A Vision for Change
Monitoring Group

Independent Monitoring Group

A Vision for Change – the Report of the Expert Group on Mental Health Policy

Sixth Annual Report on implementation 2011

June 2012

Contents

Glossary of Abbreviations

ASIST	Applied Suicide Intervention Skills Training
AVFC	*A Vision for Change*
CAMHS	Child and Adolescent Mental Health Services
CAMHT	Child and Adolescent Mental Health Team
CAWT	Co-operation and Working Together
CBT	Cognitive Behavioural Therapy
CEO	Chief Executive Officer
CMHTs	Community Mental Health Teams
CPI	The College of Psychiatry of Ireland
CSPD	HSE's Clinical Strategy and Programme Directorate
DCU	Dublin City University
DBT	Dialectical Behavioural Therapy
ECDs	Executive Clinical Directors
E&T	Education and Training
HRB	Health Research Board
HSE	Health Service Executive
IMG	Independent Monitoring Group
MHC	Mental Health Commission
NCL	National Clinical Lead for Mental Health
NCHDs	Non-Consultant Hospital Doctors
NOSP	National Office for Suicide Prevention
NSUE	National Service Users Executive
PPM	Programme Project Manager
RDOs	Regional Directors of Operations
SCAN	Suicide Crisis Assessment Nurse
WTE	Whole Time Equivalent

Executive Summary

This is the 6th Annual Report of the Independent Monitoring Group for *A Vision for Change* (IMG) and the final report of the Second Group. It is clear to the IMG that the implementation of *A Vision for Change* (AVFC) to date including 2011 has been slow and inconsistent.

There is a continued absence of a National Mental Health Service Directorate with authority and control of resources. Such a body has the potential to give strong corporate leadership and act as a catalyst for change.

The absence of a comprehensive, time lined and costed Implementation Plan has made it difficult to put in place a consistent framework for the development of all mental health specialities and has led to a lack of coherency in the planning and development of community based services.

Existing community mental health teams are poorly populated with an estimated 1,500 vacant posts. These are mostly allied health professional posts. Consequently, the service that is delivered through medical and nursing posts is not based on multiple interventions as envisaged in AVFC.

The effects of the HSE recruitment embargo and the Public Service Moratorium have disproportionately and indiscriminately reduced the availability of professional mental health service staff and reduced the overall volume of financial resources.

There is an absence of the ethos of recovery and poor development of recovery competencies in service delivery resulting in a reactive rather than proactive approach to the needs of individuals and their families.

The development of the National Mental Health Programme Plan (Clinical Programmes) is welcome although the IMG is greatly concerned that the principle of "Specialist within Generalist" framework will obstruct the development of specialist mental health care services and result in a modified version of AVFC.

On a positive note, there is evidence of many local and regional initiatives being developed in line with AVFC. These are principally "bottom-up" developments led by local leadership.

The HSE in combination with the Mental Health Commission has driven the continued closure of unfit for purpose facilities in favour of modern community based approaches. In respect of capital developments, progress has and is being made in the area of general adult mental health services, child and adolescent mental health services and forensic mental health services.

What is still required to achieve full implementation of AVFC is an operational framework for the development of recovery competencies for all staff both at entry training level and ongoing in-service development.

As a matter of urgency, the specialist mental health services for older people, rehabilitation and recovery, eating disorders, intellectual disability, co-morbid

severe mental illness and substance abuse problems and others described in AVFC need to be fully developed and delivered.

Government Departments, other than the Department of Health and the Department of the Environment, Community and Local Government need to focus on their responsibilities for the implementation of AVFC.

In order for all of these actions to be achieved there needs to be a cultural shift in how mental health services are delivered. This involves moving from professional dominance towards a person-centred, partnership approach.

There is also a requirement to move from a largely medicalised and maintenance approach towards one based on recovery competencies within the biopsychosocial model as envisaged in AVFC. Service responses to individuals and their families need to be proactive instead of reactive and be able to provide multiple interventions, as required.

The principles and practices of a recovery oriented service appear to be developing in localised services and this needs to be encouraged and reinforced by a clear national corporate policy implementation framework.

Finally, in order to complete the implementation of AVFC, mental health care services need to be able to demonstrate the following:

1. an ability to identify and respond to the individual needs of the person and his/her family
2. develop a relationship with the service user based on partnership
3. provide a timely, appropriate and quality level of service intervention which is recovery based.
4. offer each and every service user and their family the hope of recovery.

The proposed seven-year review of AVFC is an opportunity to assess the implementation of AVFC in the context of what has already been achieved and the lessons learned. The implementation of AVFC should be subject to continued monitoring over the next four years.

To be effective, AVFC the national policy for a modern Irish mental health care service must be translated into a cohesive operational policy based on the fundamental principles of person centeredness, partnership and recovery.

Chapter 1

The work of the Independent Monitoring Group

1.1 Background

In January 2006, the Government adopted the Report of the Expert Group on Mental Health Policy *A Vision for Change* as the basis for the future development of mental health services in Ireland. In March 2006, the then Minister of State at the Department of Health and Children, Mr Tim O'Malley, T.D., with special responsibility for mental health services, in line with the recommendation in AVFC, established the First Independent Monitoring Group for a three year period to monitor progress on the implementation of the report recommendations.

The Members appointed to the First Group were:

Dr Ruth Barrington, Chief Executive Officer, Health Research Board (Chair)

Dr Tony Bates, Founder Director, Headstrong

Mr Pat Brosnan, Director of Mental Health Services, HSE West

Dr Susan Finnerty, Acting Inspector of Mental Health Services (replaced by Dr Pat Devitt, Inspector of Mental Health Services in October 2008)

Mr Paul Flynn, Service User

Mr Dermot Ryan, Principal, Mental Health Division, Department of Health & Children (replaced by Ms. Dora Hennessy in November 2006)

Mr Stephen Jackson, Department of Health, Social Services and Public Safety, Northern Ireland (replaced by Ms Máire Redmond in October 2007)

Dr Terry Lynch, General Practitioner and Psychotherapist

Mr Tim O'Malley, Pharmacist (appointed in December 2007).

The term of the first IMG ceased in April 2009 and in June the Minister for Equality, Disability and Mental Health, Mr John Moloney, T.D. appointed the Second IMG. The members appointed were:

Mr. John Saunders, Director, Shine (Chair)

Dr Tony Bates, Founder Director, Headstrong (resigned from the Group in October 2010)

Ms Siobhan Barron, Director, National Disability Authority

Mr Brendan Byrne, former Director of Nursing, Carlow

Dr Pat Devitt, Inspector of Mental Health Services

Mr Paul Gilligan, Chief Executive, St Patrick's University Hospital

Ms Dora Hennessy, Principal, Department of Health and Children (replaced by Ms Sandra Walsh, Assistant Principal in April 2011)

Dr John Hillery, Consultant Psychiatrist, Stewarts Care Limited (formerly Stewarts Hospital Services), St John of God Kildare Services & Tallaght Mental Health Services

Dr Terry Lynch, GP and Psychotherapist

Mr Tim O'Malley, Pharmacist

Mr John Redican, National Executive Officer, National Service Users Executive

Dr Margaret Webb, General Manager, Eastern Vocational Enterprises Ltd.

1.2 The Group's Terms of Reference are:

- To monitor and assess progress on the implementation of all the recommendations in AVFC;
- To make recommendations in relation to the manner in which the recommendations are implemented;
- To report to the Minister annually on progress made towards implementing the recommendations of the Report and to publish the report.

1.3 Summary of the Work of the First IMG

The first meeting of the IMG was held on 25th April 2006. It met on twenty eight occasions over its three-year term. The Group submitted three annual reports and one progress report to the Minister of State with responsibility for mental health. The Group met with the Ministers of State, the Director of the Office for Disability and Mental Health, the Chief Executive, the National Director for Primary, Community and Continuing Care, Assistant National Directors and the Director of Estates in the HSE, the MHC, the Irish Mental Health Coalition and the Board for Mental Health and Learning Disability Northern Ireland.

First Annual Report – 1st February 2006 to 31st January 2007

In its First Report, the Group acknowledged the commitment of the HSE to implement AVFC but found that there was little evidence of a systematic approach to implementation. It was particularly concerned that there was no implementation plan in place and expressed concern about the lack of clarity in relation to responsibility within the HSE's management structure for implementation. The full report is available at **http://www.dohc.ie/publications/vision_for_change_review1.html**

Second Annual Report – 1st February 2007 to 31st January 2008

In is Second Annual Report, the Group found that by and large the recommendations in its first report were not addressed in 2007, although some were prioritised for implementation in 2008. The IMG continued to be concerned about the absence of clear, identifiable leadership within the HSE to implement AVFC, the recommendations in AVFC were not being addressed as a comprehensive package and the HSE's transformation process was taking precedence over the implementation of some recommendations in AVFC. The full report is available at

www.dohc.ie/publications/vision_for_change_2nd_report.html

Third Annual Report – 2008

In its Third Annual Report the IMG acknowledged the commitment and dedication of the staff of the HSE to the development of mental health services. While the IMG recognised the difficulties facing the HSE in the prevailing economic climate, the Group considered that this did not in any way diminish the HSE's responsibility to implement AVFC.

The Group acknowledged that the HSE prioritised six key areas for implementation in 2008 and 2009 and accepted that progress was made with some priorities i.e. the provision of child and adolescent services, engagement with service users and mental health information systems. However, the IMG was disappointed with the rate of progress, found that many of the recommendations made in its first two reports had not been addressed, that three years into implementation a comprehensive implementation plan was not available and that the absence of a dedicated leader at senior, national level had impeded progress and may have contributed to continuing poor facilities and standards of care in some areas and an inconsistent approach to embedding the recovery ethos in services. The full report is available at **www.dohc.ie/publications/vision_for_change_3rd_report.html**

1.4 Work of the Second IMG

Fourth Annual Report - 2009

The first meeting of the Second IMG took place on Monday 22 June 2009. In its Report for 2009, the Monitoring Group acknowledged progress in relation to the development of child and adolescent services, the appointment of the Assistant National Director for Mental Health and the gradual movement towards the creation of catchment areas as outlined in AVFC. Overall, the Monitoring Group was disappointed to report that, four years since the publication of AVFC, there was little significant progress. The Group was disappointed in the lack of development of governance, management and leadership systems within the HSE, found little evidence of the embedding of recovery within the HSE structures and processes, was disappointed at the lack of progress in the implementation of the specialist mental healthcare services and, in particular, the creation of fully staffed Community Mental Health

Teams to develop the model of service outlined in AVFC. The full report is available at http://www.dohc.ie/publications/vision_for_change_4th_report.html

Fifth Annual Report

In its Fifth Annual Report, the IMG acknowledged that some progress had been made in the implementation of AVFC in 2010, particularly in relation to the development of new adult and child and adolescent mental healthcare in Dublin, Cork and Galway and the closure or imminent closure of outdated services. However, the IMG was disappointed at the lack of a fully resourced Directorate for mental health care within the HSE. In addition, the IMG provided a separate Chapter on the ethos of Recovery, which is one of the fundamental principles for AVFC. From its deliberations, the IMG was of the view that there was little evidence that the recovery ethos and the principles and practices of recovery were ingrained in mental health care services. The IMG indicated that if mental health care services are to move towards a full realisation of AVFC then it is essential that recovery competencies and practices are the norm rather than the exception. The full report is available at http://www.dohc.ie/publications/vision_for_change_5th/hse_nat_reg/final_5th_annual_report

Sixth Annual Report - 2011

In preparing the Annual Report for 2011 the IMG met on eleven occasions. The IMG sought progress reports on implementation from the HSE and from the Department of Health on progress on implementation by relevant Government Departments. The Group met with

- Director of the Office for Disability and Mental Health, Ms Bairbre Nic Aongusa (15th November 2011).
- Dr Ian Daly, National Clinical Lead Mental Health and Ms Rhona Jennings, Project Manager (14th December 2011).
- Mr Martin Rogan, HSE's Assistant National Director for Mental Health, Ms Carol Ivory, Senior Manager, Office of the Assistant National Director, Mental Health, Mr Brian Gilroy, National Director, Estates, Mr John Browner, Office of Director of Estates, Mr Pat Healy, Regional Director of Operation (RDO), HSE South, Mr John Hennessy, RDO HSE West, Mr Stephen Mulvany, RDO, HSE Dublin North East, Mr Gerry O'Dwyer, RDO, HSE Dublin Mid Leinster, Ms Ber Cahill, Mental Health Specialist, HSE South, Mr John Meehan, Mental Health Specialist, HSE West, Ms Janet Malone, Mental Health Specialist, HSE DNE, Mr Jim Ryan, Mental Health Specialist, HSE DML, Dr Ian Daly, National Clinical Lead Mental Health (18th January 2012).

- National Service Users Executive (15th February).
- Irish College of General Practitioners (15th February).
- Mental Health Commission (15th February).
- Amnesty International (21st March).
- Mental Health Reform (21st March).
- Irish Association of Social Workers (21st March)
- The College of Psychiatry of Ireland (19th April)

A number of agencies and groups were invited to submit a short report on their organisation's assessment of progress on the implementation of AVFC and their views on the implementation priorities for 2012. A total of sixteen submissions were received and the contributors are listed in Appendix 1. The submissions are available at **http://www.dohc.ie/publications/**

As this is the last Report of the IMG as presently constituted, the Group has in addition to reviewing progress on implementation in 2011 considered two fundamental tenets of AVFC, that is, the model of service provision (Chapter 6) and the issue of Recovery (Chapter 8). The IMG also offers its view on the National Mental Health Programme Plan (Clinical Programme) (Chapter 7) and considered progress on implementation since 2006 (Chapter 9). Finally, the IMG replicated in 2012 a consultation process carried out in 2004 by the Expert Group on Mental Health Policy (Chapter 10) and gives clear guidance on future monitoring of AVFC (Chapter 11).

Chapter 2

Progress on Implementation as reported by the Health Service Executive

2.1 Introduction

Responsibility for the implementation of over 80 per cent of the recommendations in AVFC lies primarily with the HSE. Implementation of the remainder of the recommendations is the responsibility of Government Departments and their agencies.

The IMG requested the Assistant National Director for Mental Health and the four Regional Directors of Operations (RDOs) for a report on progress on implementation for 2011 with as much specific information as possible along with a progress report on the key deliverables for 2011 as identified in AVFC Implementation Plan 2009 - 2013.

An assessment of progress in 2011, as reported by the HSE, is summarised below. In this regard, it should be noted that the progress reported is additional to that reported in previous annual reports of the IMG.

A copy of the progress report which includes national and regional reports are available at http://www.dohc.ie/publications/

2.2.1 Summary of Progress on implementation as reported by the Health Service Executive at national level

The Office of the Assistant National Director, Mental Health works closely with the four HSE Regions to advance the delivery of AVFC objectives and those Regional developments are reported separately.

The Office of the Assistant National Director, Mental Health works across a number of HSE Directorates including Finance, Estates, Human Resources, Public Health, Children and Families, Cancer Control and Quality and Clinical Care.

The Report is presented under each chapter of AVFC in bulleted format.

Chapter 3 – Service Users and Carers

- Support continued to be provided to the National Service Users Executive (NSUE) with the Office of the Assistant National Director, Mental Health an active participant in the review of NSUE during 2011.
- The NSUE Survey results and Awards ceremony were hosted in tandem with the '*View from the Midpoint'* event in January 2011 at Dublin Castle, managed by Office of the Assistant National Director, Mental Health.

- The Office of the Assistant National Director, Mental Health meets with the NSUE and the Mental Health Commission (MHC) in a tripartite meeting each quarter.
- NSUE and service user representatives are active in many national projects led by the Office of the Assistant National Director, Mental Health, examples include: - *National Vision Implementation Steering Group, Forensic Reconfiguration Project Group, Linking Service & Safety, Working Groups on the development of Guidance documentation, WISDOM ICT project groups, IIMHL Network & Exchange meetings in 2011, and Mental Health Act training with external partners (e.g. Gardaí.).*
- The HSE continued to support the Irish Advocacy Network which celebrated its 11th Anniversary in December 2011. The HSE also participated in the recent review of IAN which culminated in the development of a 3-year strategic plan for the organisation.
- The Office of the Assistant National Director, Mental Health continued to sponsor and fund the Co-Operative Learning and Leadership Course in DCU with an expanded group of nine services participating in 2011/2012 programme.
- The role of the *Expert by Experience* post was independently reviewed and evaluated and the Office of the Assistant National Director, Mental Health and Dublin City University (DCU) have agreed to extend this project for a further 3 years.
- The HSE continued to provide grant aid to a number of national, regional and local mental health voluntary organisations.
- The HSE, in association with Atlantic Philanthropies, fund the Genio foundation which supports a number of person-centred initiatives promoting service user participation and capacity building initiatives. A list of mental health related projects funded is provided in Appendix 2.

Chapter 4 – Social Inclusion

- The Office of the Assistant National Director, Mental Health worked closely with the Department of the Environment, Community and Local Government in preparing the Housing Strategy for People with Disabilities. The Strategy was published in October 2011. The Office also participated in the Implementation Planning Group for the Strategy and in the preparation of a guidance document for HSE Mental Health Services to support the implementation of the Housing Strategy, which will be circulated early 2012.
- The HSE continued to support Social Housing Agencies active in mental health – HAIL, Sli Eile, Mental Health Associations and STEER.
- The Office of the Assistant National Director, Mental Health participated on the steering group for Housing First Demonstration Project led by the Dublin Regional Homeless Executive.

- The Office of the Assistant National Director, Mental Health participated in the Cross-Sectoral meetings between the HSE, the Gardai, the Departments of Justice and Health and the Irish Prison Service to improve peer to peer relationships in providing service for those with forensic needs.
- The Office of the Assistant National Director, Mental Health is an active participant in the Community and Voluntary Pillar (a *Towards 2016* initiative) at the Department of Health.

