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An Comhchoiste um Chúram Meabhairshláinte sa Todhchaí

An Tuarascáil Deiridh

Deireadh Fómhair 2018

Joint Committee on the Future of Mental Health Care

Final Report

October 2018

Contents

Chair's Foreword

In July 2017, the Joint Committee on the Future of Mental Health Care was established with the aim to achieve cross-party agreement on the implementation of a single, long-term vision for mental health care and the direction of mental health policy in Ireland.

With this report, the Committee has completed the task assigned to it. On this account, the Committee would like to thank all those organisations who took the time to prepare a submission and to all those who presented at public meetings of the Committee. These submissions and oral presentations have assisted the Committee greatly in its work. Copies of all presentations received are available on the Committee's webpage.

The Committee published an Interim Report in December 2017 in which the Committee stated that it intended to report regularly during the course of its deliberations. In that report, the Committee also identified Primary Care, Recruitment and Funding as three key areas of focus and this has remained the focus of the Committee throughout.

The Committee published its Second Interim Report: *Recommended actions arising from progress to date*, on 26 April 2018. That report set out the Committee's analysis of the realities and challenges in relation to each of its three main objectives and also recommended actions.

This, the third and final report of the Joint Committee sets out to present a clear and compelling vision for mental health care and the direction of mental health policy in Ireland and the associated actions and targets that it considers necessary and capable of implementation. More fundamentally, the Committee believes that robust political oversight is required in order to ensure that the necessary transformation in our mental health service takes place.

On behalf of the Joint Committee, I wish to formally request that this report be debated in the Dáil and the Seanad at the earliest possible opportunity.

Senator Joan Freeman
Chair
Committee on the Future of Mental Health Care

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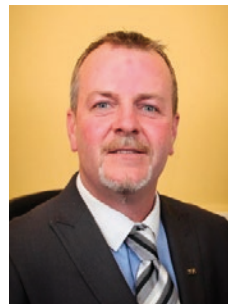
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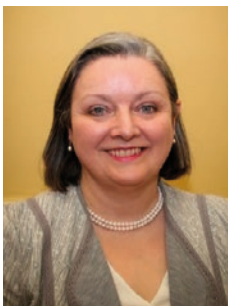
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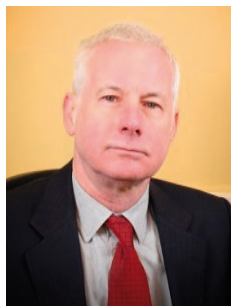
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Introduction

The Joint Committee on the Future of Mental Health Care was established by Order of the Dáil on 13th July 2017 and by Order of the Seanad on 18th July 2017 and held its first meeting on 28th September 2017.

In its first Interim Report, published on 12th December 2017, the Committee identified Primary Care, Recruitment and Funding as three key areas of focus which would occupy the majority of the Committee's time.

Subsequent to that interim report, the Committee gave further, more detailed consideration to each of these three areas, which contain what are interconnected, difficult, but ultimately, in the Committee's view, solvable problems. As current arrangements stand, difficulty in these three important areas is impacting negatively on the mental health care received by the public; and they are therefore impacting negatively on the mental health of vulnerable people.

The Joint Committee's Second Interim Report: Recommended actions arising from progress made to date, presented the preliminary findings of the Committee in the three key areas identified by it, viz. Primary Care, Recruitment and Funding. As such, the Second Interim Report represented an important step in the Committee's journey. The Committee's subsequent focus was on the steps that are necessary to achieve positive change based on the Committee's preliminary assessment of the situation.

This, the Committee's final report, sets out the Committee's vision for the future of mental health care in Ireland and the recommendations the Committee considers necessary to achieve this vision. The Committee believes that the vision set out is clear and compelling and that this vision will be realised if the actions and recommendations set out in this report and in the Committee's Second Interim Report are implemented.

The Department of Health has established an Oversight Body to produce a high level policy framework setting out future service priorities in relation to mental health. The Committee understands that this Body is due to report in December.

The Committee expects that each of the findings and recommendations in this and earlier reports, particularly in relation to the Committee's vision for mental health services, will be considered and responded to by the Oversight Body in its final report.

Finally the Committee recognises that in order to achieve the vision set out in this report there needs to be a significant increase in funding for mental health services, in fact the Committee recommends that the increase to 10% set out in Sláintecare be ring fenced and prioritised. This is the single stand alone number one priority as all the recommendations contained in this report are based on resources being available to deliver them.

Long-Term Vision for Mental Health Care and the Direction of Mental Health Policy

The following sets out the Committee's agreed long-term vision for mental health care services and the direction of mental health policy:

- No stigma will attach to mental illness;

- Those needing the services will have timely access to appropriate care on a "no wrong door" basis, whatever the level of complexity:

  - The majority of mental ill health cases will be resolved through early intervention in primary and community services;

  - Properly resourced acute services will be available for those who need them on a no wait for appointment basis;

  - Resources will be targeted at 'at risk' groups or groups of people experiencing crisis levels or significantly higher levels of mental ill health than the general population e.g. members of the Travelling Community, Young LGBTQI people.

- Outcomes will be reported on independently in a way that fosters accountability;

- The service will offer clinicians and other employees fair conditions of employment, valuable experience and career development opportunities.

Summary of Recommendations

Stigma and Mental Health Promotion

1.   The Committee recommends that the Department's Oversight Group consider and, in its report, make recommendations as to how the number of psychologists required might be objectively determined from time to time. Such determination might, for example, be based on projected demand and targets as regards levels of service.

2.   The Committee recommends that the Department of Health carry out a study to identify the causative factors, to include a priority focus on the Traveller Community, and how they can be addressed. This should be repeated over time and revalidated which will assist in identifying trends. Given the ecological approach that the Committee understands that the Oversight Body is taking the Committee expects that the body will have considered this during the course of its deliberations.

3.   The Committee recommends that more resources and funding should be targeted at the areas of highest need with particular attention to the Traveller Community and towards addressing suicide. This would be best achieved in conjunction with outcomes-based reporting which could track the impact of resources on areas of high need.

