntary sector where resources are limited.

Mental Health Awareness

Stigma related to mental health illness remains one of the major obstacles preventing individuals from seeking help with mental health issues. A HSE study in 2007 found that while 85% of Irish people agree that anyone can experience a mental health problem, 62% would not want others knowing if they themselves had a mental health problem. [71]

Funding levels must be increased for mental health awareness and suicide prevention. The media must also recognise its role in reducing stigma. (See the IMO's Position paper on Suicide Prevention for further detail)

There are an estimated 161,000 carers that save the exchequer approximately €2.5 billion a year.[72] In a survey carried out by The College of Psychiatry and The Carers Association of Ireland over half of carers reported having been diagnosed with a significant mental health problem.[73] Of those diagnosed with anxiety disorder 69% said it was caused or made worse by their caring role. Carers need adequate support and respite to enable them to care for someone as long as they wish and are able to do so, without jeopardising their own health and wellbeing.

[67] Indecon 2009 : 32
[68] O'Brien C, Report Advises Rehousing 4,200 *Irish Times* 3 February 2010
[69] College of Psychiatry of Ireland, *Submission to the 2nd A Vision for Change Monitoring Group* 2009
[70] Weaver et al 2002
[71] HSE, Mental Health in Ireland : Awareness and Attitudes 2007: vii
[72] Care Alliance Ireland 2009 www.carealliance
[73] The College of Psychiatry and The Carers Association of Ireland, *Carers of Ireland Who cares?*

IMO Recommendations

For more than a decade the IMO has been calling for adequate Mental Health Services and since the publication of *A Vision for Change* members have deplored its slow progress. The IMO have called on the Minister for Health and Children to replace rhetoric with action and implement Mental Health Policy. Specifically the IMO recommends:

Funding

- The budget allocated to Mental Health Services should be transparent, based on need and represent value for money;
- Capital funding for the implementation of A Vision for Change must be ring-fenced. Funds from the sale of psychiatric lands must be immediately released and diverted funds must be returned;

Leadership and Planning

- In keeping with the recommendations of *A Vision for Change* the HSE should set up a specific Mental Health Directorate to oversee implementation of Mental Health Policy;
- The HSE implementation plan 2009-2013 should be published showing clear links between outcomes, timeframe and resources;

Mental Health in Primary Care

- Resources and adequate support must be provided for the treatment of mental health patients in Primary Care including:
  - direct access to publicly funded counselling and psychotherapy services;
  - improved communication links between General Practice and Mental Health Services to support GPs in the treatment of patients and with appropriate referral and follow-up care;
  - a consistent nation-wide position on the provision of free medication to patients with psychiatric disorders.

Mental Health Act 2001

- The IMO calls on the Mental Health Commission to review with regard to cost and the effects on the treatment of patients:
  - the operation of Mental Health Tribunals;
  - involuntary admissions procedures.

Multi Disciplinary Community Mental Health Teams

- The moratorium on recruitment in the HSE must be lifted immediately to allow the urgent recruitment of full multi-disciplinary Community Mental Health Teams;
- Services should be of equal high standard across regions and Mental Health and Primary Care catchment areas should be co-terminus;
- Evidence based intervention programmes including home-based services, crisis intervention and assertive outreach services must be provided to respond to the needs of people with acute illness on a 24/7 basis;
- Crisis intervention requires joint collaboration between Mental Health Services and the Garda Síochána;
- Funding should be provided to roll out the early intervention in psychosis pilot programme on a national basis;

Services for people with Severe and Enduring Mental Illness

- Rehabilitation and recovery teams must be established and secure alternative accommodation provided beforehand to facilitate the closure of the remaining 15 psychiatric institutions and the transfer of patients into the community setting;
- A cross-departmental approach is required to ensure that the housing, employment, education and social welfare needs of vulnerable patients are met;
- Recovery is a cornerstone of the Mental Health Strategy and all staff should be trained in recovery-oriented competencies;

Child and Adolescent Mental Health Services (CAMHS)

- Urgent attention must be given to the completion of 100 Child and Adolescent in-patient units in order to reach the deadline of December 2011when no child under 18 years is to be admitted to an adult unit;
- Full multi-disciplinary CAMH teams must also be established to guarantee timely assessment and treatment of young people with mental illness;

Mental Health Services for Older People

- Dedicated old age psychiatry services must be rolled out throughout the country with a focus on treatment within the home and family contexts;
- Service provision must be based on actual numbers of elderly people;
- Where acute hospitalisation is required, patients should be accommodated in specialised units with staff trained in dealing with old age problems;
- Access to appropriate public residential care for elderly people who are mentally ill must be provided on an equal basis;

Specialist Mental Health Teams

- Full specialist Mental Health Services must be developed including services for patients (both adults and children) with intellectual disability, liaison services, forensic services and patients with dual diagnosis of addiction and mental health disorder and patients with eating disorders;

Mental Health Awareness

- Continued investment in mental health awareness and suicide prevention is needed. The recommendations detailed in *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014* and the report of the Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society* must be implemented in full*;*
- The media should recognise its role in reducing stigma and national media guidelines should be developed in respect of reporting on individual's mental health issues;
- Adequate psychological and financial support should be provided for carers.