Chapter 5 – Mental Health Promotion

- The National Mental Health Network was established in 2011 to underpin a partnership ethos between the HSE and a range of Non-Governmental Organisations working in the sector to review and make recommendations on current information content developed by the network members to ensure that it is in line with the recommendations of AVFC.
- The '*Your Mental Health Campaign'* was further developed in 2011 with the addition of 2 radio adverts promoting '*Talk*' and '*Listen*'. It was complemented through the www.yourmentalhealth.ie website which developed a number of vignettes on minding your mental health. In 2011, plans were developed to utilise major sporting organisations to disseminate the key messages of the *Your Mental Health* campaign during 2012.
- The *Let Someone Know* advertisement continued in cinemas. Research has shown its effectiveness with its target audience. The *Mind your mental health* TV ad. has been shortened to 30 seconds as the feedback from focus groups indicate that people are now aware of the message and plans for 2012 involve developing new targeted messages.
- The National Office for Suicide Prevention (NOSP), in partnership with the Departments of Health and Education and Skills, is developing a National Guidance Framework on Mental Health Promotion and Suicide Prevention in the Post Primary School setting.
- The NOSP is funding the Men's Health Forum to develop and implement a suicide prevention programme targeted specifically at young men. This programme commenced in 2011 and will link with all-island sporting organisations to deliver part of the intervention and deliver key messages during major sporting events in 2012, including the GAA All - Ireland Championship Series, the European Football Championships and the London Olympics.
- The NOSP continued to fund the National Farm TV Mental Health Awareness Campaign, which is shown in marts on a weekly basis throughout the country. The campaign has been supported with mental health awareness literature distributed at Farming marts.
- The NOSP supported the development of an information resource specifically for the farming and rural community. This resource was

developed by the Irish Farmers Association as part of their involvement with the *See Change* campaign and was widely distributed during the national ploughing championships and will be distributed through relevant support agencies and representative groups early in 2012.

- The HSE resources the Rural and Farm Stress Helpline based in the HSE South area. The helpline receives and responds to calls from across the country. An evaluation of the Helpline demonstrated its benefit in supporting and responding to people living in isolation with mental health problems.
- In 2011, the NOSP provided ongoing suicide prevention training through the ASIST and SafeTALK programmes to key groups working and living in rural communities e.g. IFA, Dept of Agriculture, Food and Marine and Veterinary Professionals. This training increased the capacity within rural communities to respond to individuals displaying signs of suicidal behaviour.
- The NOSP provides a Suicide Prevention Programme targeted at the Veterinary Profession which consists of a 24 hour Free-phone Professional Counselling Helpline; access to Face-to-Face Professional Counselling; anonymous or "low-stigma" online Professional Counselling accessed through e-mail and real-time "Live Connect"; and a dedicated *"Wellnet"* internet website, containing over 5,000 articles and resources on health, wellbeing, parenting, finances, legal information, consumer rights and workplace issues. The Programme has been promoted to the Veterinary Profession throughout 2011.
- The Farm Animal Welfare Advisory Council's Early Warning/Intervention System continued to operate in each county and provided a framework within which farm animal welfare problems could be identified and dealt with before they become critical.
- In 2011, the NOSP and the Resource Officers for Suicide Prevention in the HSE West developed a resource for communities detailing how they can respond in the immediate aftermath of suicide, as well as developing medium to long-term suicide prevention action plans. A section of the resource gives guidance for sporting organisations on how they can respond to the death of a member by suicide. Further work on the development and dissemination of these guidelines to national sporting organisations will be completed in 2012.

Chapter 7 – Mental Health in Primary Care

- The Mental Health in Primary Care Project and Project Director post supported and funded by the Office of the Assistant National Director, Mental Health in partnership with the Irish College of General Practitioners (ICGP) continued in 2011.
- A third cohort of Primary Care Team representatives completed the Team-based approaches to Mental Health in Primary Care accredited programme and the programme was reviewed.

- The Office of the Assistant National Director, Mental Health worked closely with the Office for Disability and Mental Health in the Department of Health to develop proposals to achieve the objectives in the Programme for Government to increase access to psychotherapy and counselling within a primary care setting.

Chapter 9 – Community Mental Health Teams (CMHTs)

- Analysis of CMHT professional profile and composition completed.
- The Office of the Assistant National Director, Mental Health worked closely with the Department of Health to develop proposals to complete the existing General Adult CMHTs.

Chapter 10 – Child and Adolescent Mental Health Service (CAMHS)

- The Third Annual Child and Adolescent Mental Health Services Report was published in December 2011.
- Additional CAMHS inpatient capacity has been provided in new bespoke units in Cork and Galway with 12 beds and 20 beds respectively commissioned in 2011.
- An interim CAMHS Inpatient unit on the site of St. Loman's Hospital, Palmerstown is in development and planned to be commissioned in early 2012.
- Additional capacity in phase 2 of St Joseph's Inpatient Unit in St. Vincent's Hospital, Fairview, Dublin is expected to come on-stream in mid-2012.
- The Office of the Assistant National Director, Mental Health is an active participant in the design of the new National Children's Hospital.
- The Office of the Assistant National Director, Mental Health actively supports the work of Dáil na nÓg.
- An Taoiseach opened the Jigsaw Galway premises in July 2011. An additional €1m Innovation Funding was allocated to extend the model to 6 new communities – Donegal, Offaly, Tallaght, Clondalkin, Balbriggan and Blanchardstown.

Chapter 12 – Rehabilitation and Recovery

- A comprehensive Guidance Document on *Implementing Recovery in Practice* is being developed and will be published in Q1 2012.
- The Office of the Assistant National Director, Mental Health has worked closely with the Department of the Environment, Community and Local Government for the past 2 years in preparing the Housing Strategy for People with Disabilities. The Strategy was published in October 2011.

- The Housing First in Mental Health guidance document has been prepared for publication in 2012 (Chapters 4 & 12).
- €2m Innovation Funding was provided to GENIO in 2011 to support a number of Recovery initiatives throughout the country. The service arrangement with GENIO is managed by the Office of the Assistant National Director, Mental Health.
- The development of the Recovery Context Inventory research, development and online iteration was supported by the Office of the Assistant National Director, Mental Health.

Chapter 13 – Mental Health Services for Older People

- The Mental Health Services for Older People have been active participants in the working group to develop a performance indicator suite for general adult and mental health services for Older People in 2011. This has been led in partnership with the Executive Clinical Directors (ECDs).

Chapter 14 - Mental Health and Intellectual Disability (MHID)

- The Office of the Assistant National Director, Mental Health through the provision of Innovation Funding to Genio has supported innovative projects to move individuals with MHID to more appropriate settings.
- The Office of the Assistant National Director, Mental Health collaborated with colleagues in Disability to support the transfer of Service Users from inappropriate psychiatric settings to suitable disability services.

Chapter 15 – Special Categories of Mental Health Service

Forensic Mental Health Services

- The Office of the Assistant National Director, Mental Health worked with the National Forensic Service Reconfiguration Project Group to prepare the business case and option appraisal which secured the capital investment to advance the new Central Mental Hospital, Intensive Care Rehabilitation Units and the forensic provision for Mental Health Intellectual Disability and Child and Adolescent Units.
- The National Forensic Service Reconfiguration Project Team and a Project Manager were appointed in 2011. Detailed project briefs were prepared and site selection and surveys were conducted during 2011. A design team will be selected in February 2012.
- Barricade Incident support to Gardai provided by the National Forensic Services commenced January 2011 (Barr Tribunal recommendation).
- A supported residential programme for individuals on conditional discharge (Criminal Law (Insanity) Act, 2006) commenced in Q4, 2011.

Substance Misuse

- The Office of the Assistant National Director, Mental Health has worked with the Chief Medical Officer in the Department of Health in preparing the National Substance Misuse strategy.

Eating Disorders

- The Office of the Assistant National Director, Mental Health and the National Clinical Lead for Mental Health worked with the Department of Health on proposals to implement an Eating Disorder Clinical Programme.

Suicide Prevention

- The NOSP continued to deliver the ASIST and Safe Talk programmes through its network of local co-ordinators. 25,000 people have now been trained in the ASIST Programme and 5,000 have been trained in the Safe Talk programme. Training for Trainers (T4T) was run in September. This brought the number of trainers to 100. Training initiatives continued with the Gardai, Veterinary, Prison and Defence Forces.
- The NOSP also began the implementation of the *Understanding Self Harm* programme which was initially developed by the HSE South and evaluated by the National Suicide Research Foundation. It is hoped that in 2012 this programme will be available on a national basis.
- The NOSP has supported the following projects in 2011:-
  - The National Youth Council of Ireland – to deliver Health Skills Based Training Programme.
  - Crosscare National Traveller Suicide Awareness Project – to develop Community Development approach.
  - Dodder Valley / Suicide Action West – to create a model of interagency support.
  - Dublin South East Cognitive Analytical Behaviour (CAT) **–** training five Clinical Psychologists in CAT.
  - Suicide Crisis Assessment Nurse (SCAN) Projects - roll-out SCAN model to three more services.
  - Health Promotion, Sligo – research to identify best practice evidence based programmes to promote mental health.
  - Pieta House – treatment model for people who engage in self harming behaviours.
  - Curam Clainne (*Family Life Services*) **-** pilot the model of "social prescribing" in County Mayo as a way of reducing the risk of suicide. In addition, an accredited counsellor will provide specialist family support in the immediate aftermath of suicide bereavement.

- Shine – national roll out of its one-day workshop *'Taking Control'*.
- Western Region of Family Resource Centres c/o Clann Resource Centre – The Family Resource Centres are part of the National Programme of the Family and Community Resource Services Programme which act as frontline support for individuals, families and communities experiencing stress, anxiety, depression and isolation.
- Senior Helpline - funding was awarded to update and up-skill Senior Helpline Volunteer staff in Mental Health / Suicide Awareness and their role in crisis intervention by composing and delivering an updated training module incorporating specific helpline skills for dealing with calls of a suicide nature.
- GROW / HSE Joint project will be delivered in three stages with the aim of empowering local communities to develop area specific suicide prevention strategies.
- Skills based Training Programme of General Practitioners in Suicide Prevention.
- BelongTo: to develop the skills of youth workers, volunteers, steering groups and young people.
- The Samaritans – to establish and provide a converged Caller Contact System (CONNECT) to improve the experience of each call connecting with Samaritans and other partner Helplines while increasing the support options available to callers via Samaritan volunteers.
- The Eden Programme – an evaluation of this is being undertaken.
- The NSRF & Cork Liaison Psychiatry Service **-** a collaborative project related to the assessment of deliberate self harm patients presenting to HSE South hospital emergency departments and training of HSE staff who come into contact with deliberate self harm patients.
- Inspire Ireland **-** a computer programme called *Silvercloud* which has been used as a platform to develop a number of therapeutic programmes.

Borderline Personality Disorder

- The NOSP has funded a number of Training programmes in Cognitive Behavioural Therapy and Dialectical Behavioural Therapy (DBT) in 2011. The therapy is specifically aimed at those with a diagnosis of Borderline Personality Disorder. Services participating in training include:
    - HSE North Dublin Mental Health Service
    - Cavan Monaghan Adult Mental Health Service
    - Ardee Adult Mental Health Services (HSE)

- Endeavour Programme, North Lee Adult Mental Health Service Training & Research
- Westport Ballinrobe Adult Mental Health Service.

Chapter 16 – Management and Organisation of Mental Health Services

- The Office of the Assistant National Director, Mental Health led on Industrial Relations negotiations with the nursing representative organisations (*PNA & SIPTU*) in relation to the establishment of the Director of Nursing role for the extended catchment areas/integrated service areas. A final meeting is scheduled for early 2012 to finalise the agreement.
- In partnership with the Joint Forum, the Office of the Assistant National Director, Mental Health has been an active participant in the review process around the second filling of the ECDs (Mental Health) posts, which is expected to progress to recruitment in early 2012.
- The Office of the Assistant National Director, Mental Health, in partnership with the ECDs, has developed a pilot Key Performance Indicator programme for General Adult CMHTs and Psychiatry of Old Age CMHTs which it is intended to integrate with Healthstat in 2012.
- The Office of the Assistant National Director, Mental Health is represented on the Consultant Appointment Advisory Committee ensuring all Consultant appointments conform to AVFC recommendations.

Chapter 17 – Financing Mental Health Services

- Total Revenue for Mental Health provision in 2011was €708m.
- Since AVFC was published, the HSE has spent €190m on mental health infrastructure and has further contracted commitments of €57m. The multi annual capital plan also shows non-contracted but planned spend of a further €170m (including €90m for the Central Mental Hospital). That means that a total of €417m of investment will be made. This does not include the community facilities that have been acquired under the primary care centre lease program (estimated equivalent value to date €20m). In that period there has been a total of €37m from sale of lands.
- In 2011, major progress was made in advancing and commissioning mental health facilities across the care spectrum including; acute inpatient units, Community Mental Health Centres, CAMHS inpatient and Day Hospital facilities, the National Forensic Hospital project, New Children's Hospital and High Support Housing developments. Attached at appendices 3, 4 and 5 are lists showing: - prioritised mental health capital projects, other significant projects in train and the closure and replacement programme for the traditional psychiatric hospitals.

Chapter 18 – Manpower, education and training

- The Office of the Assistant National Director, Mental Health led on the promotion and development of Mental Health Service e-Learning Hub and additional Mental Health Act training content.
- The Office of the Assistant National Director, Mental Health has co-chaired the *Vision for Mental Health Nursing* initiative with the National Director of Nursing. This comprehensive project brought together Senior Nurse Managers, Service Users, Educators and Academic colleagues, Staff representative bodies, An Bord Altranais, the MHC and senior service management to conduct an extensive review of the role of mental health nursing.
- 34 Clinical Psychologists graduated in 2011, funded and supported by the HSE in collaboration with Trinity College Dublin, National University of Ireland Galway, University of Limerick and University College Dublin. The Clinical Psychology Doctoral training programme is co-ordinated by the Office of the Assistant National Director, Mental Health.

Chapter 20 – Transition and Transformation

- The Office of the Assistant National Director, Mental Health developed and managed the Vision-Online-Survey which was completed by each of the ECDs for their catchment area in December 2010 and again in May 2011. This quantitative survey demonstrated progress against the recommendations of AVFC for each catchment as reported by their ECD.
- The Office of the Assistant National Director, Mental Health is extensively involved in reviewing the Mental Health Act 2001 with the Department of Health and MHC.
- During 2011, the Office of the Assistant National Director, Mental Health worked with the Office for the Minister for Disability & Mental Health and the Independent Hospitals Association Ireland to examine the potential role for the independent hospital sector in mental health in advancing AVFC recommendations.
- Through the allocation of Innovation Funding to Genio in 2011, the HSE contributed to a number of innovative projects in mental health to progress the recommendations in AVFC – projects funded are listed in appendix 2.
- The Office of the Assistant National Director, Mental Health chairs the HSE's National Counselling Service which provides a service to adults who have experienced institutional abuse. €1.8m in once-off funding was made available to the National Counselling Service in 2011 to reduce the waiting lists. Once-off funding was released to the Service in August 2011 and by the end December 2011, €602,989 was spent providing 7,800 counselling sessions to over 317 individuals with a history of childhood abuse.

- The Office of the Assistant National Director, Mental Health is collaborating with Mental Health Reform, Trinity College Dublin and Amnesty Ireland to examine opportunities for retraction modelling of the existing resource base.
- The Office of the Assistant National Director, Mental Health is facilitating the evaluation and audit of the National Psychiatric In–Patient Reporting System database with the Health Research Board to validate data quality.
- The Office of the Assistant National Director, Mental Health sponsored the Independent Evaluation of Sli Eile Housing project.
- The Office of the Assistant National Director, Mental Health worked with Misha Films and RTE in the production of the '*Behind the Walls'* TV documentary on the history of mental health provision in Ireland, which was transmitted in September 2011.
- The *National Vision for Change Working Group,* in association with the NOSP and the Office of the Assistant National Director, Mental Health, has prepared a suite of evidence based guidance documents on a range of themes. These documents have been developed by multidisciplinary groups working with service user representatives at a national level. The extensive materials prepared during 2011 will be published online at a series of public events in early 2012 and include:-
    - Implementing Recovery in Practice (Chapter 12);
    - Advancing Mental Health in Primary Care interface (Chapter 7);
    - Components of Secondary Acute Community Mental Health Care (Chapter 8);
    - Mental Health Management Teams, Role & Function (Chapter 16);
    - Housing First in Mental Health (Chapters 4 & 12);
    - Psychosocial response to Major Emergency (Chapter 15);
    - Extended Suicide & Suicide Clusters (Chapter 15).

  A number of these guidance documents were published in May 2012 and are available at **http://www.hse.ie/eng/services/News/Campaigns/VFCguidance.html**

2.2.2 Summary of progress on implementation as reported by the Health Service Executive at regional level

HSE WEST REGIONAL REPORT

The HSE West covers a total Population of 1,081,398 (2011 Census) and mental health services are managed via an Integrated Area model of service delivery. Mental health services are configured into the following extended catchment areas with an appointed ECD:

North West:	Donegal/Sligo/Leitrim	(Pop: 257,975)
West:	Galway/Mayo/Roscommon	(Pop: 444,993)
Mid West:	Limerick/Clare/North Tipperary	(Pop: 378,430)

A Regional Strategic Management Group, consisting of the ECDs, lead Area Manager for mental health and mental health specialist, reports to the Regional Director of Operations in supporting the mental health governance structure within HSE West.

AVFC Advances in 2011

HSE North West

Donegal

- New Acute Inpatient Unit opened in September 2011.
- A Homeless Planning Group was established in Letterkenny - this multi-agency group involving Mental Health Staff, St Vincent De Paul, Advocacy Group (STEER) and Donegal County Council Housing Department advanced plans for the provision of health and social services to this marginalised group.
- Carndonagh Social Housing Planning Group comprising of Mental Health Staff, Donegal County Council Housing Staff and STEER (Advocacy) was established with a remit of relocating clients from Carndonagh Supervised Residential Unit to community settings.
- Reconfiguration plans are ongoing to provide three adult CMHTs per 50k population in Q2, 2012.
- Integrated working has resulted in a mental health professional been allocated to each primary care team in Donegal.
- The base for the CAMHS team in Donegal Town has been refurbished.
- Continuing participation in the Dublin City University Project and Trialogue meetings.
- Plans to introduce Jigsaw project advanced.
- Public representatives in Donegal have participated in the ASIST training programme.

- The Mayor of Ballyshannon held a charity event in consultation with Mental Health Services, the proceeds of which will fund an anti stigma campaign through visual arts and drama in the town.
- Appointment of Co-operation and Working Together (CAWT) Eating Disorder Specialist Nurse Practitioner.
- Appointment of CAWT Addiction Counsellor for Alcohol.