4.   The Committee recommends that a national protocol for the use of smartphones and social media be developed with relevant stakeholders including schools and representative parents and young people as recommended by Dr. Harry Barry to the Committee. The HSE and the Department of Health should outline how a national protocol for the use of smartphones and social media would be developed.

Current State of Services

5.   The Department of Health should conduct a comparative study as to which countries "do mental health well" and how Ireland compares.

6.   The Committee recommends, as an interim measure, that the number of acute beds should be increased to 50 per 100,000 over the next 3 years, with a commitment to reach the EU average within the subsequent 2 years. The question of whether supply is meeting the demand should be kept under regular review thereafter by the Department of Health and bed numbers adjusted accordingly.

Physical Insfrastructure

7. The Committee recommends that the Mental Health Act be amended to provide for the regulation of all premises where mental health services are provided and to strengthen the Mental Health Commission's powers to impose penalties on service providers where they are found to be non-compliant with the regulations.

8. The Committee also recommends major additional capital investment to ensure compliance with the regulations which should also have the knock-on effect of attracting clinicians and creating environments conducive to the recovery of people experiencing mental ill health.

Signposting, Referral Pathways and Communication

9. The Committee recommends that the HSE conduct a pilot to ascertain whether the inclusion of mental health nurses and access to talk therapies in primary care teams would improve outcomes for mental health service users in primary care.

10. The Committee recommends, in agreement with Mental Health Reform, that a "no wrong door" approach should be embedded in Irish health services so that the onus is on services to ensure treatment for people presenting with problems.

Role of Psychiatry

11. The Committee recommends that consideration be given to reviewing the role of psychiatrists and streamlining their workloads by distributing some or all of the above functions to other team members. The Department of Health should take the lead on this.

Talk Therapies and Medication

12. The Committee recommends that access to a range of 'talk therapies' should be a mainstream part of Mental Health Services and alongside talk therapies, a suite of therapies with a recovery focus such as art therapy and music therapy should be embedded in community mental health services. These options should also exist in acute services alongside more intensive interventions. Having access to a wide variety of treatment options increases the likelihood that individuals will recover.

Funding and Accountability

13. In the context of legislation having been brought before the Oireachtas in an effort to make the HSE more accountable (Health Service Executive Governance Bill 2018), and since this issue is fundamentally one of accountability, leadership and responsibility for decision making in mental health, it may be necessary to appoint a senior manager with responsibility for mental health in the HSE on a statutory basis. In the meantime, the Committee recommends that a National Director for Mental Health be reinstated who will be solely accountable for decision making in mental health and that this be done within six months of the publication of this report.

14. The Committee recommends as Sláintecare is implemented that the recommended increase to 10% for mental health services be ring-fenced and prioritised, with a portion of this budget ring-fenced for a National Traveller Mental Health Strategy. This is vital as mental health services have been chronically underfunded in the past few decades. The Minister for Health should publish a timeline for the implementation of Sláintecare setting out the progress made to date.

15. The Committee recommends that systems for outcome-centric KPIs and accurate expenditure reporting (including sub-speciality reporting) be developed by the HSE within a three year time frame.

16. The Joint Committee formed the view very early on in its deliberations that a permanent Oireachtas Committee on Mental Health must be established in order to ensure ongoing accountability of mental health services to parliament. The Committee recommends that the permanent mental health committee be established without delay in order to continue the momentum gained over the last year by this Committee.

Recruitment

17. The Committee recommended in its Interim Report of April 2018 that remuneration for clinicians needed to be improved if the mental health services are to expand capacity. This is still the case and it will require meaningful increases in funding. The Committee also recommended that other incentives such as subsidised housing for mental health nurses should be developed to help solve recruitment and retention problems, as these are at the heart of the difficulty in providing timely access to care.

18. The Committee recommends that the possibility of special allowances for psychiatric nurses and psychiatrists be looked at by Government, as these roles were identified by the Public Service Pay Commission as being among those which are particularly challenging to recruit.

Staff Development

19. The Committee recommends that, as a first step, a mental health centre of excellence be established and resourced in an academic hospital.

Recruitment Processes

20.	The Committee recommends that the recruitment process be simplified to make it more efficient and less cumbersome. The Department of Health or the most relevant government department should publish a plan with specific detail as to how this can be done.

21.	The Committee recommends that consideration also be given to recruitment being carried out at a local level rather than nationally which is currently the case.

Workforce Planning

22.	The Committee recommends that work should begin immediately on a centralised staff database and a national workforce and succession plan. The staff database should also be interoperable with the expenditure reporting system recommended by the Committee, as staff pay is the biggest item of expenditure.

Stigma and Mental Health Promotion and Prevention

1. The Committee acknowledges that in recent years excellent work has been done in reducing stigma and in mental health promotion. There have been a number of campaigns such as the "Let's Talk" campaign which calls on people to reduce stigma, raises awareness and encourages people to talk about their difficulties. However, the Committee is of the opinion that there is still a lot of work to be done as stigma still impacts on the ability of people to speak about more severe forms of mental illness.

2. Also the Committee is of the opinion that the requisite services need to be in place if the HSE are to market mental health promotion campaigns encouraging people to seek help.

3. While the Committee recognises the importance of mental health promotion and indeed has dedicated meetings to this vital piece of ensuring wellbeing in Ireland, the successes of mental health promotion and de-stigmatisation efforts cannot allow for complacency in the provision of acute services.

4. The Committee understands that the decrease in such acute services has coincided with a rise of mental health needs in prisons; and that the prison system itself and the Central Mental Hospital experience a shortage in funding and recruitment to provide necessary mental health care.

5. The Committee is concerned that the decrease in acute services has resulted in the criminal justice system becoming, in effect, a de facto extension of the mental health system. Evidence from the Irish Penal Reform Trust indicated that families may be trying to get family members into prison in order for them to have better access to mental health services as they are so inaccessible in general circumstances. A related view was put forward by Dr. Shari McDaid of Mental Health Reform:

    > "We must acknowledge that the criminal justice system is now sadly an ongoing part of the delivery system for our mental health services and that we must address the mental health need arising in the criminal justice system."