IMO Motions relating to the IMO Position Paper on Mental Health Services

08/02 The IMO deplores the lack of progress in implementing *A Vision for Change* and calls on the Minister for Health & Children and the HSE to replace rhetoric with actions in this regard.

Funding

10/24 The IMO demands clarification from the Minister for Finance & the Minister for Health on whether the €42m promised by Minister Moloney in January 2009 and the €43m "new money" promised by Minister Lenihan in December 2009 for Mental Health service development are the same or different financial undertakings.

10/25 The IMO seeks clarification from the Minister for Health and Children as to when the monies promised to implement *A Vision for Change* will be released and report on their allocation in a timely fashion.

10/27 The IMO seeks the restoration to the Mental Health Services by the HSE the €24m allocated to the implementation of *A Vision for Change* it purloined in 2007/2008 and diverted from the psychiatric services.

08/03 The IMO condemns the cavalier failure of the HSE to preserve and ring-fence the resources arising from the sale of the psychiatric services' lands. Furthermore the essential re-modernisation of services in line with our National Mental Health Policy can occur and we call on the Taoiseach and the Minister for Health & Children to condemn this activity and to act swiftly to reverse such diversion of monies.

06/08 The IMO deplores the inequitable distribution of resources, both human and financial, in the Mental Health Services and demands that the HSE rectify this.

06/14 The IMO insists that the Department of Health & Children ring fence the monies released through the sale of psychiatric hospitals for the development of Mental Health Services.

Leadership and Planning

09/06 This meeting calls on the HSE to set up a specific Mental Health Directorate – in keeping with the recommendations of *A Vision for Change*.

09/07 This meeting demands that the Minister for Health & Children and the Minister for State with special responsibility for Equality, Disability & Mental Health to clearly indicate the specific time frame for the implementation of *A Vision for Change*.

07/37 The IMO calls on the Minister for Health & Children to oversee the timely implementation of our national mental health policy*A Vision for Change* and that she publishes timelines by which various aspects of this policy will have been put into practice.

Mental Health Services in Primary Care

09/04 This meeting calls on the Minister for Health & Children and the Minister for State with special responsibility for Equality, Disability & Mental Health to issue a statement as to why a consistent nation-wide position in relation to the Health Act 1970 (section 59) on the issue of issuing free medication for those with psychiatric disorders is not in place.

Community Multi-disciplinary Mental Health Teams

10/28 The IMO deplores the reduction of staff numbers in the Mental Health Services and seeks a statement from the Minister for Health on this change in direction from that espoused in *A Vision for Change* that recommends an increase in staffing of 1800 people over the 7-10 years of implementation of this policy.

09/08 This meeting calls on the Minister for Health & Children and the Minister for State with special responsibility for Equality, Disability & Mental Health to realistically fund early intervention in psychosis pilot projects and to issue a statement on the national roll out of such programme that have an evidence base of good clinical outcomes for people.

Mental Health Act 2001

08/04 The IMO welcomes the introduction of the Mental Health Act 2001 but condemns the Minister for Health & Children for sanctioning the diversion of funding from service provision to fund this legislation.

08/05 The IMO draws attention to the inordinate length of time in accessing assisted admission facilities under the Mental Health Act 2001 and calls on the HSE and the Mental Health Commission to work jointly to remedy this.

07/41 The IMO deplores the reduction in service to voluntary users of the Mental Health Services brought about by the introduction of the Mental Health Act 2001 without proper resourcing, and demands that the Minister for Health & Children remedy this without delay.

Children and Adolescent Mental Health Services

07/42 The IMO demands that the Minister for Health clarify her intention in relation to the provision of Mental Health Services for adolescents and declare the timeframe within which this will be equitably available.

06/11 The IMO calls on the Department of Health & Children to ensure, as a matter of supreme urgency, that dedicated inpatient child and adolescent beds, under the care of trained consultant child and adolescent psychiatrists are available when the Mental Health Act 2001 becomes live.

06/12 The IMO insists that the HSE provide 200 child and adolescent psychiatric beds as previously recommended by the Department of Health & Children and ignore the recent recommendation of only 100 beds.

Services for people with Severe and Enduring Mental Illness

08/06 The IMO draws attention to the plight of those who need long term supported accommodation and calls on the Department of Health & Children and the Department of the Environment to make good this deficiency.