Sligo/Leitrim

- Although not up to full staff CMHTs are in place in:
    - North Leitrim – Manorhamilton
    - South Leitrim – Carrick on Shannon
    - Sligo – Sligo Town
- Day Hospitals are operational in:
    - North Leitrim – Manorhamilton
    - Sligo Town – implemented the recommendations of the 2010 Day Hospital Review
    - Psychiatry of Older Age
- Based on the 2010 multidisciplinary team assessment of all clients in long term residential settings:
    - One Supervised Residential Unit closed in 2011
    - One Supervised Residential Unit is under review
    - One Supervised Residential Unit has been completely refurbished.
- Agreement reached on reduction of 15 acute inpatient beds.
- An integrated Working Group has been established with Older Persons Services to review admission protocols to the Alzheimer Unit.
- Integrated working with Primary Care and on Primary Care Teams has resulted in:
    - a named Cognitive Behavioural therapist has been assigned to each GP practice in the Sligo Leitrim Mental Health Services (SLMHS) catchment area.
    - a named Community Psychiatric Nurse has been assigned to each GP practice in the SLMHS catchment area.
    - Mental health is represented by either nursing or an allied mental health professional on every Primary Care Team in the SLMHS catchment area.
- Integrated working with Disability Services around Congregated Settings.
- Increased engagement with advocacy service.

- Transfer of Sligo Group Homes to Rehabilitation and Recovery Team.
- Appointment of CAWT Eating Disorder Specialist Nurse Practitioner.
- Appointment of CAWT Addiction Counsellor for Alcohol.
- Health Promotion - a research based initiative has been designed to identify best practice, evidence–based programmes to promote the mental health of the population and identify and support those individuals with early signs of mental distress. The anticipated outcome is to support / enhance the capacity of Primary Care Services when responding to people presenting with mental health difficulties, including suicidal behaviour, who may not require an immediate clinical intervention after an initial assessment.

HSE West

Galway/Roscommon

- New CAMHS inpatient facility opened on a phased basis in 2011 and became fully operational in Q4, 2011.
- Approval received for 2nd Consultant for CAMHS inpatient facility with a liaison brief to the Mid West - appointment due Q1, 2012.
- Jigsaw operating successfully in Galway with a satellite facility planned for Roscommon.
- St. Brigid's Hospital in Ballinasloe closed and patients transferred to more appropriate settings including a newly developed community nursing unit (CNU).
- Approval sought for replacement of consultant post to develop Mental Health and Intellectual Disability services in line with AVFC in Galway.
- Agreement has been reached to develop adult CMHT sectors across Galway / Roscommon based on 50k population. Final mapping of services and associated reconfiguration plans to be completed in Q1, 2012.
- Agreement reached on reduction of 37 acute beds.
- National Psychiatry of Later Life Conference held in Galway in May 2011.
- Successful GENIO funding bid resulting in the approval for a SCAN nurse for Galway.
- Planning permission granted for new acute inpatient unit in University College Hospital Galway.
- Galway Mental Health Services in conjunction with *See Change* commenced plans to deploy an Anti Stigma Campaign at Volvo Ocean Race, July 2012.

Mayo

- ImRoc Project on Recovery Oriented Practice established and Mayo is the lead site nationally for this project. There is also a project group that participates in a UK based Learning Set project. The membership of the working group and the project comprises people from the statutory, community and voluntary sectors and there is participation from the national and regional HSE mental health services on the project working group also.
- A draft Strategy on Recovery Oriented Practice is being prepared for consultation and implementation throughout the service in Mayo, which will be followed by internal consultation within the HSE and externally within the community and voluntary sectors.
- Care planning process being rolled out across all CMHTs.
- A GENIO funded "Prosper Project" focussing on Peer Support in recovery has been launched and a Project Manager has been appointed to commence work on February 1st 2012.
- Closure of 22 beds and reconfiguration of services has taken place in "The Fairways Project" in Swinford.
- Continuing participation in the Dublin City University Project and Trialogue meetings.
- Continuing to meet and build relationships with Carers and Service User Groups.
- Headquarters agreed for North Mayo team in new Ballina Primary Care Centre.
- Management Group for Mayo CAMHS established which includes the General Manager Mayo Mental Health Services, CAMHS Consultants and Professional Leads.

Mid West

Limerick, Clare and North Tipperary

- CMHTs are in the process of being reviewed to bring them in line with AVFC and the development of Primary Care Networks in the Mid-West super catchment area.
- St. Josephs Hospital, Limerick has closed 25-beds and a proposal has been approved for the closure of St. Mary's Ward. An implementation plan is being rolled out with a view to having eight female patients relocated to Community Residences in Q1, 2012.
- The redevelopment of the Acute Psychiatric Unit, 5B, Mid-Western Regional Hospital, Limerick commenced in September 2011 with a reduction in bed capacity from 50 to 40 beds for the duration of the project. Beds were reduced on a phased basis during the month of August to facilitate the commencement of the refurbishment work. It is

anticipated that building works will continue for approximately 18/24 months.

- The provision of 20 acute inpatient beds in St Michaels Unit, Clonmel ceased in September 2011 resulting in the transfer of inpatient services to Acute Psychiatric Unit in Ennis.
- Orchard High Support 16-bed Unit in Clare closed in 2011.
- Approval/Appointment Clinical Nurse Manager 2, imminent, for Mental Health Services for Adults with Intellectual Disability, Daughters of Charity Service.
- Senior Registrar in Nenagh providing Service to St. Anne's Intellectual Disability Service in Roscrea.
- Approval by An Bord Altranais for two Advanced Nurse Practitioner posts for Super Catchment Area - one post being progressed.
- Local Implementation Groups will be established in Q1, 2012 as part of the development of the Super Catchment Area in Limerick, Clare and North Tipperary.
- National Advocacy Network Representative structure to be rolled out to the entire Mid-West.
- Shared Resources: plans are being developed to accommodate one client from North Tipperary in High Support Residence in Limerick mental health services.
- Consumer Panel: Both Clare and North Tipperary mental health services are engaging with stakeholders in progressing the establishment of a Consumer panel for the area. This is being progressed in line with consumer panels in existence in Limerick Mental Health Services and it is hoped that this initiative will evolve into an Integrated Service Area wide Consumer network.
- Mental Health Super Catchment Area Management Team established and in place with inaugural meeting held on the 24th October 2011.
- Appointment of Business Manager for the Super Catchment Area finalised in the third quarter of 2011.

Conclusion

The Mental Health Service Plan 2011 included a mixture of measures aimed at improving service user health, independence and experience and, at the same time, continuing to reconfigure service delivery to ensure increased efficiency. This, in combination with the Capital Investment in mental health, has progressed the modernisation of the mental health services in line with the recommendations of AVFC, albeit slowly.

HSE SOUTH REGIONAL REPORT

HSE South Mental Health Services include a broad range of acute, community and specialised inpatient services for children and adolescents, adults and older people.

Resources

The financial allocation for mental health services in HSE South in 2011 was in the order of €186m which supported the provision of the following services:

- 301 Acute inpatient beds
- 405 Long stay beds
- 709 Community Residential Places: 456 High Support, 137 Medium Support, 116 Low Support
- 267 Day Hospital places
- 610 Day Centre places

The table below shows the population, budget and wholetime equivalents for Mental Health Services in HSE South in 2011 by expanded catchment area/integrated service area.

Expanded Catchment Area	Population	Budget 2011	Total WTE's
North Lee	167,701	32,014,065	383.2
North Cork	80,769	22,732,537	346.26
Total ECA	**248,470**	**54,746,602**	**729**
South Lee	179,260	13,459,753	180.47
West Cork	53,565	7,504,519	105.33
Total ECA	232,825	20,964,272	286
Total Cork	**481,295**	**75,710,874**	**1,015**
Kerry	139,835	22,558,644	298.83
Total Kerry	**139,835**	**22,558,644**	**299**
Wexford	131,749	18,738,803	256.72
Waterford	123,844	16,894,028	243.47
Total Wexford / Waterford	**255,593**	**35,632,831**	**500**
C/KK	120,631	31,681,808	466.5
Sth Tipp	84,614	20,461,667	298.51
Total Carlow / Kilkenny / South Tipperary	**205,245**	**52,143,475**	**765**
Overall Total	1,081,968	186,045,824	2,579

Development of Mental Health Model

In line with AVFC recommendations, four ECDs have been appointed in the HSE South. They have been selected to lead on the development of Executive Clinical Directorates in mental health based on revised catchment areas serving populations of approximately 300,000.

HSE South Implementation of AVFC

In planning the implementation of AVFC in HSE South there were significant challenges to be faced in the South East which required urgent reconfiguration of the service both to meet the standards of AVFC, and to address the deficiencies identified in a number of key reports including the Section 55 Report (the review of care and treatment practices in St. Michael's Unit, South

Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel), the Annual Reports of the Inspector of Mental Health Services and ongoing engagement with the MHC.

In this regard a decision was made to target the South East initially for development. This focus on the South East resulted in significant levels of progress in the development of Implementation Plans for both Carlow / Kilkenny / South Tipperary (CKST) and Waterford / Wexford (WTWX) and significant progress has been made to date in the implementation of these plans including the closure of beds in old institutions and transfer of patients to more appropriate settings, infrastructure developments, reduction in acute beds and development of community based services. Given the significant change process which has been undertaken both areas are at an advanced stage in the implementation of AVFC.

It is important to acknowledge that in progressing the implementation of AVFC, choices had to be made around the prioritisation of developments and in that context HSE South prioritised South Tipperary, Waterford and Wexford over other areas in the region as the need was greater there. In particular, capital funding has been prioritised to these locations to support the change programmes and as a result HSE South did not have the resources required to finalise the closure of St. Finan's Hospital in Kerry or the development of community based infratsruture in South Lee. At the same time, HSE South has made progress across the whole region in terms of the development of teams and some key specialist services.

A 50-bed AVFC compliant unit based on the grounds of Cork University Hospital is to go ahead pending approval of the Capital Funding, this is part of the enabling works for the Cancer Strategy. Planning Permission has been received and the tender documents are prepared - 18 month build once approval is received.

Reduction in bed complement in line with AVFC

A key priority for the HSE South has been to close the old long stay institutions and thereby reduce long stay beds and to utilise the resource freed up to support the development of community based services. At the same time, HSE South continued to focus on the reconfiguration of acute inpatient services in line with AVFC recommendations. Progress is being made on all these fronts including:

- The transfer of the North Tipperary Acute Service from St. Michael's Unit to HSE West was completed in October 2011. 20 beds closed in St. Michael's unit in October 2011.
- Work is continuing to relocate the patients in St Luke's, South Tipperary and with the completion of the CNU in March 2012 and the Community Residences in June 2012, St Luke's will close as an approved centre.
- St Dympna's Hospital in Carlow closed its long stay beds in October 2011 with patients re-accommodated in other more appropriate sites according to their needs.
- Closure of St Canice's Hospital, Kilkenny.

- Patients resident in St Senan's Hospital will be accommodated in the new developments due to be completed in 2012 - these include a CNU and a number of Community Residences.
- St Finan's Hospital, Kerry will no longer take direct admissions and long stay beds will continue to be reduced having only the high dependency beds within the main building. The remainder of the patients will transfer to more appropriate accommodation either on site (O'Connor unit) or community residences.
- South Lee – St Monica's ward in St Finbarr's Hospital closed its 13 long stay beds.

In respect of HSE South, AVFC recommendations indicate a requirement of 193 acute inpatient beds for the population of the South that is 50 beds per 300,000 population, this is predicated on implementation of recommendations in AVFC with regard to CMHTs, specialist services etc being in place. At the beginning of 2011, HSE South had 352 beds in place (159 above recommended number). There are now 301 following closure of acute beds in St Senan's (31 in April 2011) and reduction of beds in St Michael's Clonmel (20 in October 2011). In 2012, additional bed reductions are planned.

Community/Specialist Mental Health Teams

In relation to the development of Community/Specialist Mental Health Teams in HSE South, the table below shows the number of Community/Specialist Mental Health Teams required using AVFC norms and the number currently in place in HSE South. In 2011, as part of the reconfiguration of services a number of teams were amalgamated to form enhanced CMHTs. This will bring together the key professionals to provide a range of mental health interventions for a defined community. This includes:

- Carlow/Kilkenny/South Tipperary - enhanced CMHTs in development (three CMHTs in South Tipperary will amalgamate into one, two CMHTs in Carlow amalgamate into one and three CMHTs in Kilkenny amalgamate into one) (population 205k). Home Based Treatment Teams in operation since 31st October in South Tipperary (7 day service) and operational in Carlow and Kilkenny since 5th December.
- Waterford/Wexford – adult sector teams have been re-organised into four large sectors with eventual progression to five sectors (population 255k).
- Cork – plans in development to re-organise the existing 13 CMHTs to 10 to cover sectors of approx 50k.

Services	No. of Teams Required	No. of Consultant-led Teams in Place	Minimum no. of WTEs required per team	Total no. of WTEs required	Approx no. of WTEs in Place	Remaining WTEs to be filled
Child & Adolescent Mental Health Services	22	12	13	286	93 (33%)	193
General Adult Mental Health Services	22[1]	25[2]	21	468	278 (59%)	190
Rehabilitation	10	6	22	220	44 (20%)	176
Mental Health Services for Older People	11	5	12	132	38 (28%)	94
Mental Health Services for Adults with Intellectual Disability	8	1	10	80	5[3] (13%)	75
Total	**72**	**49**	**N/A**	**1,186**	**458(39%)**	**728**

[1]Note: This is the number of teams required as they are described in AVFC where each CMHT has two consultant psychiatrists

[2]Note: The majority of existing CMHTs have only one consultant psychiatrist, hence the apparent excess in the number of teams currently in place. Amalgamations of teams in South Tipperary, Carlow, Kilkenny, Waterford & Wexford and North Lee and South Lee have reduced teams from 35 to 25 in 2011.

[3] Note: By and large, these WTEs comprise consultant and Non-Consultant Hospital Doctor posts associated within patient facilities voluntary providers and/or stand alone community based consultant provided services

Development of Community Mental Health Facilities in Primary Care

In the development of Primary Care Centres, facilities for mental health are being accommodated where required, which can be dedicated space in some Primary Care Centres or bookable rooms for visiting clinicians. Centres in a number of areas have been completed and mental health services have dedicated accommodation in Mallow Primary Care Centre and access to bookable rooms if required in Gorey Primary Care Centre.

Developments in the following areas are progressing and are at different stages of development: Macroom, Clonakilty, Fermoy, Charleville, Schull, Ballincollig, Blackrock, Listowel, Newmarket, Kilkenny, Callan, Waterford City, Dungarvan, Enniscorthy, New Ross, Tipperary, and Clonmel. As Centres are completed facilities for Mental Health services will be accommodated where required.

Service User Involvement

As part of the overall process, the development of the service user role is a fundamental component of the model being developed in HSE South. Formal arrangements have been put in place with the NSUE to develop a

comprehensive framework for service user involvement over the next few years.

HSE South Capital Developments

In recent years HSE South has completed a number of significant Capital Projects in Mental Health Services. These include:

Project – Brief description	Year	Capital Spend HSE/Other	Additional Service	Clients Served
Interim Inpatient Unit for Child & Adolescent Services	2009	2.2m	8 beds for Child & Adolescent Services	Regional Unit – for Children up to 18 years.
Inpatient Unit for Child & Adolescent Services at Bessboro	2010/2011	8m	20 Inpatient beds for Child & Adolescent Services (replacing the interim bed unit)	Regional Facility for children up to 18 years.
Sth Tipp Clonmel Mental Day Centre & Day Unit	2008/2009	1.58m	Day Centre	Mental Health
Carlow/KK Replacement of Kelvin Grove, Carlow	2008/2009	3.5m	Relocation of clients inappropriately placed in Psychiatric Hosps.	17 clients within St. Dympna's Hospital with co-morbid mental health and intellectual disability.
Carlow/KK Crisis House, KK	2008/2010	2.5	Additional beds	Mental Health
Wexford Maryville CMHC.	2006/2007	1.22	Community	Mental Health
Wexford Gorey, CMHC	2008/2009	4.22	New Mental Health Day Hospital: Day Hospital and base for multi-disciplinary Sector team. .	Mental Health
Waterford, Grangemore	2008/2009	2.62	Rehabilitation	
North Cork Kanturk Cois Alla Housing Project	2006/2007	HSE & CMHA	Relocation of clients from St. Stephens.	14 beds, 4 independent flatlets
South Lee Carrigaline MH Resource Centre	2010	HSE/Cluid - 1m HSE	Day Hospital	Mental Health

In addition to the Capital Projects completed, HSE South is engaged in an ongoing Mental Health Capital Programme to facilitate the completion of reconfiguration of services. In this regard, a number of facilities are included in the National Capital Plan & National Service Plan 2012 including the following:

South	Location	Facility	Completion date	Operational date
South	Dungarvan	Day Hospital (with Primary Care)	Q4 2012	Q4 2012
South	Tipperary South	Provision of a 40 Bed Residential Unit, on the existing site, to accommodate current residents of St Luke's	Q1 2012	Q1 2012

South	Tipperary South	High Support Hostel, Clonmel.	Q2 2012	Q2 2012
South	St John's Enniscorthy	Rehab House	Q4 2011	Q4 2011
South	St John's Enniscorthy	13 Place High Support House Mill View. In the grounds of St John's Enniscorthy. To rehouse residents from St Senan's.	Q4 2012	Q4 2012
South	Clonmel, Tipperary South	Day Hospital & Accommodation for Sector Team and Psychiatry for Later Life Team. Funded from sale of lands.	Q1 2012	Q1 2012
South	Waterford Regional	Upgrade Acute MH Unit.	Q1 2012	Q1 2012
South	Waterford	Day Centre	Q1 2012	Q1 2012
South	Wexford	2 ID Houses Haven view 1 & 2	Q4 2012	Q4 2012
South	Tipperary South	Crisis/Respite House (permanent)	Q4 2012	Q1 2013
South	Wexford	50 Bed CNU	Q3 2012	Q4 2012
South	Kerry General Hosp	High Observation Unit	Q4 2012	Q4 2012

Summary of Developments since March 2011 Report

The implementation of AVFC across HSE South continued as planned throughout 2011 with very significant milestones throughout the year. A summary of the development since March 2011 includes:

Carlow / Kilkenny / South Tipperary

The Carlow/Kilkenny/South Tipperary Mental Health Services are currently implementing a comprehensive change programme which is transforming the existing service into a modern, fit for purpose service providing a service of excellence to the local population.