6. While the Committee is firmly of the opinion that it is vital that mental health services in the criminal justice system are funded appropriately, the Committee also believes that better provision of mental health services in general circumstances might help to stop people reaching a point of distress which causes them to be brought into the criminal justice system in the first place. Parallels between the high levels of mental ill health among the Travelling Community and the percentage within the Irish prisoner population can be easily drawn. If a lack of access to mental health treatment is a causative factor to people becoming prisoners, whether intentionally or not, this should not be an accepted state of affairs.

7. The Committee is of the view that education has an important role to play in this and that it is very important to ensure that the National Educational Psychology Service (NEPS) is sufficiently resourced and that links to community mental health services are encouraged.

8. The Committee heard evidence from NEPS that there are currently 179 educational psychologists employed and that it is planned to recruit a further 15 in 2018. However the Committee is concerned that this increase (which does not, the Committee understands, take account of vacancies that may arise) may not be sufficient. Early intervention and prevention is critical for health and wellbeing so as to alleviate distress and prevent crisis admissions.

9. Schools are important community settings where well-being can be encouraged from a young age. The Committee feels that this should be utilised formally, especially in light of rising reported incidences of mental ill health in children. The Committee feels that age-appropriate well-being programmes should be introduced in schools to help children develop resilience and well-being skills. This would also help to mainstream positive attitudes to mental health and reduce stigma. NEPS should have a role in developing this programme which heightens the importance of increasing the number of psychologists in the service.

Recommendation 1

The Committee recommends that the Department's Oversight Group consider and, in its report, make recommendations as to how the number of psychologists required might be objectively determined from time to time. Such determination might, for example, be based on projected demand and targets as regards levels of service.

10. Jigsaw stated in their submission to the Committee that "areas such as research and stigma reduction remain under-invested in and innovations in areas such as e-mental health, school supports and services operating outside 9 a.m. to 5p.m. are limited in scale and ambition."

11. Statements from witnesses, including Jigsaw, have indicated that levels of anxiety among young people seem to be increasing. Certain groups of young people have been identified as particularly at risk, including LGBTQI young people and young Travellers. While the Committee acknowledges the great work that is being done in mental health promotion, including as part of Healthy Ireland, quick and easy access to early intervention and low intensity primary care needs to be in place to deal effectively with rising anxiety.

Causative Factors

12. With indicators of mental ill health, or at least reporting of them, on the rise, especially in the country's young population, it was incumbent upon the Committee to explore the causative factors. While the Committee is strongly of the opinion that the maintenance and strengthening of acute services should be the number one priority to realise its vision for excellence in mental health, identifying causes of mental ill health also has an important role.

13. Inequalities in society and the stress of living in poverty can result in mental ill health. Other general trends as identified in evidence given to the Committee which may be contributing to an increase in mental ill health include sleep deprivation, the increased prevalence of social media, smartphones and the internet generally, overwork and alcohol and other substance abuse.

Recommendation 2

The Committee recommends that the Department of Health carry out a study to identify the causative factors, to include a priority focus on the Traveller Community, and how they can be addressed. This should be repeated over time and revalidated which will assist in identifying trends. Given the ecological approach that the Committee understands that the Oversight Body is taking the Committee expects that the body will have considered this during the course of its deliberations.

14. As Ireland experiences a period of relative economic success as compared to the years following the recent economic crisis, it is possible that this is accompanied by increased work pressures, status pressure exaggerated by social media, and hardship around meeting rising costs of living. It is also important to note that alcohol is acknowledged to be a contributory factor to poor mental health. As Dr. McDaid emphasised to the Committee, alcohol can impact mental health, but abuse of alcohol can also be a form of self-medication for underlying, untreated mental health problems. In this light, Ireland's long, destructive relationship with alcohol can be seen as a symptom of the mental health problems which have always existed in our society.

15. Recognising that socio-economic conditions can be significant contributory factors to incidence of mental ill health, the Committee asked Deep End, a group of GPs working in deprived communities, for a submission on the topic. They drew the Committee's attention to the relevancy of the inverse care law to mental health and asserted that "mental health problems are more than twice as prevalent in the most deprived areas compared to the most affluent areas."

16. Poverty, poor housing and socio-economic factors as well as prejudice and discrimination are also factors contributing to the exponentially high levels of mental ill health among the Travelling Community where suicide was the cause of 11% of all Traveller deaths and most common in young Traveller men aged 15-25. The suicide rate for Traveller women is 6 times higher than settled women and the rate is 7 times higher for Traveller men. (Ireland Traveller Study/AITHS)

Recommendation 3

The Committee recommends that more resources and funding should be targeted at the areas of highest need with particular attention to the Traveller Community and towards addressing suicide. This would be best achieved in conjunction with outcomes-based reporting which could track the impact of resources on areas of high need.

17. The above contributory factors will need whole of society (and not just whole of government) responses to be meaningfully tackled. However the Committee is of the opinion that robust and accessible primary care mental health services are a necessary part of any resolution.

Recommendation 4.

The Committee recommends that a national protocol for the use of smartphones and social media be developed with relevant stakeholders including schools and representative parents and young people as recommended by Dr. Harry Barry to the Committee. The HSE and the Department of Health should outline how a national protocol for the use of smartphones and social media would be developed.

Primary Care and Acute Services

18. From the outset, the Committee recognised primary care as playing a vital role in the provision of mental health services and agreed to focus on this area to identify where the gaps are. The Second Interim Report of the Committee set out its findings in detail in this area.

19. *A Vision for Change* recognised the crucial role of the primary care sector in the provision of mental health care, stating that "primary care is a very important part of the mental health framework for two reasons:

   ■ Most mental health problems are dealt with in primary care without referral on to specialist services. Primary care is therefore the main supplier of mental health care for the majority of the population.

   ■ The GP in primary care is also the main access point to specialist mental health care for most of the population."