06/13 The IMO insists that the HSE does not allow the closure and selling off of psychiatric hospitals and lands until appropriate community services are in place as recommended by the Expert Group on Mental Health Services.

Mental Health Services for Older People

10/22 The IMO calls on the Minister for Health & Children and the HSE to end the current post-code lottery which currently exists and in its place roll out dedicated old age psychiatry services throughout the country.

08/07 The IMO draws attention to the petty discrimination in terms of Nursing Home access of hospitalised elderly people who are mentally ill and who have to wait inordinate periods of time to access appropriate residential care and calls on the HSE to rectify this as a matter of urgency.

Mental Health Awareness

10/23 The IMO calls on the Minister for Communications and the Minister for Health & Children, in conjunction with the relevant stakeholders, to develop national media guidelines in respect of reporting on an individual's mental health issues.

09/09 The IMO calls on the DOHC and the HSE to fully implement the recommendations detailed in Reach Out: *The National Strategy for Action on Suicide Prevention 2005-2014 and the Report of the Joint Oireachtas Sub Committee on the High Level of Suicide in Irish Society.*

09/10 The IMO deplores the inadequate funding for suicide prevention services and calls on the DOHC to deliver sufficient funding for *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014*.

Specialist Mental Health Services

08/08 The IMO deplores the casual dismantling of community based secure facilities within the psychiatric services before alternatives have been developed and calls on the Minister for Health & Children to halt this and to provide safe working environments for staff in keeping with Health & Safety legal obligations.

04/09 The IMO urges the Department of Health and Children to actively consider the opportunity presented by the proposed health reforms to develop dedicated regional services for adolescents, eating disorders, learning disabilities, forensic services etc.

Appendix 1 – IMO Survey Results

GP Survey of Issues affecting the treatment of Mental Health Patients	% of respondants
Access to (public) counsellors/psychotherapists	70%
Access to Psychiatric Services	41%
Inadequate Child and Adolescent Services (CAMHS)	28%
Access to Addiction Services	17%
Time constraints	16%
Mental Health Act 2001 (Admissions Procedures)	15%
Affordability of therapy - CBT etc	12%
Resources allocated to General Practice	12%
Access to psychiatric nurses	10%
Improve Communication between GPs and Mental Health Services	10%
Lack of inpatient beds	9%
Mental Health catchment areas different to Primary Care	9%
Follow-up/Liaison Services after discharge	8%
Other Issues Raised	
Support from CMHTs	
Over-reliance on drug therapy	
Need for Out-of-hours/24 hour service	
Poor/Antiquated inpatient facilities	
Access through ED	
Access to Old Age Psychiatry Services	
Access to Rehabilitation Services	
Stigma	
Cost of medication	
Lack of Continuity of care	
GP training	
Lack of transport for acute patients	
Need for Directory of available services	
Need for Crisis management service	
Need for Family support	
Need for Patient education	

Consultant Psychiatrist Survey of Issues affecting Mental Health Services	% of respondants
Undeveloped Multi-disciplinary teams	57%
Funding	43%
Lack of Child and Adolescent beds	29%
Inadequate Child and Adolescent Services (CAMHS)	21%
Leadership/Planning	14%
Moratorium on recruitment	14%
Stigma	14%
Other Issues Raised	
Access to Addiction services	
Lack of Budget autonomy	
Continuing structured training	
Access to Community-based accommodation	
Need for Electronic patient records	
EWTD impedeing on continuity of care and consultant time	
Need for Standardised evidence based approaches	
No Input from service users	
Intra-service communication	
Lack of Community outreach care	
Lack of Psychiatric nurses in Primary Care	
Mental Health Act	
Mental Health catchment areas different to primary care	
Outdated Psychiatric facilities	
Patient Confidence in Service	
Public education	
Time-consuming requests from other Depts/Services	
Too much attention to “fashionable issues”	
Training in psychotherapy at NCHD level	

Position Papers published by the Irish Medical Organisation are available on www.imo.ie

Universal Health Coverage	April 2010
Suicide Prevention	Sep 2008
Lifestyle and Chronic Disease	Sep 2008
Protecting the vulnerable –	
A Modern Forensic Medical Service	Mar 2008
Disability, Ages (0-18 years)	Nov 2007
Co-Location and Acute Hospital Beds	July 2007
Role of the Doctor	Apr 2007
Medical Schools	Aug 2006
Obesity	Apr 2006
Care of the Elderly	Jan 2006
Health Service Funding	Mar 2005
Acute Hospital Bed Capacity	Mar 2005
Medical Card Eligibility	Mar 2005
Road Safety	Mar 2005
Accident & Emergency	Mar 2005
Manpower	Mar 2005