- The transfer of the North Tipperary Acute Service from St. Michael's Unit to HSE West was completed in October 2011.
- 20 beds closed in St. Michael's unit in October 2011.
- Re-deployment of 17.5 staff from St. Michael's Unit to the development of Community Mental Health Services in South Tipperary.
- Construction has commenced on the new Day Hospital and Community Mental Health Team Base in Clonmel and is on schedule for target completion date of April 2012.
- While the permanent Day Hospitals and CMHTs are being developed, an interim Day Hospital was established in Clonmel on the 31st of October 2011 and a further Day Hospital became operational in Cashel.

- Development of a Home Based Treatment Team in South Tipperary that is now operating on a 7 day basis. This enables service users to receive treatment in their own home environment.
- Reallocation of acute bed provision in St. Luke's Hospital, Kilkenny to accommodate admissions from South Tipperary.
- Extension of Acute Day Hospital Services in Carlow & Kilkenny.
- Development of a Home Based Treatment Team in Carlow / Kilkenny.
- Amalgamation of CMHTs in Carlow.
- Amalgamation of CMHTs in Kilkenny.
- Ongoing review of residents in Hostel accommodation.
- Involvement of service users and their carers in service planning and development through their membership of consumer panels. This is progressing well.
- Ongoing consultation with Staff and Unions.

Wexford / Waterford

- Re-organisation of Sector Teams – adult sector teams have initially been re-organised into four large sectors to accommodate operationalising this system of patient management with eventual progression to five sectors.
- Building of CNU commenced - completion date Q3, 2012.
- Development of day hospitals underway in a number of areas (Dungarvan, Gorey, and Waterford) completion dates in 2012.
- Extension of day services from 5 to 7 day a week service.
- Rehab/Crisis House – Tus Nua completed.
- Three High Support Residences – underway due for completion end of 2012.
- Refurbishment of Acute Unit Waterford underway - to be completed Q1, 2012.
- Development of multi-faceted community based mental health services has allowed acute psychiatry bed capacity to be reduced with the closure of acute unit in St Senan's Hospital and the Department of Psychiatry, Waterford Regional Hospital providing acute beds for the combined catchment area.
- Reduction of long stay beds in St Senan's Hospital, Wexford.

Cork

The establishment of the Cork Integrated Service Area (population - 518,218) and the subsequent management restructuring introduced by the Area Manager brings all mental health services in Cork under a unified management structure.

A senior manager has been tasked with responsibility and accountability for all mental health services in Cork and is also tasked with translating the AVFC goals, objectives and vision into a model and design for mental health services in Cork. To support this endeavour a representative steering group has been established. First draft report has been completed – Recovery: Unleashing the Potential in MHS in the Cork Integrated Service Area. Two interim management team structures have been put in place – North Lee & North Cork and South Lee & West Cork. These will move to one management structure over time. The following initiatives/outcomes have been implemented or achieved since March 2011.

West Cork & South Lee

- A 13 bed ward closed in St Finbarr's Hospital allowing for the development of a small community rehabilitation team to support those patients discharged from long term care to work with and support difficult to engage/treatment resistant patients with severe and enduring mental illness along assertive principles.
- The team headquarters and Day Hospital for the Psychiatry of Older Age team opened Q1, 2012, funded through revenue cost savings (rent) at the former St Monica's Approved Centre, St Finbarr's Hospital.
- Regular 'Trialogue' events were held across West Cork, in which professionals, service users, carers and members of the local communities meet to discuss mental health issues in an open and relaxed forum. An event focussing on youth mental health was held on 7th October which has instigated the development of a youth mental health forum consisting of all secondary schools and youth organisations such as Youth Reach, Foroige, UCC peer mentoring programme etc.
- A range of therapeutic groups (creative writing, art, music, and gardening) have been developed in the resource centres. A *Creativity in Mental Health Group* has been formed in conjunction with West Cork Arts Centre and HSE South Arts.
- On the basis of independent research with its members, the National Service Users Executive named West Cork *'the most improved mental health service in Ireland'*.
- In June 2011, following an unannounced inspection of the service, the Mental Health Inspectorate provided very positive feedback and were particularly encouraging about service-user involvement, the commitment to the recovery philosophy and multi-disciplinary way of working.
- Based on an assessment of the service, GENIO Trust awarded service grants in 2010 (€100,000) and 2011 (€55,000) towards the development of 'person-centred care'.
- Elderwood – a Cluid Housing/HSE Project will provide 2x2 bed apartments in the community for clients of the mental health services.
- In partnership with Cluid Housing, an initiative involving the employment of a support worker is currently underway.

North Lee & North Cork

- Reduction in long stay bed capacity – Owenaccura Centre and St Stephens Centre for Recovery and Social inclusion - Charitable foundation promoting multidisciplinary professional development in HSE South and over the internet.
- Rehabilitation Services – Inniscarrig Centre at the Erinville complex linking with Cork Mental Health Association, Cork Anti-Poverty Resource Network, The Basement Resource Centre and GROW offering flexible programmes of care activities for clients in community settings.
- Expansion of Endeavour Programme – Dialectical Behavioural Therapy for persons with a diagnosis of Borderline Personality Disorder.
- City Links – Social Inclusion project facilitating the introduction of mental health clients to educational facilities (St. John's Central College) and traditional craftsmanship.
- Community Recovery Group – encourages service users to take a more central role in the management of their own mental health issues and provides practical information to achieve this.
- Arts & Minds Group – Providing clients with an opportunity to have self expression through art.

Kerry

The establishment of the Kerry Integrated Services Areas (population - 139,835) and the subsequent management restructuring brings mental health services in Kerry under the area manager for Kerry. The following are some initiatives/outcomes achieved since last report:

- Reduction of long stay beds in St Finan's Hospital (St Paul's ward)
- No new direct admissions to St Finan's Hospital.
- Review of residential care provision.
- Jigsaw Programme for young people across the county.
- Trialogues held in Killarney.

Conclusion

This paper outlines the overview of AVFC implementation across HSE South and gives details on the specifics of progress in each of the four Expanded Catchment Areas. In HSE South, the recommendations of AVFC form the key priorities for the development of HSE South mental health services. The guiding principle for the HSE South development of mental health services is the implementation of AVFC.

HSE DUBLIN NORTH EAST REGIONAL REPORT

Introduction

The publication of the preliminary 2011 Census figures in June 2011 indicates that the population in Dublin North East has increased by 9.2% since 2006. This represents the largest increase in population of any of the four regions and is slightly above (1.7%) the national average of 7.5%. In 2011, four HSE Areas were established in Dublin North East and four Area Managers appointed as follows:

- Cavan/Monaghan
- Louth/Meath
- Dublin North
- Dublin North City.

In 2011, implementation of AVFC in the Dublin North East region primarily focused on continuing to progress the closure of traditional psychiatric hospitals and on providing more appropriate accommodation for patients requiring acute inpatient admission.

A major objective for Dublin North East in the 2011 Regional Service Plan was to set out a 3 to 5 year Vision for Change Workforce Reconfiguration Plan to identify what progress could be made in terms of changing the disciplines, care settings and locations of staff to support implementation of the recommendations in AVFC. While recognising that Dublin North East has insufficient resources to fully meet the objectives of AVFC, all multidisciplinary teams in Dublin North East were mapped in 2011. A gap analysis was also conducted. However, the development of concrete plans, against the background of ongoing reconfiguration of mental health services in response to challenges in the internal and external environment including the number and impact of early retirements, has proved challenging.

Maintenance of CMHT staffing levels have been particularly challenging, nevertheless, Dublin North East made a concerted effort to maintain the numbers of psychiatric nurses. However, Dublin North East's share of the 400 posts allocated in the 2012 National Service Plan in the context of the €35m ringfenced funding for mental health, will assist in maintaining community-based mental health services.

Pending national agreement on the second filling of ECD posts in Mental Health, an Acting ECD has been appointed in Cavan/Monaghan. This brings to four the number of the ECDs in Dublin North East. Plans to establish multidisciplinary Area Mental Health Management Teams from within existing resources are at different stages in each of the Areas.

Cavan/Monaghan Mental Health Services

- Pending provision of a purpose built acute inpatient unit on the Cavan General Hospital site, a refurbished interim acute unit has been provided in Cavan General Hospital. This centralisation of acute admissions has

facilitated the closure of Ward 15 in St Davnet's Hospital, Monaghan, which means that in line with the recommendations in AVFC, all acute admissions in the Cavan/Monaghan area are now to an acute unit on a general hospital site. Service users were actively involved in the planning and implementation of this service change.

- In October 2011, the Cavan Monaghan Rehabilitation Service commenced participation in the Co-Operative Learning Leadership Programme in DCU which invites tripartite teams comprising a service user, a carer and a mental health professional to develop together, leadership and change management skills. On completion of the programme, the trio will return to the service and work together to advance AVFC objectives.

Dublin North Mental Health Services

- In early 2011, Dublin North East reported on plans to refurbish the 'ABC' unit in St. Ita's Hospital, Portrane. It was originally anticipated that the refurbished 'ABC' unit would operate as an interim acute admission unit for the Dublin North Area pending completion of the new acute unit at Beaumont Hospital in 2012. However, these plans had to be revised when it became apparent that, in the context of a worsening fiscal position, the funding required for the refurbishment works was not available.
- Consequently, acute admissions subsequently transferred, in September 2011, from St. Ita's Hospital to the Joyce Rooms in the newly built community nursing unit at St Vincent's Hospital Fairview (24 general adult beds) and to the Hawthorn Unit in Connolly Hospital (6 beds for people over the age of 65 years). Service users were actively involved in the planning and implementation of this service change.
- This reconfiguration of acute inpatient services also involved the extension and enhancement of home-based treatment services in North County Dublin.
- Planning permission for the new acute inpatient unit in Beaumont Hospital was granted in 2011. Building works will take approximately 12 months. A further 4-6 months will be required to fully commission the new units (38 general adult beds and 6 beds for people over the age of 65 years), which it is estimated will be ready for occupation by mid 2013.
- In March 2011, twenty-five Mental Health Services for Older People clients transferred temporarily to the O'Casey Rooms in the Fairview Community Nursing Unit. Service users and their families were actively involved in the planning and implementation of this service change. This move not only provided these clients with single room ensuite accommodation but also facilitated the permanent closure of Unit 1 Male, Unit 1 Female and Unit 8 in St. Ita's Hospital in accordance with the conditions attached to its registration.
- Plans to relocate the remaining 26 residents in St. Ita's Hospital, clients of the North Dublin Rehabilitation Services, to more appropriate accommodation were agreed with the Mental Health Commission in December 2011. Ultimately, implementation of these plans will complete

the closure of mental health services on the St. Ita's traditional psychiatric hospital site.

- The HSE appreciates the patience and co-operation of patients, relatives and carers throughout the year in bringing about these significant service changes. The ongoing co-operation and assistance of staff in reconfiguring the North Dublin mental health services, which was accomplished under the auspices of the Croke Park Agreement, is also acknowledged.

Louth/Meath Mental Health Services

- In line with the recommendations in AVFC and the North East Acute Hospital Transformation Programme, planning for a new acute inpatient unit in Drogheda, which will replace the admission units in St. Brigid's Hospital, Ardee and Our Lady's Hospital, Navan, progressed in 2011 with the drafting of the schedule of accommodation and completion of the design brief.
- The HSE is now in a position to progress with the detailed design and tender process and expects to have tenders received, assessed and contracts awarded (subject to no planning permission issues) by Q2, 2012. The expected completion date for the new unit will be Q3/Q4, 2013.
- The Day Hospital in Navan is fully operational.

Dublin North West and Dublin North Central Mental Health Services

- Arising from the establishment of the new HSE Areas, Dublin North West Mental Health Services will be bisected; the CMHTs in Dublin 15 will merge with the North Dublin Mental Health Catchment area to form the Dublin North area while the CMHTs in Cabra and Finglas will merge with Dublin North Central Mental Health Catchment area to form the Dublin North City Area.
- A multidisciplinary working group was established in 2011 to develop proposals on the division of resources in the Dublin North West Mental Health Catchment Area across the two new areas. A report, comprising the deliberations and recommendations of the working group was submitted to the relevant Area Managers and members of the Steering Group.
- Construction on the new purpose built 54-bed replacement facility on the St. Brendan's Hospital site in Grangegorman site commenced in 2011. It was originally envisaged that the building works would be completed in early 2012; however, due to circumstance beyond the HSE's control, they will not be completed before the end of 2012.
- Plans for the refurbishment of the acute inpatient unit in the Mater Hospital were revised to take account of the establishment of the new HSE Areas and will be progressed as the allocation of capital funding permits.

Child and Adolescent Mental Health Services (CAMHS)

- While work on Phase Two of St. Joseph's Adolescent Unit in St. Vincent's Hospital, Fairview, commenced in 2011 as planned, delays in receiving Department of Health and Department of Finance approval for the HSE's Capital Plan have extended the original timeline for completion. It is now anticipated that the building works, which will increase the number of beds for 16 & 17 year olds from 6 to 12 and will incorporate St. Joseph's Day Hospital, will be completed and the unit fully commissioned by mid 2012.
- Primary notifications were issued in respect of 10 additional psychiatric nursing posts to support the expansion of the inpatient unit and day hospital, and to pilot provision extension of child and adolescent mental health services to 16 and 17 years olds in Dublin North City.

DUBLIN MID LEINSTER REGIONAL REPORT

	AREA	Population
-	East Coast	372,107
-	Dublin South City/West	389,750
-	Midlands	457,244
-	Central Mental Hospital	

Service Objectives

In HSE Dublin Mid Leinster (DML), Mental Health Services provide care for people of all ages who need specialist assessment, care and treatment for mental illness. This entails a continued shift to community based services to support people living as independently as possible.

Service Overview

- Total Budget for mental health services was €197million in 2011.
- Total no of staff is approx 1,900.
- Total population of DML is 1,219,101 - Estimated 8% Increase in 2011 Census but subject to fluctuation.
- The Mental Health Services are delivered through:
  - 8 Acute adult units (Approx 260 beds in use)
  - Approximately 300 continuing care beds provided by HSE/external agencies
  - Range of High/Medium/Low support hostels
  - CMHTs
  - Warrenstown – Child and Adolescent Inpatient Unit
  - CAMHS teams.

Changing Model of Care

- DML has the lowest number of acute inpatient beds in the Country i.e. 20.6 per 100,000 V 24.2 National norm.
- Lowest first admission rate of 22.4.
- Engagement with Local Authorities and Housing Agencies in the placement of patients with Mental Health difficulties.
- Development of Executive Clinical Directorates across DML.
- Involvement of service users in planning and management of services.
- Creation of Multidisciplinary Management Teams.

Improvements in Infrastructure

- Refurbishment of Hostel accommodation in Dublin South East and Dublin South City (Ballyfermot and Clondalkin).
- Development of new child and adolescent Day Hospital in Cherry Orchard - opening in Q1, 2012.
- Renovation of Day Hospital in Dublin South City – Ballyfermot.
- Refurbishment of acute Unit in St Loman's Hospital, Mullingar:
  - Provision of 24 Bed Acute Unit
  - Provision 20 Bed long stay Unit
  - Development of 50 Bed Continuing Care Unit on St Marys site Mullingar
- Planned Closure of St Loman's Hospital, Mullingar in Q4, 2012.
- Planned development of interim Adolescent Inpatient Unit in St Loman's, Palmerstown - minor capital works complete.
- Refurbishment of acute and low secure facilities in St Loman's Hospital, Mullingar.
- New development of Community Nursing Unit in St Mary's, Mullingar.
- Hostel and Day Centre developments in Dublin South City and Rathmines.
- New Day Hospital for Child and Adolescent Services in Cherry Orchard.
- New premises for Celbridge CAMHS.
- Development of mental health facilities as part of Primary Care Development.

Innovation and responsiveness

- Further development of early intervention psychosis services in greater Dublin area.
- Implementation of range of strategies to reduce CAMHS waiting lists.
- CAMHS audit.
- Implementation of Quality Framework for Mental Health Services – a National Mental Health Collaborative in conjunction with the MHC.
- Partnership with voluntary organisations to deliver services in a flexible and timely manner.
- Development of Jigsaw Projects in Tallaght and Clondalkin.

- Use of external agencies in provision of additional services where necessary e.g. St Patrick's Hospital, St John of God Hospital Ginesa Suite.

Service Plan 2011-Progress

Key Result Areas

- Changing Models of Care
  - Further reduction in use of in patient beds-reduction of approx 10 beds achieved in 2011.
  - Priority given to maintaining day and community services given reducing staff resource.
- Improvements in Infrastructure
  - Completed refurbishment of High Support Hospitals and Day Hospitals.
  - Provision of Adolescent Mental Health Facility.
  - Development of business case for the new CMH - Government approval to proceed with building project for 120-bed Hospital, 10-bed CAMHS Forensic, 10-bed Mental Health Intellectual Disability Forensic and development of 3 new Intensive Care Rehabilitation Units.
- Responsiveness
  - Development of High Support Hostels to meet legislative requirements under Criminal Law Insanity Act - commenced in Q4 2011 and will be completed in 2012.
  - Provision of support to Gardaí during siege/barricade incidents-in place since Q1 2011.

Chapter 3

Commentary on progress as reported by the Health Service Executive

Introduction

As per usual the IMG requested for 2011 detailed progress reports on implementation of AVFC from the Assistant National Director, Mental Health and the four RDOs. The request was for specific written information and separate meetings with the Assistant National Director, Mental Health, the four RDOs, the National Director, Reconfiguration and the National Clinical Lead for Mental Health.

Despite a number of requests for separate meetings, those meetings were not agreed and with the insistence of the Assistant National Director, Mental Health one meeting was arranged which was attended by the Assistant National Director Mental Health, the four RDOs, the National Director, Reconfiguration and the National Clinical Lead for Mental Health. A separate meeting was also held with the National Clinical Lead for Mental Health.

The Assistant National Director for Mental Health indicated that while the HSE was anxious to support the work of the IMG, the HSE must have regard to the limitations within which it was currently operating with reduced staffing, administrative support and increased demands on senior managers' time and indicated that the HSE representatives would attend one collective meeting.