20. The Committee's interim report of April 2018 found that, while greater enhancement of primary care services would theoretically alleviate pressure on acute services, many problems exist in the sector which are reducing capacity for such alleviation. Such problems include a lack of communication between different service providers in the sector and in tertiary and secondary care, ad hoc access to 'talk therapies' at primary and community care levels, a lack of out of hours services and, most fundamentally, the failure to implement *A Vision For Change* fully in terms of recruiting the required number of clinicians to the sector.

The Historical Context

21. The Committee is of the opinion that viewing mental health services in the State through an historical lens provides an illuminating perspective that should inform planning for the future. Prior to the 1980s, Ireland experienced high levels of admissions to asylums, a situation which the Committee obviously does not wish to return to. There were 12,484 inpatient beds in 1984 which reduced to 4,173 by 2004 [PNA]. Coinciding with this, mental health issues tended to be more highly stigmatised and unacknowledged as a mainstream reality. However, leaving aside whether these services are now seen as desirable or not, this period also saw a much higher provision of services including beds in the mental health system by the State.

22. With the advent of the *A Vision for Change* era from 2006, institutional settings were further reduced to 1,002 beds [PNA] by 2016, while efforts were made to enhance service provision within the community. However, most of this period coincided with a financial crisis for Ireland that reduced the State's ability to implement the new community and primary services as envisioned in *A Vision for Change*.

23. Instead these services have been implemented in a partial fashion, while the reduction of acute services from 2006 onwards proceeded apace. The Committee is of the opinion that this has resulted in community and primary services coming under more strain than had been envisaged or allowed for.

Current State of Services

24. Published in July of 2018, the Mental Health Commission's Annual Report 2017 stated that there is much to be concerned about in the national mental health services. This warning, which is not the first note of alarm from the State's statutory body for quality assessment of mental health services, should be a sobering check for the reality of mental health services.

25. In much of its work over the past year, the Committee has sought to deal with the reality of those working on the frontlines and those using or attempting to use the services. At many points, the Committee was alarmed by the evidence received. This has highlighted for the Committee the gap that sometimes exists between stated policy and reality as experienced. The Committee therefore hopes that this report can help to highlight the difference between theoretical plans against the reality of the core difficulties experienced by the services and service users. The Committee therefore wishes to sound a warning note against any new initiatives which due to theoretical "improvement" may result in reduction of current existing services, and to assert the necessity of investment to reverse a state of decline.

26. The Mental Health Commission's Report also highlighted the issue of children being admitted to adult in-patient units, viz.:

    "A most unsatisfactory situation still prevails whereby children are being admitted to adult in-patient units. There were 82 such admissions to 19 adult units in 2017 compared to 68 in 2016."

27. This is of concern to the Committee. While the numbers had reduced in recent years it seems now that they are on the rise again. The Mental Health Commission further stated that:

    "A contributory factor to the continued admission of children to adult units is a shortage of operational beds in dedicated child units."

28. The Committee welcomes that *A Vision for Change* sought to improve primary and community supports. Indeed, in its interim report in April 2018 the Committee strongly endorsed the idea that the majority of care provision should take place in primary care. However, it needs to be acknowledged that for this model to work the supports in primary and community settings need to be there, reliably and accessibly. Further, this model may not work for everyone and acute settings of care are badly in need of bolstering.

29. As was highlighted in the Committee's Interim Report of April 2018, figures provided by the Psychiatric Nurses Association showed a reduction in beds from 12,484 in 1984 to 1,002 in 2016. Martin Rogan of Mental Health Ireland told the Committee that Ireland now has 22 acute beds per 100,000 people, with the European average being closer to 70.

30. The Committee is firmly of the opinion that acute services cannot continue to decline while we aim to reach the promised land of thorough and accessible primary care. Acute services should only be lessened if and when primary care has developed to such an extent that the demand for acute services has declined. As of now, demand for acute services far outstrips supply and an interim measure is necessary as well as a long-term plan.

Recommendation 5

The Department of Health should conduct a comparative study as to which countries "do mental health well" and how Ireland compares.

Recommendation 6

The Committee recommends, as an interim measure, that the number of acute beds should be increased to 50 per 100,000 over the next 3 years, with a commitment to reach the EU average within the subsequent 2 years. The question of whether supply is meeting the demand should be kept under regular review thereafter by the Department of Health and bed numbers adjusted accordingly.

31. The Committee understands that some of the expansion plans in the National Development Plan include the creation of more acute beds in the mental health sector. However, evidence to the Committee is that the biggest of these, the planned new Central Mental Hospital in Portrane, (a forensic mental health unit) will not meet continuing demand. Furthermore evidence to the Committee from the Mental Health Commission and Community Healthcare Organisations is that many mental health buildings are not fit for purpose.

Physical Infrastructure

32. The Mental Health Commission, which has statutory responsibility for regulating, promoting, encouraging and fostering the establishment and maintenance of high standards and good practices in the delivery of mental health services, inspected 57 HSE approved centres in 2017 and found 79% of these to be non-compliant with the regulations. 69% (31) of non-complaint premises were deemed to be a high or critical risk to residents. 51% (29) of regulated services were non-compliant on an ongoing basis (i.e. for three or more consecutive years). Such a state of affairs is neither in the interests of patients nor conducive to a good working environment for staff. The committee recommends that all HSE-approved centres shall be fully compliant with the regulations and is firmly of the view that the current compliance levels are unacceptable.

33. The Committee heard evidence that in many locations the physical infrastructure in which mental health services are delivered is not fit for purpose. The Mental Health Commission informed the Committee that there are significant deficiencies in the physical premises of regulated services (in-patient mental health units) across all CHOs, in terms of their safety, maintenance and physical environment.

34. As an additional problem more and more people are receiving mental healthcare services in unregulated centres.

35. Under the Mental Health Acts the Commission is allowed to inspect any place where mental health services are provided. However, it does not provide for the Commission to regulate or impose changes in those places. The Commission can make recommendations regarding changes that need to be made, however, it cannot enforce them because the Act does not provide for this.