It is the view of the IMG that notwithstanding the above there was some frustration of its arrangements by the Office of the Assistant National Director Mental Health and this matter was brought to the attention of the Chief Executive of the HSE. The Assistant National Director and four RDOs provided a written report on progress which is detailed in Chapter 2 of the Report. Below is a commentary from IMG on the report submitted.

In respect of Progress on implementation as reported by the HSE at national level, the IMG is concerned about the reporting relationship between the Office of the Assistant National Director and the four RDOs. The Office of the Assistant National Director, Mental Health has a brief for the strategic development of mental health services broadly encompassing AVFC. The Office does not have budgetary or operational authority. The four RDOs have control of resources and are directly responsible for delivery of services and report directly to the National Director of Integrated Services. The Assistant National Director reports directly to the CEO. This separation of strategy from operations was highlighted in previous IMG reports. The IMG is of the view that the Assistant National Director's Office should have more authority over the RDOs in the implementation of AVFC, in the absence of a fully resourced Directorate as envisaged in AVFC.

Service users and their families

Despite the results of an NSUE Survey of service user satisfaction levels with mental health services and the MHC research on inpatient satisfaction levels, the IMG is of the view that service user involvement while growing is still not consistent across all regions. There is a fragmented and inconsistent process of consultation across the four regions and at various levels in the hierarchy of operations. It is also clear to the IMG that little attention has been given to the proactive involvement of family members in the provision of mental health care services. This is reflected in the results of the National Mental Health Services Collaborative, discussed in Chapter 7 of this Report.

In submissions to the IMG, it is suggested that there is an inconsistent approach to the development and support of Consumer Panels. At present, it would appear that there is greater commitment to service user involvement in some HSE areas, most notably HSE South. In order for the aspirations of service users and carers to be fully realised there needs to be a consistent national approach to their inclusion in all aspects of service delivery.

In respect of family members it would appear that more often than not the specific needs of members are not identified and acknowledged in the care planning process.

Quality Mental Health Services

Within the first recommendation of AVFC the principles and values which should underpin mental health services in Ireland are outlined. One of the key principles identified is the quality principle which states that mental health services and the treatment and care offered in them should be of the highest standard. The Mental Health Commission is the statutory body tasked with setting and monitoring standards in mental health care. The Commission has established a range of regulations and standards and assesses adherence to these standards through its annual inspection process. The IMG is concerned that none of the submissions from the HSE mental health services discusses compliance ratings with the Commission's standards and regulations. The MHC's Annual Report identifies that in 2011 only three centres run by an independent service provider were fully compliant with the standards and regulations. The IMG recommends that the HSE develop an action plan to ensure all existing mental health services become fully compliant with the current regulations and standards.

Social Inclusion

It is internationally recognised that people with mental health problems are one of the most excluded groups in society. This social exclusion is best conceptualised as a lack of recognition of basic rights or where that recognition exists, a lack of access to the political or legal systems necessary to make these rights a reality. The social exclusion of those with mental health problems includes: being subjected to discrimination and stigma and failing to obtain adequate healthcare, basic education, basic material wellbeing, adequate employment and housing. Combating social exclusion involves a cohesive and comprehensive approach and is best achieved through main stream policy

formation and implementation in the areas of health, education, employment, economic regeneration and housing.

AVFC acknowledges the issue of social exclusion and makes a number of key recommendations. Primary among these recommendations is that the National Mental Health Service Directorate be specifically represented in the institutional arrangements which implement the *National Action Plan Against Poverty and Social Exclusion* with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.

The National Economic Social Forum report entitled *Mental Health and Social Inclusion 2007* identifies that co-ordinated action is needed at all levels to increase the social inclusion of those with mental ill health. Based on international evidence the report identifies that strategies are required to focus action at a society level, at an organisational level, at the community level and at the individual level. The report identifies that work is the best route to recovery and that integrated services play a key role in recovery. The report further identifies that reducing stigma contributes to social inclusion and that strengthening communities and social supports protect against mental ill health and support good mental health. The report recommends that responsibility to drive forward and oversee follow up on its recommendation should be given to the senior officials group under the Government's National Action Plan for Social Inclusion.

The IMG acknowledges the work of the Department of the Environment, Community and Local Government, the Department of Health and the Assistant Director Mental Health in preparing the housing strategy for people with disabilities. However, work on addressing social exclusion at a broader level has been extremely slow and the IMG recommends that a comprehensive social inclusion strategy with implementation timelines be developed for those with mental health problems, as a priority.

Mental Health Promotion

The IMG acknowledges the range of measures reported in relation to the *Reach Out* Strategy on Suicide Prevention. The IMG, while noting the actions do not come under the direct remit of AVFC, is very supportive of the vast range of activities engaged in by the NOSP. These actions, which are community based and in partnership with statutory and voluntary agencies, are a necessary component in developing proactive mental health strategies in the community.

Mental Health in Primary Care

The IMG acknowledges and welcomes the work being progressed to improve access to mental health care services through and in primary care and notes a slow down of progress in this area. As GPs are independent contractors in the health service, there are significant challenges to achieving coherent working relationships with secondary mental health care services. In the submission received from the ICGP it was noted that GP services still have difficulty in establishing clear communication with secondary mental health services in respect of the treatment interventions provided. The IMG is of the view that

further work needs to be undertaken to develop collaborative working relationships between primary care and mental health services. Responsibility for this primarily rests with the ICGP, CPI, and the health service providers, in particular the HSE.

The IMG notes the commitment in Budget 2012 to allocate up to €5 million for the development of counselling support services in primary care. The IMG welcomes this development as an enhancement of the range of services available to people at primary care level.

At the time of writing, the agreed new posts to be funded under this commitment are set out in the Table below:

Mental Health in Primary Care National Counselling Service Initiative – to provide access to counselling and psychotherapy for those eligible under General Medical Services

Counselling in Primary Care Allocation to National Counselling Service in each Region		
HSE Area	**Counsellor/Coordinator - WTE**	**Total WTEs allocated**
West	3	3
South	2	2
Dublin North East	2	2
Dublin Mid Leinster	3	3

The IMG is of the view that this is an important foundation for the development of a comprehensive psychological support service integrated into Primary Care.

In Chapter 7, the IMG discusses the National Mental Health Programme Plan in respect of primary care involvement. The IMG notes that while there is some acknowledgement of the role of primary care in the Programme there is, in the view of the IMG, a need to have more involvement and collaboration between primary care services and the final National Mental Health Programme Plan.

Community Mental Health Teams

AVFC envisaged that there would be fully populated CMHTs in General Adult and Specialist mental health services and the detailed membership of those teams are fully described in AVFC. Year-on-year, the IMG has been told that CMHTs are for the most part incomplete with a paucity of psychology, social work, occupational therapy and other Allied Health Professional posts. Figures supplied by the HSE and MHC support this trend. This situation continues to exist despite the submissions from the HSE proposing that posts can be relocated from institutional services to community based services.

It is clear from submissions received from the HSE that there is a strong focus on the closure of inappropriate institutions and inpatient beds and the transfer of resources to the community. It is clear also that there is a desire to provide services in more appropriate care settings. This policy, however, has been stifled by the HSE embargo and the present Pubic Service Moratorium on recruitment. The IMG welcomes the commitment in Budget 2012 of the

additional €23 million for the deployment of 414 new community based posts in mental health services. The IMG, however, is concerned, based on previous experience, that some of these resources could be used to finance existing posts thereby decreasing the populating of CMHTs. The IMG is clearly of the view that funding granted for new posts in CMHTs should only be used for that purpose. The IMG understands that the new posts required are in the main for allied health professionals. At the time of writing, the IMG is aware of agreed plans for the creation of new posts based on the 2012 commitments. Details of these posts are set out in the tables below:

Initiative 1 – To "Professionally Complete" General Adult Community Mental Health Teams in line with the recommendations in A Vision for Change ensuring that, at a minimum, each team has one of each of the following professionals, Social Work, Clinical Psychology and Occupational Therapy

General Adult Community Mental Health Team Allocation				
HSE Area	**Basic Grade Clinical Psychologist**	**Basic Grade Social worker**	**Basic Grade Occupational Therapist**	**Total WTE's Allocation**
West	22	20	20	62
South	21	21.5	22.5	65
Dublin North East	19	19.5	26.5	65
Dublin Mid Leinster	TBC	TBC	TBC	61

Initiative 2 - To "Professionally Complete" Child and Adolescent Community Mental Health Teams in line with the recommendations in A Vision for Change ensuring that, at a minimum, each team had one of each of the following professionals, Social Work, Clinical Psychology , Occupational Therapy, Nursing, Speech and Language Therapy and Childcare Worker

Child and Adolescent Community Mental Health Team Allocation							
HSE Area	**Basic Grade Clinical Psychologist**	**Basic Grade Social Worker**	**Basic Grade Occupational Therapist**	**Basic Grade Speech and Language Therapist**	**Child Care Worker**	**Nurse**	**Total WTEs allocated**
West	10	3	7	9	2	2	33
South	3	4	9	8	11	5	40
Dublin North East	3	0	3	3	5	6	20
Dublin Mid Leinster	TBC	TBC	TBC	TBC	TBC	TBC	57

As can be seen there is agreement in three HSE regions with discussions still taking place in respect of Dublin Mid Leinster. Once again, the IMG reiterates its view that new funding should support new posts and not existing posts and associated pay costs.

Much has been written about team working and shared care planning in mental health services. The concept of CMHTs is firmly rooted in the practice of team working and shared care. Team working and shared planning must also involve the service user and, where appropriate, family members. The IMG welcomes the publication of a guidance document by the HSE on team working. In combination with the policy document produced by the MHC on team working there are now adequate guidelines for developing team working practices. Additionally, the IMG welcomes the MHC Guidance document on individual care planning in mental health services published this year which is intended to assist service users and health care providers to devise individual care plans.

Child and Adolescent Mental Health Services

The IMG acknowledges the progress made in the development of additional residential places for children and adolescents and the commitment of the HSE to reduce and eliminate the inappropriate admission of children and adolescents to adult units. In addition, the IMG notes that staffing of the 56 existing teams is only at 63.8% of the recommended level, a decrease on the 70% level reported in the 2009 – 2010 Annual Report on CAMHS.

The IMG welcomes the production of the comprehensive Annual Reports for CAMHS, first published in 2009, and recommends that a similar report should be produced by other mental health services.

Rehabilitation and Recovery

The IMG in its Report for 2010 noted the concerns that Rehabilitation and Recovery teams were being contracted in favour of populating acute adult mental health teams. Despite written assurances from the HSE that this was not the case, the College of Psychiatry of Ireland (CPI), in its submission to the IMG, expressed grave concern at attempts by the HSE to reduce already existing rehabilitation services. The CPI referred to the 2007 MHC funded study led by Dr Ena Lavelle on Mental Health Rehabilitation and Recovery Services, which found that only 16 specialist rehabilitation services existed across Ireland. AVFC recommended 39 teams. No team had full AVFC staffing complement. It is the view of the CPI that this study confirmed the need to continue to adequately resource these services. This Study is available at http://www.mhcirl.ie/Research/Dr_Ena_Lavelle.pdf

The IMG acknowledges the reporting on rehabilitation and recovery by the Inspector of Mental Health Services in 2011 and notes that a number of catchment areas have no such services. The services appeared to have developed in relation to the need to place patients from long stay institutions. Where there were no large psychiatric institution, rehabilitation and recovery services were, in the main, extremely under-developed.

Those areas that have rehabilitation and recovery services have poorly staffed teams in all disciplines. No area had a fully staffed rehabilitation team as outlined in AVFC. In some areas there were no occupational therapists. Social work and psychology were also lacking in many areas. Very few rehabilitation and recovery services had an assertive outreach team. In the area of

rehabilitation and recovery services there has been a lack of implementation of AVFC.

In summary, there were insufficient rehabilitation and recovery teams to provide a comprehensive service nationally. In existing teams there was a lack of adequate staffing. Where teams existed it was evident that there was strong team working, good service user input, excellent care planning and good service provision within the constraints of poor resourcing. The Inspector's report is available at

http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/National_Overview_Reports/R+RMHS_report11.pdf

The IMG is still concerned that in reality there is a de-prioritisation of rehabilitation and recovery teams as a direct response to the demands for staffing of acute adult mental health teams. This unwritten policy is a direct contradiction to the stated policy of AVFC.

Specialist Mental Health Services

A continual finding from the IMG and the theme consistently repeated in submissions to the IMG is the lack of progress in developing specialist mental health care services. There has been a worrying absence of development of appropriate mental health care services as envisaged in AVFC in the areas of intellectual disability, old age, eating disorders, rehabilitation and recovery, as described earlier, co-morbid severe mental illness and substance abuse problems. This is one of the significant implementation failures of AVFC and continues to be a major obstacle to the provision of responsive specialist mental health care services.

Borderline Personality Disorder

The IMG notes the detail provided around the funding of a number of training programmes in Dialectical Behavioural Therapy and Cognitive Behavioural Therapy. The NOSP funded a number of Training programmes in CBT & DBT in 2011. The therapy is specifically aimed at those with a diagnosis of Borderline Personality Disorder. Five Teams in Cork Adult Mental Health Service, One Team in Ardee Adult Mental Health Service, One Team in Cavan Monaghan Adult Mental Health Service, One Team in Westport Ballinrobe Adult Mental Health Service and One Team in St. Ita's North Dublin Mental Health Service now provide this service.

The National Clinical Programme Director has indicated that the next round of clinical programmes in mental health will include evidence based approaches to Emotionally Unstable Personality Dialectical Behavioural Therapy which is a sub-branch of cognitive behavioural therapy and is an intensive and extended intervention which has shown significant benefit to some individuals. DBT is best offered in the context of a local community mental health team where a range of disciplines and interventions can be provided in an integrated fashion.

The IMG notes that this is the first year that the progress reports have made specific reference to interventions for borderline personality disorder.

National Forensic Services

The IMG acknowledges the long awaited policy decisions and planning for the development of a new forensic mental health care service to replace the existing CMH at Dundrum. Despite the protracted delay arising out of disagreements about location, the IMG welcomes the plan to build a facility at Portrane, which will accommodate adult forensic mental health services, children's forensic mental health services and forensic services for people with intellectual disability and in addition, the provision of four regional intensive care rehabilitation units.

Additionally, the IMG notes the proactive development of prison in-reach teams and court diversion services for prisoners on remand. Such services need to be expanded to cover all prison locations.

The IMG congratulates the Irish Prison Service and the HSE's Forensic Mental Health Service on winning the World Health Organisation's "*Health in Prison – Best Practice* Award for the High Support Unit in Mountjoy Prison.

A major development in 2011 was the coming into operation of the Criminal Law Insanity Act 2010 which amended the 2006 Act. The new Act gave the Review Board the authority to make orders for the discharge of patients subject to such conditions as the Board considers appropriate, including conditions relating to outpatient treatment or supervision or both. In 2011, the Board approved the conditional discharge of seven patients from the CMH.

Suicide Prevention

The HSE submission detailed actions which are rightly delivered under *Reach Out* and as such do not come under the direct remit of AVFC. Notwithstanding the above, the IMG is impressed at the range of initiatives being delivered in the area of suicide prevention. For the most part these initiatives are based on the principles outlined in AVFC e.g. the principle of service user involvement, community and recovery oriented services, person centredness and partnership with voluntary organisations.

Management and organisation of mental health services

AVFC envisaged that the leadership for its implementation would come from the creation of a National Mental Health Service Directorate which would be of central importance in the modernisation of our mental health services. Full details of the responsibilities and structure of the Mental Health Service Directorate are detailed in Chapter 16 of AVFC. Year on year, many submissions and all previous IMG reports have called for the creation of this National Directorate which should be fully staffed, have authority to shape services in line with AVFC and have control over existing resources and any new resources made available to mental health services. The absence of a Directorate significantly reduces accountability for the delivery of AVFC.

Despite the preponderance of calls for such a Directorate, the HSE has not responded. Instead, it has put in place the Office of Assistant National Director for Mental Health which is focussed on the strategic development of mental

heath care services and which carries additional responsibilities beyond AVFC. The IMG is of the view that this Office is under resourced and does not have the authority to lead the implementation of AVFC. The absence of a full implementation plan makes it difficult to assess the value of the current Office of the Assistant National Director, Mental Health.

Presently the authority and control of resource allocation in mental health services rests with the four RDOs, who report directly to the National Director of the Integrated Services Directorate. Over the last few years the posts of ECDs have been created within the HSE system. The rationale for the creation of ECDs in mental health has been to support a more appropriate clinical management structure for the delivery of AVFC. In the context of implementation, however, it is unclear what precisely are the role and responsibilities of ECDs in mental health services and what is the scope and limitations of their authority.

The IMG is aware of recent Ministerial announcements and the preparation of the Heads of a Bill for the appointment of Directors of Programmes to replace the present HSE Board. There is no detail available to the IMG or publicly about how such structures will operate. The IMG is concerned to make the distinction between an overall "Director" of Mental Health Services and a Directorate to support the implementation of AVFC. The Director of Mental Health Services and AVFC Directorate are not synonymous.

Financing Mental Health Services

AVFC recommendation

> *"Substantial extra funding is required to finance this new Mental Health Policy. A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services".*

AVFC envisaged the additional allocation of capital and revenue funding to mental health services to allow the development of supports for AVFC. Additionally, AVFC spoke of freeing up existing resources by way of transforming old models of service to community models. This would involve the closure of outmoded 'unfit for purpose' services in favour of more locally based comprehensive community services and the consequent transfer of manpower.

In reality during 2006 and 2007, the Minister of State with responsibility for Mental Health allocated additional resources of €26.2 million in 2006 and €25 million in 2007 recurring. In 2008, the Minister of State announced that he could not allocate additional resources until he was assured that the resources already allocated were utilised appropriately. Subsequently, Freedom of Information reports confirmed that in fact the majority of the additional funding allocated in 2006 and 2007 was either not spent or reallocated to other health programmes. In 2009 and 2010 nominal additional amounts were allocated against the backdrop of top sliced reductions in allocations – 2010 – 8.3%; 2011 - 1.8%; 2012 – 1% *(net of 2012 budget allocation).* In respect of 2011, the

IMG acknowledges that the 1.8% reduction applied to mental health expenditure was a specific exception to the overall health reduction of 5%.