36. There is no regulatory framework to assess or enforce the physical infrastructure of unregulated mental health services (i.e. community residences) despite the number of units and the vulnerability of service-users accommodated in such units. Community residences would not commonly be considered as 'clinical accommodation', despite the 24-hour care provided.

37. The Committee was dismayed at these facts particularly when considering the vulnerability of the service users.

Recommendation 7

The Committee recommends that the Mental Health Act be amended to provide for the regulation of all premises where mental health services are provided and to strengthen the Mental Health Commission's powers to impose penalties on service providers where they are found to be non-compliant with the regulations.

Recommendation 8

The Committee also recommends major additional capital investment to ensure compliance with the regulations which should also have the knock-on effect of attracting clinicians and creating environments conducive to the recovery of people experiencing mental ill health.

Signposting, Referral Pathways and Communication

38. The Committee's Interim Report of April 2018 highlighted that signposting of services available was an issue that needed more attention so there could be greater clarity around what is available in each geographical area, both for patients and GPs who make referrals. The Department of Health's response to the Committee's recommendation that a national service be set up was

    "As part of the development of both the renewed web presence and the associated dynamic signposting tool(s), research on the signposting tool technical specification and user testing of prototypes are being undertaken to ensure that users of the website will receive clear options and information in relation to accessing a range of mental health supports including on referral options to health practitioners."

39. However, the Committee has received evidence from witnesses, including a GP, that pathways of care are still not well defined and that there can be bureaucratic shuffling in referrals, particularly for children, between services like the Child Psychology Service and Child and Adolescent Mental Health Services. A reasonable belief on behalf of GPs should be that the service they refer people into will deliver a quick assessment and treatment.

40. In order to ensure that information about services is accessible, information should be easy to understand, free from jargon using images or graphics where possible, so that all levels of literacy can be accommodated.

41.   The Committee's interim report of April 2018 identified that communication problems in the primary care sector were creating obstacles to accessing services. The Irish College of General Practitioners subsequently told the Committee that "lack of mental health input on primary care teams is one of the barriers for a lack of GP engagement with primary care teams" and have recommended the deployment of community mental health nurses in primary care teams to tackle this problem.

Recommendation 9

The Committee recommends that the HSE conduct a pilot to ascertain whether the inclusion of mental health nurses and access to talk therapies in primary care teams would improve outcomes for mental health service users in primary care.

Dual diagnosis and the "no wrong door approach"

42.   "Dual diagnosis" of mental health and other health factors, including addiction, is very relevant to the aforementioned interpretation of alcohol abuse as a mental ill health symptom, an especial problem for Ireland. The Committee highlighted in its interim report of April 2018 that too often people are turned away from services as they are identified as having presented to the wrong service (e.g. mental health services instead of addiction services).

Recommendation 10

The Committee recommends, in agreement with Mental Health Reform, that a "no wrong door" approach should be embedded in Irish health services so that the onus is on services to ensure treatment for people presenting with problems.

Out-of-hours services

43.   The Committee strongly believes that pressure placed on emergency departments which are not equipped to deal with mental health presentations and the lack of service to deal with crises is a huge problem and that out of hours mental health services, i.e. moving from a weekday normal working hours approach to round-the-clock care, is a sorely needed shift.

44.   The Committee welcomes aspirations towards moving to 7/7 care and subsequently 24/7 care, but stresses that funding and consequent recruitment has to be increased sufficiently to enable this.

Role of Psychiatry

45. The Committee is aware that the consultant psychiatrist role currently occupies a large part of the delivery of mental health services, including some statutory requirements. The Committee sought to establish whether some of the functions carried out by consultant psychiatrists would be better performed by other staff, given the highly specialised nature of this grade. The Committee therefore asked the Irish Hospital Consultants Association and the Psychiatric Nurses Association for their views on this matter.

46. The IHCA told the Committee that there is potential for other roles to take on some functions, viz.:

    "A greater involvement of Pharmacists in providing medication histories and monitoring side effects and drug interactions

    Psychologists could have a greater role in the provision of specialised aspects of neuropsychological testing, and in the provision of therapies, as well as in directing aspects of treatment by other team members

    Nurse managers on community teams or inpatient units could liaise with families on specific concerns, engage in discharge coordination, manage repeat audit cycles and risk reports

    Team social workers could be the main contact for family members and other stakeholders

    Presence of Health & Social Care Professionals in Emergency Departments at night could more appropriately deal with patients who present with homeless or domestic violence issues.

    Child protection social workers in Tusla need to be on 24 hour call for children and adolescents presenting to emergency departments with psychosocial and care issues who have no mental illness."

47. The PNA told the Committee that Psychiatric Nurses have a diverse skillset which allow for management of patients including:

    "Accepting referrals

    Undertaking assessments

    Providing diagnostic supports

    Formulating and implement care plans

    Developing links with other services to facilitate smooth transfer to the most appropriate service or support discharge".

Recommendation 11

The Committee recommends that consideration be given to reviewing the role of psychiatrists and streamlining their workloads by distributing some or all of the above functions to other team members. The Department of Health should take the lead on this.

Talk Therapies and Medication

48. The Committee is concerned that there is a lack of accessible counselling services and the money spent by the State on the services is insufficient, as compared to expenditure on psychotropic medication.

49. Evidence also supports that there is an over reliance on medication as a response to preventing 'mental ill health' issues in the absence of alternatives in primary, community care levels.

50. While the Committee is mindful that psychotropic medication has its place in recovery and management of conditions for many individuals, it is concerned at its seeming ease of access compared to talk therapies. Yet affordable talk therapy services must be accessible for this imbalance to be redressed. Dr. Harry Barry described the issue for the Committee as follows:

     "The biggest single issue with talk therapy in my life as a general practitioner has been access. While vast amounts of money have flowed into the provision of drug therapy, some of which is justified and some of which is not, there is a definite dearth of State funding and organisation of talk therapy."