The IMG also acknowledges the allocation of an additional €35 million to mental health services in the 2012 Budget and notes that this is specifically targetted towards the filling of vacant posts in CMHTs.

Notwithstanding the above, the IMG notes that the 2012 Budget reduced overall mental health revenue expenditure by €41 million. The net effect, taking into account the allocation of €35 million, is a 1% reduction in 2012.

The expected capital investment also failed to materialise despite a commitment by Government to invest mental health monies generated from the sales of un-required lands and buildings. The Government's commitment was to allocate up to €50 million per annum for capital investment, the amount to be recouped from the sale of lands. In reality due to the collapse of property and land prices a sum of €37million was recouped from sale of lands.

As a consequence of the HSE Embargo, the Public Service Moratorium on recruitment, reduced revenue and reduced capital expenditure the related expenditure on mental health services has fallen to 5.3% of all health expenditure far short of the figure of 8.4% envisaged in AVFC. The IMG is of the view that full implementation of AVFC will require additional revenue and capital allocations.

Manpower, Education and Training

AVFC makes twenty eight recommendations as regards Manpower, Education and Training. It is disappointing to observe that little progress seems to have occurred. Though it is obvious that the economic situation and resource issues will impact on these three areas, little effort seems to have been made to introduce a governance and implementation structure that would make maximum use of the resources available. Once again the IMG must point to the key role the National Mental Health Service Directorate as envisaged in AVFC would play in the planning of manpower, education and training. Both the centralisation of planning and funding of education and training and the development of a multi-profession manpower plan are not beyond the scope of the stakeholders despite the very straitened economic circumstances the country is in.

Many of the discussions of education and training that took place during IMG meetings this year unfortunately gravitated towards a traditional model both of the method of education and of the roles of the various professionals. It seems as if little opportunity for multidisciplinary training is sought out. The training of doctors seems to continue mainly in the mode of brief encounters either at outpatient clinics or in hospitals. This would seem to be less than satisfactory for service users and for trainees. As referred to in other chapters in this document several key issues need to be addressed which include: the need to ingrain the philosophy and practice of Recovery in the education of all clinicians involved in delivering mental health care; the need to ensure all mental health professionals are trained in the biological, psychological and social factors and in multidisciplinary work; the need to ensure that all training involves service users and carers; and the need to ensure that all health

professionals have a sound knowledge of the appropriate use and possible side-effects of medications used in treating mental illness.

Currently, certain professionals have funding delegated to them in their contracts for personal training and development (i.e. Doctors) while other professionals are reliant on their employers or their own resources to take part in such activities. AVFC recommended that *"A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services"*. The move to a community based service brings ongoing training requirements for staff. Especially in a time of limited resources the best use must be made of available funding to ensure a practical impact on outcomes for service users. The establishment of a properly functioning centralised Education and Training (E&T) Authority as part of the National Mental Health Service Directorate working with the relevant professional bodies could ensure that this is the outcome. A strong case can be made that such an approach would maximise value and ensure that the aspiration of AVFC that *"E&T should be directed towards improving services as a primary goal and must have the welfare of service users as its ultimate objective"*.

The ongoing support for the training of Clinical Psychologists by the HSE is vital and the call in AVFC for expansion of these programmes is still relevant. In view of the fact that the majority of first contacts by service users are with primary care the IMG welcomes efforts by the ICGP to include mental health in its training themes and recommends that this be a core of specialist training and continuing professional development programmes. The IMG welcomes the development by the ICGP and the CPI of training in mental health issues for General Practitioners and acknowledges the work done by the CPI in developing a new curriculum and training programme for psychiatrists. The IMG also welcomes the continued delivery and expansion of advocacy training across the country. Training for service users is essential to ensure that those who wish to actively engage with the services can represent themselves and others. There remains a need for formalised training for volunteers nationally and taking into account the valuable contribution of voluntary groups, co-ordination of their training should be a priority. The IMG emphasises the continuing need for training in care planning for all mental health service staff, including management.

Several issues recurred in the submissions and discussions on manpower. The primary ones were the HSE embargo and the Government moratorium. These along with the shortage of Non-Consultant Hospital Doctors (NCHDs) and the planned early retirement scheme coming into play in early 2012 were forecast to have negative effects on a wide range of services. It seems as if much was happening in a piecemeal way and, once again, the need for a National Manpower Plan and a body to co-ordinate it would seem even more important in these times. The IMG were told on several occasions that it was open to the HSE to apply to Government for exceptions from the moratorium in specified cases. The IMG received little evidence that this was happening in a productive way.

As regards NCHDs recruitment, the IMG would see current problems as an opportunity to change the way mental health services are delivered and the way

training is delivered to NCHDs. While it is becoming very difficult to fill the NCHD posts in Psychiatry nationally, the current number of these posts is beyond that required in AVFC. This taken with the evidence that service users desire to have more continuity in their care and not be subject to the lack of continuity brought about by the rotational nature of NCHDs work placements should cause pause for thought on the continuation of a model of service delivery where the NCHD has the pivotal role. An appropriately structured community mental health service must make use of a variety of professionals in a variety of roles. Examples of options include the development of the roles of Advanced Nurse Practitioners and Clinical Nurse Specialists in order to improve continuity of care and access to clinical decision making.

The IMG proposes that urgent attention be given to reviewing the training, registration and roles of various mental health professionals in line with international models. The IMG believes that the call in AVFC that *"Future manpower requirements must be driven by service requirements rather than historical factors and should not be wedded to the perceived needs of any single discipline"* is more relevant than ever. A co-ordinated approach to manpower planning is an urgent requirement and should be led by a properly functioning Mental Health Service Directorate.

To ensure quality of psychological interventions, it is important that the Government pursues the statutory regulation of psychotherapy and counselling. The IMG notes that the Government is presently legislating for the statutory regulation of professions designated in the Health and Social Care Professionals Act 2005 which does not include psychotherapy and counselling.

Notwithstanding the above, the Government could look at innovative ways of engaging accredited therapists presently working in the community to support the development of multiple interventions in mental health care services.

Developments in research and information

In Chapter 6, the IMG acknowledges the changes in the relationship between the CPI and the Pharmaceutical industry in respect of research.

AVFC envisaged that mental health research would be funded independently of vested interests. The IMG encourages such research by the CPI, HRB, MHC, and relevant 3rd level institutions.

In respect of information and data collection, the IMG encourages the development of comprehensive systems which allow for the measurement of inputs, processes, and outcomes of service delivery leading to a more systematic evaluation of mental health services. Research and information gathering should focus on both quantitative and qualitative data capturing the subjective experiences and narratives of service users, carers and families.

The involvement of service user researchers is an essential component of an inclusive recovery-oriented research strategy. Investment will be required to ensure that competencies and capacity are developed to support this ambition.

Transition and Transformation

The IMG notes that the HSE has been proactive in publicising activities and progress in its newsletter *A Vision for Change Advancing Mental Health in Ireland.* The IMG also notes the preparation of a range of Guidance documents for the implementation of AVFC, some of which were published in May 2012.

Chapter 4

Progress on implementation as reported by Government Departments

Implementation of 20% of the recommendations in AVFC is the responsibility of Government Departments and their agencies. The Government Departments are: -

Department of Health (formerly Department of Health and Children)

Department of Education and Skills

Department of Justice and Equality (formerly Department of Justice and Law Reform)

Department of Social Protection

Department of Environment, Community and Local Government (formerly Department of Environment, Heritage and Local Government

Department of Children and Youth Affairs (established in June 2011)

The IMG requested the Department of Health to provide a report on progress in 2011 on the implementation of the recommendations in AVFC that relate to Government Departments with as much specific information as possible.

An assessment of progress in 2011, as reported by Government Departments, is summarised below. In this regard, it should be noted that the progress reported is additional to that reported in previous annual reports of the IMG.

Copies of full progress reports are available at http://www.dohc.ie/publications/

Summary of Progress Reported by Government Departments

Department of Health

Recommendation 5.3: *A framework for interdepartmental cooperation in the development of crosscutting health and social policy should be put in place. The NAPS framework is a useful example of such an initiative.*

During 2011, the Office for Disability and Mental Health (ODMH) worked in partnership with Government Departments: Children and Youth Affairs; Environment, Community and Local Government; Social Protection and Justice & Equality to progress the implementation of the recommendations in AVFC.

Progress in the areas of Health, Justice and Housing include

- The Cross Sectoral Team on Health & Justice continued its work to bring about improvements in services for people with mental health difficulties who come into contact with the criminal justice system. During 2011 arrangements were finalised for the provision of on call support for Garda

critical incident negotiators. Such arrangements will ensure that Gardai in critical emergency situations are provided with any necessary forensic consultant psychiatric support. In addition by the end of the 2011, two facilities were opened in south Dublin inner city to provide step-down accommodation for persons conditionally discharged from the Central Mental Hospital.

- The Department worked closely with the Department of the Environment, Community and Local Government and the HSE to develop the National Housing Strategy for People with a Disability. The strategy, which was published in October 2011, sets out a framework for the delivery of housing for people with a disability through mainstream housing policy by directing the efforts of housing authorities and the HSE to support people with a disability to live independently in their own homes rather than having to move into residential care settings. It will redirect the efforts of Departments, agencies and publicly funded voluntary bodies away from managing institutionalised dependency to ensuring mainstream assessment of individual housing needs, finding person centred community based housing solutions and providing appropriate tenancy, health and social care support to people with disabilities from within the resources currently available across the sector.

Recommendation 17.1: *Substantial extra funding is required to finance this policy (Chapter 17, AVFC). A programme of capital and non-capital investment in mental health services as recommended, adjusted in line with inflation, should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.*

Recommendation 17.4: *Approximately 1,800 additional posts are required to implement this policy. This significant non-capital investment will result in mental health receiving approximately 8.24% of current, non-capital health funding, based on 2005 figures.*

Recommendation 17.9: *The comprehensive and extensive nature of the reorganisation and financing of mental health services recommended in this policy can only be implemented in a complete and phased way over a period of seven to ten years.*

- Budget 2011 provided special consideration for the mental health and disability sectors, which sought to ensure a reduction of 1.8% in the 2011 allocation for those sectors. The relatively lower reduction, compared to other sectors of health, recognises that these services are provided to vulnerable groups. Total spend on mental health in 2011 was €712 million.
- A special allocation of €35m for mental health was provided in Budget 2012 (announced on 5th December, 2011) in line with the Programme for Government commitments. Funding from this special allocation will be used primarily to strengthen CMHTs in both Adult and Children's mental health services. It is intended that the additional resources will be rolled out in conjunction with a scheme of appropriate clinical care programmes based on an early intervention and a recovery approach. Some of the funding will

also be used to advance activities in the area of suicide prevention and response to self-harm presentations and to initiate the provision of psychological and counselling services in primary care specifically for people with mental health problems. Some provision will also be made to facilitate the re-location of mental health service users from institutional care to more independent living arrangements in their communities, in line with AVFC. Approximately 400 additional staff will be recruited to support these initiatives.

- The Department continued its support for *See Change* the National Stigma Reduction Campaign in 2011. National Lottery funding of €145,000 was provided in 2011 in support of the initiative.
- In 2011, €2m was provided to *Genio* to further their work in supporting people to move from institutional to community based care. Over 109 applications were received from projects supporting the development of community alternatives to congregate or institutional care and from those involved in supporting the development of alternative care models. Following evaluation, grants have been allocated to 22 projects.
- €1m was made available to fund the expansion of *Jigsaw* an innovative community based support service for young people, which has been developed by Headstrong and is designed to promote systems of care that are accessible, youth-friendly, integrated, and engaging for young people. This allocation will be a recurring allocation for 3 years from 2011. Jigsaw is currently in five sites around the country - Galway, Kerry, Ballymun in Dublin, Meath and Roscommon. An additional 6 sites were announced in 2011 – in Clondalkin, Tallaght, North Fingal, Dublin 15, Donegal and Offaly.
- The Minister for Health announced in December 2011 that new administrative structures would be put in place within the HSE which would reflect the need for greater operational management focus on the delivery of key services, and greater transparency about funding, service delivery and accountability. This will involve appointing a number of directors at national level in charge of public health, primary care, hospital care, social care, mental health, and children & family services. The main function of the mental health director will be to develop clearer funding and commissioning systems governing the delivery of mental health services as appropriate in the primary, acute and social care settings. Arrangements for the structures, including the selection and appointment of the new directors, are being developed by the Department and the HSE.

Recommendation 19.9: *The recommendations of the Health Research Strategy should be fully implemented as the first step in creating a health research infrastructure in mental health services.*

Recommendation 19.10: *A national mental health services research strategy should be prepared.*

Recommendation 19.11: *dedicated funding should be provided by the Government for mental health service research.*

Recommendation 19.12: *People with experience of mental health difficulties should be involved at every stage of the research process including the development of research agendas, commissioning, overseeing, conducting and evaluating research as well as supporting the use of the emerging evidence base in policy and practice.*

- The HRB has current commitments of €22.5 million in research relevant to mental health and wellbeing, including neuroscience. This is an increase of €8.2 million over the 2010 figure and reflects an increase in the number of applications from the mental health and neuroscience areas. It also reflects the HRB's new Strategic Business Plan 2010-2014, which puts particular emphasis on health services and population health sciences research.
- The Mental Health Information Systems Unit (MHISU) manages and reports on national information systems in the mental health area e.g. the National Psychiatric In–Patient Reporting System (NPIRS). Annual reports are provided along with regional and national Bulletins. An inpatient census on the patients in psychiatric units and hospitals was published in 2011. In addition, the HRB in collaboration with the HSE services provide quarterly performance indicator reports on the functioning of the mental health services.
- The HRB is actively involved in the European Joint Programme in Neurodegenerative Diseases, a European Research Strategy, aimed at coordinating and developing neurodegenerative disease research across member states. In conjunction with this European initiative, an Irish strategy for neurodegenerative disease research is being prepared by a national steering committee, which is chaired jointly by the HRB and Science Foundation Ireland.
- The MHC in collaboration with the HRB developed a draft minimum mental health data set.

Recommendation 20.5: *An independent monitoring group should be appointed by the Minister for Health and Children to oversee the implementation of this mental health policy.*

An independent Monitoring Group was established in 2006 to monitor and assess progress on the implementation of AVFC. Since then, the Group has provided Annual Reports on implementation to the Minister.

Department of Education and Skills

Recommendation 3.4: *The adult education system should offer appropriate and supported access to information, courses, and qualifications to service users, carers and their representatives that would help to enhance and empower people to represent themselves and others.*

The Government has embarked on a programme of institutional reform as part of labour market activation policy, the objective of which is to prevent the drift into and reduce long-term unemployment. Chief amongst these are the establishment of the National Employment of Entitlements Service (NEES) and

the establishment of a new further education and training authority – SOLAS. NEES is designed to be a 'one stop shop' public employment and benefits service for unemployed people and SOLAS is designed to bring a unifying and central management structure to the further education and training sector.

These developments will play an important role in making further education and training more easily accessible, appropriate and beneficial to participants in the future.

Recommendation 4.1*: All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.*

Further and Adult Education Programmes range from adult literacy and community education programmes to second-chance education for early school leavers and adults with low skills to advanced vocational training. These programmes have a strong focus on personal development and empowerment and are provided free of charge and are available on a full-time and part-time basis at FETAC Levels 1 – 6.

Recent data from the Higher Education Authority (HEA) indicates that participation by students with a disability in higher education has improved significantly over the last decade. In 2010-11 students with a disability represented 6.4% of new entrant undergraduates in higher education institutions, compared to 0.6% in 1994.

Higher Education Institutions are allocated funding by the HEA and the Department of Education and Skills for the provision of access, disability and counselling services.

In 2009, the Department of Education and Skills and the HEA secured €2.4m from the Dormant Accounts funding for access based initiatives in the Institutes of Technology (IOT), which include supports for students with disabilities. Fifty-six projects were approved funding in the IOT sector and the projects will be finalised in 2011 and 2012.

Supports for students with mental health difficulties are supplemented through the ESF aided Fund for Students with Disabilities. In the 2010-11 academic year, an allocation of €13.7m was approved for institutions for 6,090 students, an increase of +23% on the number of students supported in the previous year. With regard to students with a mental health difficulty, 419 were granted supports under the Fund in 2010-11, representing 7% of the total number of students approved. It also should be noted that between 2005-6 and 2010-11 the numbers of students with mental health difficulties accessing the Fund increased by 635% (from 57 students to 419).

Core elements in an institutional disability service include individual needs assessment for all registered students, student mentoring, academic accommodations, lecture notes, assistive technology services, learning support service and access to library materials. The objective of these supports is to empower this group of students to become independent learners by tailoring supports to enhance their academic, personal and social development to achieve

their academic potential and ultimately make a successful transition to employment.

Some higher education institutions provide support services such as institutional-based counselling, mental/psychiatric services or general learning support. The Unilink Service, a specialised occupational therapy mental health support service in Trinity College Dublin, was the focus of a Cross Party Oireachtas Group on Mental Health to explore the Service as a model of best practice for supporting students experiencing mental health difficulties within third level education. Discussions focused on service usage, retention levels in students attending the service and the trends encountered within the service. The philosophy and values within the Unilink Service were shared and connected to the national and international policies on mental health. Outreach services connected to Unilink were also explored and future potential for developments on a national scale were outlined to the committee. Additionally, institutions have developed online *pleasetalk* information services to assist students with mental health conditions - http://pleasetalk.ie/

Department of the Environment, Community and Local Government

Recommendation 4.1: *All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.*

The housing policy statement, launched in June 2011, reiterates the importance of ensuring an appropriate framework of supports is in place to provide for the housing needs of vulnerable and disadvantaged households. These include supports for older people and people with disabilities, including those with mental health disabilities, under the Capital Assistance Scheme, the existing suite of housing adaptation grants, the new housing strategy for people with disabilities, interventions needed to alleviate homelessness and the provision of Traveller-specific accommodation. Delivering more and better returns for vulnerable, disadvantaged and specific needs households, while achieving maximum return for the resources invested in these areas is a key priority for the Government.

The voluntary and co-operative housing sector has a particular role to play in meeting specific categories of housing need, including those of people with a mental health disability, and the Department continued to support a vibrant voluntary and co-operative housing sector through CAS. Under CAS, funding of up to 100% of the approved cost was available for the provision of accommodation to meet the needs of persons with specific categories of housing need and included support for a number of projects progressed by approved housing bodies in association with local authorities that are specifically intended to meet the housing needs of people with disabilities, including those with mental health disabilities. Expenditure under CAS in 2011 was over €38.4m.

On 1 April 2011, a new system for assessing applicants for social housing support came into effect and a new standard procedure was introduced in every housing authority. One of the categories of housing need required to be

considered by authorities when assessing applications specifically relates to the extent to which a household's current accommodation meets the accommodation requirements arising from the enduring mental health disability of a household member. The ultimate aim of the new system is a fairer, consistent and transparent approach to eligibility for social housing support across the country.

The policy on the type of accommodation to be provided in each authority, and the priority to be given to applicants on an authority's list is now contained in Allocation Schemes which may include setting a policy to reserve a certain proportion of dwellings for particular categories of households – this could include a proportion for households with people with disabilities, including mental health disabilities. New allocation schemes were put in place in housing authorities by June 2011.

Recommendation 4.7: *The provision of social housing is the responsibility of the Local Authority. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.*

The National Housing Strategy for People with a Disability, 2011 - 2016 was published in October 2011. The new strategy was developed by the Department in conjunction with the Department of Health and the HSE, and with the assistance of a National Advisory Group, comprising of relevant stakeholders, including organisations representing people with mental health disabilities.

The Strategy sets out proposals to progress the commitments contained in AVFC in relation to meeting the housing needs of people with mental health disabilities who have low and medium support needs within appropriate community based settings. In this context, it is estimated that some 1,600 people with low and medium support needs, currently residing in HSE facilities, are likely to require local authority sourced accommodation over the course of the lifetime of the Strategy.

To support the effective transitioning of people with mental health disabilities to more independent living arrangements, a detailed implementation plan is currently being developed by a high level implementation planning group (IPG), chaired by the Department of the Environment, Community and Local Government and including the Department of Health, HSE, Housing & Sustainable Communities Agency and the City and County Manager's Association. The IPG will also be responsible for identifying sustainable funding mechanisms to resource the implementation of the strategy, including through the provision of appropriate housing solutions for people with mental health disabilities that have low and medium support needs.

As part of a broader approach to supporting the specific housing needs of people with mental health disabilities, a protocol governing liaison between housing authorities and the HSE in relation to the individual housing needs of people with a mental health disability has been developed and was adopted for implementation by housing authorities and the HSE in March, 2011. This protocol sets out arrangements for cooperation and coordination between

housing authorities and the HSE in addressing the housing and related support needs that arise as a result of a mental health disability.

A further protocol has been developed which governs liaison arrangements between the housing authorities and the HSE in relation to the provision of revenue funding, for health service related support costs for projects provided by approved housing bodies for people with a disability. This protocol, which provides for improved coordination of capital and revenue funding was also adopted for implementation in March 2011.

The Departments of the Environment, Community and Local Government and Health are committed to developing an additional protocol, the Strategic Assessment of Need Protocol, which will govern the strategic assessment of the nature and extent of the local housing needs of people with disabilities. This will improve the capturing of data on overall need, improve liaison between relevant agencies and assist in longer term planning to meet housing need. It is expected that this protocol will be developed by end 2012.

Recommendation 4.9: *Community and personal development initiatives which impact positively on mental health status should be supported e.g. housing improvement schemes, local environment planning and the provision of local facilities. This helps build social capital in the community.*

In 2011, the Department funded over €180 million of regeneration, remedial and energy efficiency improvement works in local authority housing areas. In addition, over €1m of funding was provided to local authorities in 2011 under the Sustainable Communities Fund in respect of 34 community based initiatives.

Recommendation 12.4: *Opportunities for independent housing should be provided by appropriate authorities with flexible tenancy agreements being drawn up in accordance with each service user's needs. Arrangements that best enable service users to move from high support to low support and independent accommodation need to be considered***.**

The new National Housing Strategy for People with a Disability Implementation Plan will underpin the framework for the phased deinstitutionalisation of mental health facilities and the provision of more appropriate community based accommodation, supported by the necessary community based health related supports, for people with a mental health disability that have low and medium support needs. The HSE will work with the housing authorities to affect this process and, as a starting point, will undertake a liaison process to provide housing authorities with relevant information relating to potential applicants for social housing. This process will be managed in line with the provisions of the individual assessment of need protocol for people with mental health disabilities. Further, to support more independent living arrangements for people with low and medium support needs, the Department will examine the development of a scheme of tapered supports based on the 'housing led' principle.

The transition to the new configuration will be implemented on a phased basis and will be subject to a number of variable factors such as ongoing clinical assessment and review of individual service users; discussion with service users, their advocates, where appropriate and their families on their preferred choice of accommodation, the availability of appropriate housing, living environment and tenancy arrangements; the availability of appropriate community mental health services; and the adequacy of other community and social supports required to facilitate independent living. It is envisaged that the new configuration will be implemented during the lifetime of National Housing Strategy for People with a Disability.

Recommendation 15.2.1: *A data base should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.*

Recommendation 15.2.2: *In the light of this information, scientifically acquired and analysed, make recommendations as to requirements and implement them.*

A statutory assessment of housing need is carried out every three years by all housing authorities. The last assessment took place on 31 March 2011.

The National Strategy to Address Adult Homelessness 2008 – 2013 is committed to the development and implementation of a single integrated data information system on the use of homeless services. The development of this new client based data system (PASS) has now been completed and the system went live in the Dublin region in 2011. Rollout nationally has now commenced and should be completed by end 2012.

Recommendation 15.2.3: *The Action Plan on homelessness should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.*

A devolved allocation-based system for the provision of performance related homelessness funding to housing authorities to improve overall efficiency, value for money and promote greater local decision making in homeless services has been developed. It has been implemented in the Dublin region since 1 January 2012 and will be rolled out nationally during 2012.

Recommendation 15.2.4: *A range of suitable, affordable housing options should be available to prevent the mentally ill becoming homeless.*

A new scheme Support to Live Independently (SLI) commenced operation in Dublin in the last quarter 2010 and is now operational nationwide. Other housing options were assertively pursued for the provision of long term accommodation for the homeless including providing long term tenancies in homeless facilities. In addition, there was sufficient bed capacity on a nightly basis to accommodate all those in need of emergency accommodation and an assertive outreach service assisted in eliminating the need for homeless persons to sleep rough.

Department of Justice and Equality

Recommendation 4.1*: All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.*

Diversity and Equality

People with mental health problems are protected by the prohibition on discrimination in the field of employment and vocational training on the ground of disability, one of the nine grounds protected under the Employment Equality Acts 1998 to 2011. A similar prohibition applies in regard to the supply of and access to goods and services under the Equal Status Acts 2000 to 2011, which also covers housing and education. Service providers are obliged under this legislation to do all that is reasonable to accommodate a person with a disability, who could not otherwise access their service, provided this does not impose other than a nominal cost.

Under the ESF Human Capital Investment Operational Programme 2007-2013, an Equality Mainstreaming Approach activity, managed by the Equality Authority, is facilitating and supporting institutional change within providers of vocational education and training, labour market programmes and within small to medium enterprises. Projects undertaken to date have ranged from enterprise level to sectoral interventions, such as the Irish Hospitality Institute's guidelines on incorporating equality and diversity practice and principles in everyday work, now reflected in the Institute's Annual Diversity Awards.

Recommendation 15.1.1: *Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done. Where mental health services are delivered in the context of prison, they should be person-centred, recovery-oriented and based on evolved and integrated care plans.*

The Irish Prison Service (IPS) continues to engage with the HSE specifically on the issue of mental health. Particular difficulties can exist in effecting the transition to Community Mental Health Services on release from custody, specifically in relation to homeless prisoners - due to catchment area issues between HSE ECDs. This presents the IPS with a dilemma where clinical judgement stipulates a requirement for inpatient treatment post-release and apparent discrimination on non-clinical grounds.

Similar to other healthcare services, mental health services in prison will operate best where there is good integration, co-operation and support between prison and community mental health services. However, the ECD group while recognising the particular vulnerability of individuals in prison state they "...are not in a position to provide an in-reach service from their local Community Mental Health Teams."

Recommendation 15.1.2: *Forensic Mental Health Services (FMHS) should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place.*

1. Criminal Law Reform

Commencement of the Criminal Law (Insanity) Act 2010

The Criminal Law (Insanity) Act 2010 was brought into operation on 8 February 2011.

Review of the Criminal Law (Insanity) Act 2006

The Department of Justice and Equality has commenced a comprehensive review of the Criminal Law (Insanity) Act 2006. In the context of the review, the Department, in consultation with the Department of Health, will examine the question of the extent to which the 2006 Act could be amended to facilitate schemes for the diversion of persons with mental disorders who have committed minor offences from the criminal justice system.

2. Irish Prison Service

The HSE has advised the Irish Prison Service that the Psychiatric In-reach & Court Liaison Service will continue to liaise between the IPS and the local mental health services whereby an individual on remand can be guided toward their local Community Mental Health Team.

Recommendation 15.1.8: *Education and training in the principles and practices of Forensic Mental Health should be established and extended to appropriate staff, including An Garda Siochana Mental Health Awareness training is provided across a broad range of training courses delivered by the Garda College.*

An Garda Síochána

The existing Student / Probationer programme is being replaced with a new BA in Applied Policing. This new BA in Applied Policing programme implements recommendations for best practice in police education resulting from a significant research and review exercise undertaken by the Garda Siochana Training and Development Review Group.

The BA programme adopts a hybrid Problem Based Learning approach when in the Garda College, and a Work Based Learning approach when attached to operational divisions. Students will learn in small groups through engagement with realistic policing scenarios. This methodology emphasises the development of learning to learn skills, the development of reflective practice and supports the transition into learning in an operational policing environment.

The new programme will be delivered in modular format. There is a module entitled 'Policing with Communities' which aims to equip the students with the personal and professional expertise, to proactively police a modem, diverse and bilingual community, whilst being responsive to the needs of its vulnerable members. Unit 5, 'Mental Illness Awareness', will cover areas such as types of

mental illness, Garda powers and procedures and transportation of persons with a mental illness. This unit will also include the two day internationally recognised ASIST suicide prevention programme which will be co-delivered with the HSE. Where any gaps in mental health awareness training are identified, they will be examined with a view to developing further training in this area.

Recommendation 15.1.9: *A senior Garda should be identified and trained in each Garda division to act as resource and liaison mental health officer.*

An Inspector has been nominated in each division to act as liaison person to the approved centre for the catchment area(s) that extends to their division. A training programme has been developed and delivered by the Garda College for these liaison Inspectors.

Department of Social Protection

Recommendation 3.2: *Advocacy should be available as a right to all service users in all mental health services in all parts of the country.*

The National Advocacy Service (NAS) was rolled out under the Citizens Information Board (CIB), under the aegis of the Department of Social Protection in January 2011. The NAS replaced the Community and Voluntary Sector Advocacy Pilot Programme which was funded up to the end of 2010.

NAS provides independent, representative advocacy services for people with disabilities. It is organised and managed on a regional basis by five Citizens Information Services (CIS) based in Clondalkin, Westmeath, Offaly, Waterford and Leitrim, which employs 35 advocates (WTEs) and 5 Regional Advocacy managers across the country.

A National Advisory Group was established to support the programme nationally. The membership of this group reflects stakeholders at a national level working with people with disabilities. Regional Advisory Groups are also being established to support the programme on a regional basis. The membership of such groups ensures geographical spread in order to support CIS boards to link with relevant organisations across their regions.

Since its roll out, NAS has developed an Access and Eligibility policy which allows NAS to be pro-active in focusing on the most vulnerable people, working to ten eligibility criteria in order to make decisions on the cases they take on. NAS work to ensure that people requiring an advocacy service will be appropriately referred to other relevant services if not eligible for a NAS service. In this regard, NAS plans to develop referral protocols with organisations such as the Irish Advocacy Network. The NAS dealt with 859 clients in 2011.

In parallel, CIB is working to build the capacity of mainstream CIS services to advocate on behalf of any person who needs support to access their rights and entitlements and can access mainstream services. Five Advocacy Support Workers are employed by five CISs (one per region) to enhance their capacity to deliver mainstream advocacy as part of an integrated information, advice and

advocacy service to the general public and particularly to people with disabilities. The mainstream advocacy service dealt with 1,144 clients.

Advocacy services are delivered by the CIB in the context of the overall 2011 allocation, some €46.64m. The outturn in 2011 on Advocacy related expenditure is estimated to be some €3.67m.

Recommendation 4.1: *All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.*

FÁS has mainstreamed its services, including employment services, for people with disabilities. All FÁS services are open to people with disabilities. Access to employment for people with disabilities, including those with mental health issues are currently dealt with in the Sectoral Plan of the former Department of Enterprise, Trade and Employment under the Disability Act, 2005. This Plan outlines key initiatives in promoting equal opportunities for people with disabilities in the open labour market. A key focus is on ensuring that systems, programmes and supports are integrated and complementary across the range of Government services with a view to providing a continuum of supports that address the full spectrum of needs of people with disabilities who wish to avail of training and employment opportunities.

In 2010, a Government decision was taken to restructure FÁS wherein responsibility for Training would be transferred to a new agency, SOLAS, under the Department of Education and Skills, and responsibility for Employment Services and Community Services would transfer to the Department of Social Protection. This transfer is now complete and the process of integration has begun. The Department of Social Protection (DSP) now has responsibility for Employment Services; this will be reflected in the new DSP Disability Sectoral Plan which will be finalised by the end of 2012.

Recommendation 4.4: *Measures to protect the income of individuals with mental health problems should be put in place. Health care access schemes should also be reviewed for this group.*

Social protection in the form of income support is provided by the Department of Social Protection through a combination of insurance based payments and assistance based payments targeted at need. These payments include a range of schemes specifically for people with illness and disability. The insurance-based schemes are Illness Benefit, Invalidity Pension and Occupational Injuries Benefit while the means-tested schemes are Disability Allowance and Blind Pension. These schemes are not differentiated on the basis of the nature or type of illness or disability.

Weekly rates of payments to pensioners (those 66 and over) were maintained in 2011, as were other supports such as the Household Benefits package which includes the free TV licence, electricity/gas allowance and telephone allowance. The Living Alone and Over 80 allowances were also retained at existing levels.

In Budget 2011, in the context of the National Recovery Plan introduced to address the deterioration in the public finances, it was necessary to introduce

reductions in some welfare rates. Reduced rates of income support payments came into effect in 2011 for all categories of welfare recipients who were under 66 years of age. Rates were reduced by between 3.5% and 4.2%, which equated to a reduction of €8.30 on the basic rate. Additional payments such as the Half Rate Carers Allowance, Half Rate Jobseekers and Illness payments were retained. Other supports such as the non means tested Respite Care Grant worth an additional €1,700 annually for Carers also continued to be paid in 2011.

Primary weekly social welfare payment rates were protected in Budget 2012: rates for weekly payments such as Jobseeker's Benefit and Allowance, Illness Benefit, Invalidity Pension, Disability Allowance, Blind Pension, Carer's Benefit and Carer's Allowance and Widower's Pension have been maintained.

Recommendation 4.6: *Evidence-based approaches to training and employment for people with mental health problems should be adopted and such programmes should be put in place by the agencies with responsibility in this area.*

FETAC Certification is a requirement for all FÁS Training Programmes

Recommendation 12.7: *The development of formal coordination structures between health services and employment agencies should be a priority if the delivery of seamless services is to be facilitated.*

Following the 2010 Government decision, the Department of Social Protection now has responsibility for Employment Services.

The Minister for Disability, Equality, Mental Health and Older People has established a new National Disability Strategy Implementation Group (NDSIG) to develop, monitor and to progress an Implementation Plan for the National Disability Strategy (NDS). This group will replace the former NDS Stakeholder Monitoring Group while maintaining its cross-departmental focus and collaboration with stakeholders. The Department of Social Protection is represented on the newly formed NDSIG.

The purpose of the NDSIG is to provide a forum under the leadership of the Minister within which Government officials and disability stakeholders, including the health services and employment agencies, can work together to guide the development of a National Disability Strategy Implementation Plan and to collaborate on its implementation including advising on resolution of implementation difficulties. The NDSIG will also bring the lived experience of people with disabilities to bear on strategic and cross-sectoral implementation issues and support the Minister in reporting on the Implementation Plan as required to the Cabinet Committee on Social Policy.

The terms of reference for the NDSIG are to:

- re-energise the National Disability Strategy, maximising what can be realistically achieved within available resources, towards enhancing the quality of life of people with disabilities;

- guide the development of an Implementation Plan for the NDS in accordance with the commitments in the Programme for Government, setting actions and targets that can be realistically achieved as a three year programme of work;
- collaborate and monitor the implementation of the plan.

Recommendation 12.8: *To facilitate the service user in re-establishing meaningful employment, development of accessible mainstream training support services and coordination between the rehabilitation services and training and vocational agencies is required*

All FÁS Services are open to people with disabilities and the organisation welcomes applications from those who wish to progress and enter the open labour market. Both FÁS and the HSE recognise that the transition for people with disabilities from HSE rehabilitative training to FÁS Vocational training can be difficult and this has been evidenced by high drop-out levels in the past.

As a follow on from the FÁS 2010 Report under this section, the HSE and FÁS scheduled 2 short Test Bridging Programmes between HSE Rehabilitative Training and FÁS Vocational Training in 2011. These tests took place in Dublin and Castlerea over a 12 week period ending in December 2011 with 9 participants on each. Both programmes will be evaluated in early 2012 and will inform policy and practice.

Department of Children and Youth Affairs

Recommendation 4.9: *Community and personal development initiatives which impact positively on mental health status should be supported e.g. housing improvement schemes, local environment planning and the provision of local facilities. This helps build social capital in the community.*

The Department of Children and Youth Affairs provides grant-in-aid funding to the Youth Work Sector which actively works with young people outside, yet alongside, the formal education sector. The programmes operated by the voluntary youth work organisations vary widely. Qualities and skills such as leadership, co-operation, decision-making, motivation, and self-responsibility are acquired by young people through voluntary participation in this non-formal learning process. In addition, Youth Work often acts as the point of contact and referral in the interface with other youth-related services spanning the realms of care, health, and welfare.