51. The Committee recommended in its second interim report that the over-reliance on the prescribing of medication should be reduced by increasing investment in counselling and talk therapies. The Department of Health's response to this recommendation was

     "The HSE have commenced a Service Improvement Initiative on Talking Therapies which will examine the access to Talking Therapies where clinically indicated. It is planned to finalise the Model of Care and conduct quality control as per HSE National Framework by Q 4 2019."

52. The provision of more talk therapy is especially urgent for children, as the Committee has experienced a sense of growing mental health problems at younger ages. The role of medication is also relevant to this, with the Child's Ombudsman, Dr. Niall Muldoon, informing the Committee that children themselves have identified a rush to medicate in their treatment.

Recommendation 12

The Committee recommends that access to a range of 'talk therapies' should be a mainstream part of Mental Health Services and alongside talk therapies, a suite of therapies with a recovery focus such as art therapy and music therapy should be embedded in community mental health services. These options should also exist in acute services alongside more intensive interventions. Having access to a wide variety of treatment options increases the likelihood that individuals will recover.

Funding and Accountability

53. The Committee is of the opinion that mental health has, in recent years, experienced under-investment compared to other elements of the health service. Mental Health requires a person in a position of authority to fight for its resource allocation and to oversee the implementation of changes which will be required to meet the vision set out in this report.

54. The Committee was therefore concerned to learn, during the course of its work, that a decision had been taken to restructure the HSE from senior management level down which would in effect subsume discrete managerial authority for mental health into the general management structure, focussed through twin pillars of strategy and operations across all service areas. Notwithstanding the rationale for the restructuring which was given by senior management of the HSE to the Committee, the Committee strongly feels that the role of Director of Mental Health (across both strategy and operations) should be reinstated. This role should oversee both community services in CHOs and acute services.

Recommendation 13.

In the context of legislation having been brought before the Oireachtas in an effort to make the HSE more accountable (Health Service Executive Governance Bill 2018), and since this issue is fundamentally one of accountability, leadership and responsibility for decision making in mental health, it may be necessary to appoint a senior manager with responsibility for mental health in the HSE on a statutory basis. In the meantime, the Committee recommends that a National Director for Mental Health be reinstated who will be solely accountable for decision making in mental health and that this be done within six months of the publication of this report.

55. While the Committee would be wary of calling for increased funding without an increase in accountability to coincide it is clear from what the Committee has heard that a substantial increase in funding is required for mental health services if *A Vision for Change* is to be implemented fully. Currently 6.3% of the total operational health budget is allocated to mental health services. While *A Vision for Change* recommended 8.24% and Sláintecare 10%.

Recommendation 14

The Committee recommends as Sláintecare is implemented that the recommended increase to 10% for mental health services be ring-fenced and prioritised, with a portion of this budget ring-fenced for a National Traveller Mental Health Strategy. This is vital as mental health services have been chronically underfunded in the past few decades. The Minister for Health should publish a timeline for the implementation of Sláintecare setting out the progress made to date.

56. As was detailed in the Committee's report of April 2018, transparency over expenditure in mental health is insufficient. The Committee's engagement with the HSE revealed that it is not known what is being spent in different mental health service areas, although a certain level of detail was possible to ascertain to varying extents through manual reporting by the CHOs when they were directly requested by the Committee (for details see report of April 2018). However, it is not possible for insightful detail to be produced on how money is being spent in a consistent, systematic manner.

57. Accurate reporting of expenditure, while needed, is not sufficient on its own. Expenditure needs to be tied to patient outcomes for there to be confidence that money is being well spent. The Committee therefore reiterates its recommendation from its report of April 2018 that a new suite of performance indicators to match funding be developed, as the current suite of performance indicators measure activity but not operational outputs or outcomes. These, in tandem with a system that can detail transparently where money is going, are essential to ensuring that money is being spent where it is needed and increases in funding which the Committee calls for should only be pursued alongside the serious development of these two systemic features.

58. The Committee understands that the Department of Health has commissioned Mental Health Reform to propose outcome-centric KPIs.

Recommendation 15

The Committee recommends that systems for outcome-centric KPIs and accurate expenditure reporting (including sub-speciality reporting) be developed by the HSE within a three year time frame.

Recommendation 16

The Joint Committee formed the view very early on in its deliberations that a permanent Oireachtas Committee on Mental Health must be established in order to ensure ongoing accountability of mental health services to parliament. The Committee recommends that the permanent mental health committee be established without delay in order to continue the momentum gained over the last year by this Committee.

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Recruitment

59. Soon after its establishment, the Committee identified recruitment as a key theme which it would be necessary to explore. Over its year of work, the challenges in recruitment and retention of clinicians were closely considered by the Committee, and it quickly became obvious that most of the problems manifesting in mental health services stem from an inability to maintain a sufficient number of clinicians within the mental health services.

Recommendation 17

The Committee recommended in its Interim Report of April 2018 that remuneration for clinicians needed to be improved if the mental health services are to expand capacity. This is still the case and it will require meaningful increases in funding. The Committee also recommended that other incentives such as subsidised housing for mental health nurses should be developed to help solve recruitment and retention problems, as these are at the heart of the difficulty in providing timely access to care.

60. The Committee accepts that, as the Public Service Pay Commission (PSPC) have made clear, there are a multiplicity of factors which influence recruitment and retention difficulties, including difficult working conditions. However, working conditions are impossible to improve without attracting more staff. The PSPC confirmed to the Committee that they found that pay was not the only issue at play, but they did not find that pay was not an issue in solving rectuitment and retention problems.

61. The Committee is of the opinion that pay is a significant factor hindering recruitment and retention and therefore the problems in the mental health services are at root a problem of insufficient funding.

Recommendation 18

The Committee recommends that the possibility of special allowances for psychiatric nurses and psychiatrists be looked at by Government, as these roles were identified by the Public Service Pay Commission as being among those which are particularly challenging to recruit.

Staff Development

62. The Committee is of the opinion that greater use of psychiatric nurses' skills, as discussed in the role of psychiatry section, could help to improve services. It would also help to ensure development for psychiatric nurses, which has been identified by the Committee as a key component in improving retention of clinicians.

63. All staff involved should be able to access reflective practice as a normal part of their work, as well as training and development.

64. As Professor Harry Kennedy told the Committee, in order for professional development to exist as a meaningful incentive, delivery of services tied to research must be designed to encourage it, viz.:

> "A vital way to improve recruitment is to have a culture of excellence. The HSE must urgently shift towards a culture of clinical excellence. Excellence is inseparable from the virtuous circle of research, development, teaching and training. Only centres of excellence should be empowered to train postgraduate mental healthcare professionals."

65. The Committee is of the view that Ireland should aim to create a culture of excellence and aim to become a centre of excellence for the provision of mental health care. The political energy that has been put into the work of this Committee is an opportunity for Ireland's political system to prioritise excellence in mental health care and clinical academia.

Recommendation 19

The Committee recommends that, as a first step, a mental health centre of excellence be established and resourced in an academic hospital.

Recruitment Processes

66. While the Committee is aware that the central issues of clinicians' pay and conditions need to be meaningfully addressed if the situation is to improve, it is also concerned by the processes involved in acknowledging post vacancies and recruiting staff which are overly bureaucratic and make the process more difficult and cumbersome than appears to be necessary.

67. The Committee heard evidence from the Psychiatric Nurses Association (PNA) and the Irish Hospital Consultants Association which illustrates the extent of the overly bureaucratic processes in place.

68. The process to recruit a psychiatric nurse was summarised by the PNA as follows:

> "…what appears to be 25 steps to recruit a nurse in the Mental Health Services with a multitude of signatures required to complete the process. This "system" of recruitment is totally unsustainable to ensure the delivery of an effective Mental Health Services."

69. The Consultant Appointments Advisory Committee (CAAC), a body within the HSE which advises on the approval of Consultant posts, was set up in 2008 when recruitment was slowing down due to financial constraints. It meets monthly and all posts being approved for recruitment must be approved there, including posts which already exist and are being vacated, whether due to retirement or other factors.

70. This step, like many others in the post approval and recruitment processes, can be justified for quality assurance reasons. Factors that can cause delays in post approval are argued to be needed to ensure the posts are best situated to meet patient need, and likewise factors that delay recruitment once a post is approved can be argued as necessary vetting.

71. The Committee respects the need for quality control and, certainly, posts which do not create the most value in meeting patient need should not be filled endlessly with no review. However, as much as the CAAC was a Committee set up to filter the approval of posts at a time of financial crisis when funding was extremely problematic and post approval was rarer, the systems that our mental health services employ to conduct quality control should be sensitive and responsive to the conditions that we are faced with today. Therefore the Committee questions whether, in the context of much-needed recruitment, an ongoing review of whether posts are still meeting need, with those which are not marked for non-renewal, would be more efficient than re-authorising every single post at great delay.

72. The Committee also heard evidence that recruiting nationally is unhelpful due to a lack of communication between the local level need and the national level recruitment drive. Dr. Frank Murray, Director of the NDTP told the Committee that:

> *"If it is within the public appointments committee it is done with relatively little representation of the local whereas if it was advertised and filled locally in the hospital group, for instance, or within the CHO, I think we would have a process that might have advantages in terms of recruitment."*

Recommendation 20

The Committee recommends that the recruitment process be simplified to make it more efficient and less cumbersome. The Department of Health or the most relevant government department should publish a plan with specific detail as to how this can be done.

Recommendation 21

The Committee recommends that consideration also be given to recruitment being carried out at a local level rather than nationally which is currently the case.

Workforce planning

73. According to HSE figures as of December 2016, 1,752 nurses or 34.2% of the Mental Health Nursing workforce were expected to retire within four years.

74. From the evidence given to the Committee it appears that there is a serious lack of workforce planning in mental health services. For example, the Committee understands that the recruitment process does not begin until after a position becomes vacant. The PNA informed the Committee that it can take from six months to one year to recruit a nurse.

75. The Public Service Pay Commission impressed on the Committee the importance of proper workforce planning which would utilise a centralised database, giving a clear picture of how many staff are currently in the system and where. The current lack of data available for workforce planning was illustrated by the PSPC's evidence that they had to go to 40 different sources for data on staff numbers despite there being one central HR department in the HSE, which the Committee found extraordinary.

Recommendation 22

The Committee recommends that work should begin immediately on a centralised staff database and a national workforce and succession plan. The staff database should also be interoperable with the expenditure reporting system recommended by the Committee, as staff pay is the biggest item of expenditure.

Conclusion

76. Just over a year ago, the Committee was appointed and tasked with formulating a cross-party vision on the future of mental health care. Included also in the Committee's terms of reference was an awareness of *A Vision for Change*. The Committee recognises that document's good points while also noting its imbalanced implementation, which has been damaging.

77. In developing its vision, the Committee heard from a wide range of stakeholders and dedicated significant time to engaging with different management levels of the HSE in trying to understand systemic problems. While relations with the HSE have sometimes been strained, the Committee also acknowledges that the organisation has a hard job running a mental health service if funding is not sufficient, and many within the HSE are doing wonderful work with limited resources.

78. The Committee also sought engagement, initially with limited success, with the Oversight Group in the Department of Health that was, in parallel, charged with developing a "refresh" of *A Vision for Change*. While engagement has improved since the Committee's interim report of April 2018, the Committee does not know what the conclusions and recommendations of that group will be.

79. The Committee recognises that community based primary care is the direction for mental health services and also recognises that the Department will most likely be eager to pursue the policy proposals contained in its own Oversight Group's report. However, the central themes of the Committee's vision, including that acute services need to be bolstered rather than further cut, are important, even vital ones. The Committee expects that the recommendations in this report, which represents a cross-party view of the way forward, will be reflected in or addressed by the Oversight Groups' report and be a significant influence in the future development of mental health care.

80. The Committee's vision and this final report place an emphasis on realism regarding what can be achieved out of policy re-orientations and assessments.

81. According to Peter Hughes of the Psychiatric Nurses Association, *A Vision for Change* "and its predecessor, *Planning for the Future*, were used as cost-saving methods to take beds out of the mental health service."

82. The Committee sympathises with this analysis and is adamant that the experience of *A Vision for Change* must not be repeated. Therefore the ecological framework which the Committee expects the Oversight Group to endorse will be welcome insofar as it supports and enhances current services rather than diminishing them.

83. As mentioned with this final report, the Committee hopes to place an emphasis on the need for realism. This entails realism in our planning and in assessing our current situation. Realism should apply to the role of prisons in our mental health system and whether they have become de facto a major part of our mental health services. If this is the case, they need to be appropriately resourced to fulfil this role. Realism should also be employed when assessing the increasing mental health needs of children and young people and the causes of this phenomenon. Realism is needed in assessing clinical staff's pay against the cost of living. Most fundamentally, realism is needed relating to the funding of our mental health services. If we want improved mental health services with timely access for those in need, we will have to pay for it. As Martin Rogan of Mental Health Ireland said to the Committee, "if we want these services we will have to invest" and "if the answer is "No", then let us stop pretending, but if the answer is "yes" then let us get on a do the work".

Appendix 1: Terms of Reference of the Committee

That, notwithstanding anything in Standing Orders –

(a) Dáil Éireann noting –

  (i) the pressures on mental health services, the waiting times for services, and the need to improve services in certain parts of the country,

  (ii) the consensus that the 2006 policy 'A Vision for Change' charts the best way forward for mental health services, and

  (iii) the fact that, eleven years after its publication, 'A Vision for Change' is not yet fully implemented,

  hereby appoints a Special Committee (hereinafter referred to as 'the Committee'), to be joined with a Special Committee to be appointed by Seanad Éireann, to form the Joint Committee on the Future of Mental Health Care;

(b) the Joint Committee shall aim to achieve cross-party agreement on the implementation of a single, long-term vision for mental health care and the direction of mental health policy in Ireland, while recognising that the Department of Health is simultaneously conducting a review of 'A Vision for Change';

(c) in the context of the implementation of 'A Vision for Change', the Committee shall examine –

  (i) the current integration of delivery of mental health services in Ireland;

  (ii) the availability, accessibility and alignment of services and supports (including the work of the National Task Force on Youth Mental Health and the Youth Mental Health Pathfinder Project);

  (iii) the need to further develop prevention and early intervention services;

  (iv) the significant challenges in the recruitment and retention of skilled personnel; and

  (v) the efficacy of establishing a permanent Mental Health Oireachtas Committee;

(d) the Joint Committee shall, having carried out the examination at paragraph (c), and taking account of the Department of Health review of 'A Vision for Change', make recommendations on how best to align Ireland's mental health services and supports to increase availability and accessibility, recruit and retain personnel and complete the implementation of 'A Vision for Change' in order to provide a more integrated mental health service of the highest quality;

(e) the number of members of the Committee shall not exceed 15, and the members shall be appointed as follows:

  (i) four members appointed by the Government,

  (ii) four members appointed by Fianna Fáil,

  (iii) two members appointed by Sinn Féin, and

  (iv) one member each appointed by the Labour Party, Solidarity-People Before Profit (Sol-PBP), Independents 4 Change, the Rural Independent Group and the Social Democrats-Green Party Group;

(f) the Ceann Comhairle shall announce the names of the members appointed under paragraph (e) for the information of the Dáil on the first sitting day following their appointment;

(g) the quorum of the Joint Committee shall be eight, at least one of whom shall be a member of the Dáil, and one a member of the Seanad;

(h) the Joint Committee shall elect one of its members to be Chairman;

(i) the Joint Committee shall have the powers defined in Standing Order 85(1), (2), (3), (4), (5), (7), (8) and (9);

(j) the Joint Committee shall produce an interim report, which shall contain its proposed work schedule, within two months of its first meeting in public; and

(k) the Joint Committee shall make its final report to both Houses of the Oireachtas by 31st October, 2018, and shall thereupon stand dissolved."

Appendix 2: Membership List

Joint Committee on the Future of Mental Health Care

Deputies:

John Brassil (FF)

James Browne (FF) [Vice-Chair]

Pat Buckley (SF)

Joe Carey (FG)

Marcella Corcoran Kennedy (FG)

Seán Crowe (SF)

Dr. Michael Harty (RIG)

Alan Kelly (LAB)

Gino Kenny (S/PBP)

Catherine Martin (SD/GPG)

Tony McLoughlin (FG)

Tom Neville (FG)

Fiona O'Loughlin (FF)

Thomas Pringle (IC4)

Anne Rabbitte (FF)

Senators:

Máire Devine (SF)

Frank Feighan (FG)

Joan Freeman (IND) [Chair]

Colette Kelleher (IND)

Gabrielle McFadden (FG)

Jennifer Murnane O'Connor (FF)

Notes:

1. Committee established by order of the Dáil of 13 July 2017

2. Seanad members announced 20 July 2017

3. Deputy Joan Collins replaced Deputy Mick Wallace on the 28 September 2017

4. Deputy Mick Barry discharged and Deputy Gino Kenny appointed to serve in his stead by the Fifteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann 12 December 2017.

5. Deputy Joan Collins discharged and Deputy Thomas Pringle appointed to serve in her stead by the Sixteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann 13 February 2018

6. Deputy Mary Lou McDonald discharged and Deputy Seán Crowe appointed to serve in her stead by the Eighteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann 6 March 2018

7. Senator Máire Devine discharged and Senator Niall Ó Donnghaile appointed to serve in her stead as agreed by Seanad Éireann on 1 March 2018.

8. Senator Niall Ó Donnghaile discharged and Senator Máire Devine appointed to serve in his stead as agreed by Seanad Éireann on 9 October 2018.

Appendix 3: Link to Submissions

Submissions can be viewed online at: *http://www.oireachtas.ie/parliament/oireachtasbusiness/committees_list/ futureofmentalhealthcare/presentationsandsubmissions/*

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