The National Youth Health Programme, a partnership between the National Youth Council of Ireland, the HSE and the Department of Children and Youth Affairs, aims to provide a broad-based, flexible health promotion / education support and training service to youth organisations and to all those working with young people in out-of-school settings.

The training provided aims to enhance the professional and personal development of the youth worker. Opportunities are provided where participants can develop skills, gain knowledge and critically examine the

attitudes which can enhance their own health and well-being and those with whom they work. The training courses cover a broad range of specific health issues and generic health promotion theory.

A total of 53 Training Events over 87 days was delivered to 1,060 Participants. Training in 2011 included:

- Specialist Certificate in Youth Health Promotion Accredited by NUI Galway, 5 Blocks of 3 days - 18 Participants
- Mental Health Promotion: MindOUT
- Applied Suicide Intervention Skills Training
- SafeTALK Suicide Awareness training
- Managing Psychosis in the Youth Work sector
- Building Self Esteem
- Introducing Mindfulness to the Youth Sector
- Managing Challenging encounters / Defusing Anger
- Healthy Eating Active Living
- Relationships & Sexuality Education / B4U Decide:
- Drugs & Alcohol
- 3 regional seminars on Youth mental Health Promotion:

Health Quality Mark

The aim of the Health Quality Mark (HQM) is to develop and sustain quality youth health promotion in youth organisations. A new support manual was published in 2011 to support this process and complement the National Quality Standards Framework for youth for youth work. 40 youth organisations currently hold HQM awards at various levels, and are supported by the programme by staff training, policy development and site visits.

Healthy Eating Active Living Resource

The National Youth Health Programme and the Irish Heart Foundation formed a partnership to develop a Healthy Eating Active Living (HEAL) resource for the youth sector. The resource aims to equip youth workers with the skills necessary to create a healthy eating; active living environment in their organisation by providing information on health education, healthy eating, active living policy guidelines and key contact information. The resource is disseminated at training events and through HSE health promotion officers.

Irish Youth Health Promotion Bibliography

In 2011, a user-friendly bibliography of health promotion research in the youth work sector was developed in conjunction with the Health Programme Health Promotion research centre in NUI Galway. The accompanying report identifies gaps in Irish research on youth health promotion in the youth work sector.

Chapter 5

Commentary on progress reported by Government Departments

Introduction

The IMG received detailed reports from Government Departments concerned with implementing some aspect of AVFC. A summary of progress reported is detailed in Chapter 4 and is available on the web at www.dohc.ie/publications/

Department of Health

The policy of AVFC arose out of work of the Expert Group on Mental Health Policy appointed by the Minister of State at the Department of Health and Children with responsibility for mental health in 2003. Since its launch in 2006, the policy has been promoted as Government policy by the Department of Health and Children (now Department of Health) acting as lead Department.

As part of its responsibility, the Department of Health works closely with other Government Departments to support the implementation of AVFC.

Under the last Government, the Office of the Minister of State for Disability and Mental Health was reconfigured and had responsibilities in the context of the implementation of AVFC in three other Government Departments i.e. Enterprise, Trade and Employment, Education and Science and Justice, Equality and Law Reform.

This arrangement was acknowledged and welcomed by the first and second IMGs as a proactive and structured arrangement to encourage the implementation of AVFC. This new arrangement led to the establishment of the Office for Disability and Mental Health within the Department of Health.

Under the present Government Programme, the Minister for State has reverted back to the original Ministerial responsibilities for mental health in the Department of Health with responsibility for equality in the Department of Justice and Equality. The IMG considers this to be a retrograde step. Notwithstanding this, the IMG is aware that there is significant inter-departmental communication at official level on the implementation of AVFC. The IMG is of the view that Departmental co-operation and communication could be strengthened by the creation of AVFC Implementation Plan for Government Departments not unlike the one created for the National Disability Strategy.

In respect of 2011, the IMG notes the allocation of €35 million in Budget 2012 for the development of additional services in line with AVFC.

The IMG welcomes the decision and planning around the development of a new Forensic Mental Health Service and welcomes this long overdue development.

Department of Environment, Community and Local Government

The IMG notes the work of the Department of the Environment, Community and Local Government on developing the Housing Strategy which sets out a framework for the delivery of housing to people with disabilities through mainstream housing policy. The Housing Strategy which was published in October 2011 sets out a framework for the delivery of housing to people with disabilities through mainstream housing policy. The strategy has a particular focus on addressing the housing needs of people with mental health disabilities. It commits to the completion of the housing elements underpinning the mental health policy *A Vision for Change* in relation to the transition from institutional settings to independent living for people with mental health disabilities, who have low and medium support needs.

An implementation plan is being developed with achievable timescales and targets and the IMG understands that the plan will be finalised mid-2012. This is being undertaken by a high level implementation planning group, chaired by the Department of the Environment, Community and Local Government which will also be responsible for identifying sustainable funding mechanisms to resource the implementation of the strategy. It is expected that the implementation plan will be finalised over the coming weeks.

The IMG welcomes the appointment of an Implementation Monitoring Group with representation from the mental health sector to monitor ongoing progress on the Housing Strategy.

Department of Justice and Equality

The IMG welcomes the development of formal co-operation between the Irish Prison Service and the HSE in providing Psychiatric In-reach and Court Liaison systems and services. The IMG also welcomes the Review of the Criminal Law (Insanity) Act 2006 which commenced in 2011.

A major development in 2011 was the coming into operation of the Criminal Law Insanity Act 2010 which amended the 2006 Act. The new Act gave the Review Board the authority to make orders for the discharge of patients subject to such conditions as the Board considers appropriate, including conditions relating to outpatient treatment or supervision or both. In 2011, the Board approved the conditional discharge of seven patients from the CMH.

The IMG congratulates the Irish Prison Service and the HSE's Forensic Mental Health Service on winning the World Health Organisation's "*Health in Prison – Best Practice* Award for the High Support Unit in Mountjoy Prison.

Department of Social Protection

The IMG welcomes the National Advocacy Service, which was launched in 2011 and is being delivered by the Citizens Information Board, and hopes that the Service will respond proactively to the advocacy needs of people with mental health problems.

In addition to a National Advocacy Service for Adults there is a requirement to put in place an advocacy service which specifically responds to the needs of children and adolescents. The development of such a service should be considered the responsibility of the Department of Social Protection with the co-operation of the Department of Children and Youth Affairs.

The IMG notes the work undertaken to restructure FÁS and hopes that the restructuring will strengthen the ability of the new Agency to respond to the training and employment needs of people with mental ill-health.

Department of Children and Youth Affairs

This is a new Department established under the Programme for Government. The IMG welcomes its participation and responsibilities for mental health related issues.

Department of Education and Skills

The IMG notes the ongoing work of the Department of Education and Skills but notes no new initiatives were reported for 2011.

Chapter 6

Addressing the biological, psychological and social factors that contribute to mental health problems

AVFC "*.. proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It proposes a person centred approach which addresses each of these elements through an integrated care plan, reflecting best practice and evolved and agreed with service users and their carers. Special emphasis is given to the need to involve service users and their families and carers at every level of service provision. Interventions should be aimed at maximising recovery from mental illness and building on the resources within service users and within their immediate social networks to allow them to achieve meaningful integration and participation in community life".*

Integral to this, is the fundamental philosophy of the provision of multiple interventions by multidisciplinary mental health teams in a holistic manner. The concept of multidisciplinary working had been long established and the concept of the biopsychosocial model long espoused by mental health professionals.

However, in practice, for whatever reason, much of the mental health services are delivered by doctors and nurses utilising mainly biological methods, with little input from other disciplines.

While there has been some improvement in the populating of CMHTs with all disciplines, this is far from complete and has stalled in recent years, largely because of reduced finances and the effects of the Public Service Moratorium.

Some presentations to the IMG suggested an unwillingness by psychiatrists to whole heartedly embrace the principles of recovery, multidisciplinary working and the centrality of the service user.

Instead, some psychiatrists are said to focus narrowly on a medical approach to treatment (biological/medical treatments include medication and ECT and very rarely psycho surgery).

The medical model of treatment involves the presentation by a patient (or family) to a medical centre with specific problems seeking amelioration or relief. The medical person assesses the patient's symptoms, organises tests or investigations, arrives at a diagnosis according to established criteria and formulates a treatment plan which may include medical interventions such as simple advice, medications or procedural intervention.

The medical approach is positivist and linear in manner and critics have pointed out that it does not sufficiently allow for more individualistic contextual factors.

It has also been suggested that in the field of mental health services, in particular, where the process of diagnosis may be less robust than other branches of medicine, even more account should be taken of contextual and individual factors.

The CPI, in its presentation to the IMG, has fully endorsed the biopsychosocial approach to the delivery of mental health services and has called for an expansion of multidisciplinary team working.

The IMG recognises that financial constraints combined with low numbers of psychologists, social workers and occupational therapists may sometimes lead to an undue focus on and use of psychotropic medication. This possible over reliance on medication is consistent with the findings of the Inspector of Mental Health Services, which identified instances of prescribing of benzodiazepines in older persons services and anti-psychotic medication in community based residences above recommended guidelines. The development of a more balanced holistic model will lessen the reliance on medication-only interventions.

Monitoring of medication, according to well established guidelines, is a matter of governance of the mental health services regarding which AVFC is quite explicit with respect to mental health catchment area management teams and the National Mental Health Service Directorate within the HSE, as described in Chapter 16.

The IMG urgently recommends these types of robust governance measures are put in place.

The IMG is of the view that six years into the implementation of AVFC there has been a gradual, slow and inconsistent transition to a biopsychosocial model of mental health care. Much of the progress has been due to local clinical and administrative leadership rather than national policy. There are not many examples of services in transition to the biopsychosocial model.

Many of the submissions received by the IMG refer to the prevailing presence of the medical model. This is exemplified in the formation of the CMHTs where many teams are incomplete because of vacant posts in psychology, social work, occupational therapy and other allied health disciplines.

This slow progress is further exemplified by the findings of the National Inpatient Perception study commissioned by the MHC which indicates that:

- 33% of respondents reported that they were not given a key worker upon admission into the mental health services
- 30% have no care plan
- 35% of users did not have a discharge plan on leaving hospital
- 24% of services users would have welcomed involvement in decisions regarding their care and treatment
- 43% of mental health patients surveyed said that the possible side effects of medication were not explained to them.

Building a mental health care service on a biopsychosocial model is not only an essential aspect of ensuring service users receive the highest quality mental health care but is also fundamental to consolidating a recovery model of mental health care.

The IMG believes that to provide more impetus and momentum to this transition the following actions need to be taken:

1. The work of the National Mental Health Services Collaborative on Care Planning should be continued and extended by the Partners to ensure the concept of care planning is embedded in all mental health services.
2. Equal priority should be given to filling vacant allied health professional posts on multidisciplinary teams.
3. The Department of Health with support from all relevant stakeholders including service users, carers, CPI, ICGP and Pharmaceutical Society of Ireland should develop a robust strategy to monitor, audit and report on the use and side-effects of medication used in mental health treatment on a regional and national basis.

Funding for Research and Training

Related to the holistic model of service delivery is the question of mental health service research.

Unfortunately, too much emphasis to date has been on pharmaceutical industry funded research and training which may have led to too much reliance on the biological aspect of treatment.

In that regard, the IMG welcomes the development by the CPI of a position paper on its relationship with the pharmaceutical industry.

The IMG noted that in September 2010, the CPI passed a motion that "The College would cease receiving any sponsorship from pharmaceutical companies, for its academic meetings or other activities".

Further, meetings which are organised and funded by a pharmaceutical company cannot be approved for external Continuing Professional Development (CPD) credits (which are granted by the College). However, meetings which are organised by clinicians, with unrestricted funding from a pharmaceutical company can be submitted to the CPI for approval for external CPD. The IMG encourages the College to review this exception with a view to severing all links between research and education meetings and pharmaceutical funding.

The IMG urges that the relationship between the medical profession (and to some extent the mental health nursing profession) and the pharmaceutical industry be carefully monitored so that no undue influence arises. The IMG recommends that future research in mental health services be funded through non-pharmaceutical sources.

The IMG recommends that training of GPs and psychiatrists and indeed all multidisciplinary members be funded from non-pharmaceutical sources and that training of all clinicians involved in the delivery of mental health services be along biopsychosocial lines with particular emphasis on multidisciplinary working, service user involvement and the concept of recovery.

Psychological Therapies

One of the essential requirements towards achieving the biopsychosocial model is the development and presence of the various psychological therapies. The

IMG acknowledges the work done by the CPI in developing a new curriculum and training programme for psychiatrists. In the new programme, psychiatrists have formal training and interactive learning in psychotherapy. For the first four years of training, psychotherapy is mandatory. Trainees also get formal teaching in the different theoretical psychotherapy modules.

Chapter 7

National Mental Health Programme (Clinical Programmes)

Introduction

The HSE Clinical Strategy and Programmes Directorate (CSPD) has been established to improve and standardise patient care throughout the HSE by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of HSE services.

The Directorate has established a number of National Clinical Programmes. The Programmes are based on three main objectives:

1. To improve the quality of care delivered to all users of HSE services.
2. To improve access to all services.
3. To improve cost effectiveness.

There were five main developments in CSPD in the mental health area in 2011:

- The establishment of three College of Psychiatry of Ireland Groups focused on three clinical programmes of Early Intervention (Early intervention in First Episode Psychosis, Early intervention in Eating Disorders and Management of Self-harm Presentations among service users to Emergency Departments. The membership of these initial Groups is outlined in the Discussion Document and it is notable that certain key groups (e.g. Nurses) were not represented).
- The appointment of a Programme Project Manager (PPM) in August 2011.
- The nomination of an ICGP Co-Lead for the Programme in September 2011.
- The establishment of a Working Group in October 2011.
- The publication of a draft National Mental Health Programme Plan in November 2011 (available at http://www.dohc.ie/publications/).

Though the focus of this IMG Report is 2011 it should be noted that there have been further developments in 2012 and these will be addressed later in this chapter.

The IMG received the draft National Mental Health Programme Plan of November 2011 prior to meeting with the National Clinical Lead for Mental Health (NCL) and the PPM. The meeting allowed a detailed discussion of the draft, its rationale and the plans for its implementation. Further information, particularly in relation to developments since November 2011, was provided by the PPM.

Principal IMG Concerns

Though the IMG welcomes the developments in this area and the brave attempt to systemise nationally clinical interventions and service delivery in the face of decreasing resources the IMG is concerned by certain issues and the effect they may have on the implementation of this Programme and of AVFC.

Following review of the document and meeting the National Clinical Lead and the Programme Project Manager the IMG has eight major concerns:

- The Programme Plan declares its support for and adherence to the principles of AVFC and reiterates this in its outlining of Governance in general and in the three chosen programme areas. However, the IMG is concerned that the sense in the document that key parts of AVFC will evolve if certain programmes are developed may be optimistic and result in further delay in the delivery of mental health teams nationally.
- The National Mental Health Programme Plan must not be seen as a substitute for the delivery of the core principles and activities outlined in AVFC.
- The appointment of a National Clinical Lead must not be seen as a substitute for the establishment of a fully resourced and empowered Mental Health Directorate as proposed in AVFC.
- The role of Primary Care in the delivery of mental health care is not given the attention it requires in the 2011 draft document.
- In its last report, the IMG welcomed the appointment of the National Lead within the CSPD but recommended that the post be a full time post. This has not as yet happened. Considering the key role Primary Care must play in the delivery of community based mental health services the appointment of a Co-Lead by the ICGP is also very welcome. The IMG still holds that the work involved in establishing uniform care pathways nationally is of such importance that the posts charged with this work needs fulltime input at least until the structures are fully established.
- The Governance Structure proposed in the Programme Plan is complex and seems to assume the existence of fully resourced functioning CMHTs nationally.
- The Plan may be difficult to implement as it is predicated on the existence of such CMHTs and the availability of resources for both staffing and staff training.
- Despite the assertion by the NCL that the vision for the Programme is that it will complement and enhance the delivery of AVFC, the IMG is of the view that already stressed existing CMHTs will be stretched to breaking point by the requirements of the "Specialist within Generalist framework". The resultant requirement for horizontal and vertical availability of frontline clinicians for the cross team interventions that are proposed in the document are demanding.

IMG Overview of the Programme Plan

The footnotes to the document explain that this is an overall development strategy for mental health. There is no mention made of the Mental Health Service Directorate, as proposed in AVFC. This is a worrying omission as any governance structure for mental health services must be overseen by this

Directorate. All the Ministers responsible for the delivery of Mental Health Services (including the current incumbent) have supported the call by the IMG for the establishment of the Directorate. Of greater concern, however, is the implication in the document that the delivery of a structure based around chosen specialist programmes will deliver the requirements of AVFC.

The document is divided up into four sections each of which has several subsections. Section one is the National Mental Health Programme Plan and Sections Two, Three and Four outline three initial programmes that are proposed within the National Programme.

Section 1.1 and 1.2 - Policy Context

The outline of policy nationally and internationally is helpful and it is welcome that the Programme Plans are to be informed by these. It is particularly welcome that the place of mental health within the generality of health promotion and illness prevention and intervention is acknowledged. The first draft did not emphasise clearly the role of Primary Care and this has been rectified to some degree in the second draft produced in 2012. It is to be hoped that the appointment of the Co-Lead from Primary Care will increase this emphasis in line with international best practice and AVFC.

The IMG would like to see a greater emphasis on Recovery as a core concept informing the Clinical Programme as it evolves and is rolled out.

Section 1.4 - Aims and Principles

The Aims of the Programme Plan are worthy. Though Recovery is listed as a principle it would be a better term than Positive Outcomes in the four stated Aims as it is core to AVFC, it encompasses a broader philosophy than the term 'Positive Outcomes' and brings the terminology into line with the overall philosophy of AVFC.

Section 1.5 - Outline of Programme Plan

The Outline recognises the core role of CMHTs as proposed in AVFC. The Programme Plan proposes a delineation of the scope of work for CMHTs in three main "Strands" with a resultant Three Stage development of community mental health services. This seems to be done on the basis that it will focus the use of existing resources and give a framework to attract future resources. It is not clear from the document how the Strands were created or how the issues that are to be addressed in each Stage were chosen and prioritised.

The framework proposed does not encompass primary care in its general outline. The Clinical Lead is to be congratulated however for this attempt to systemise the development of standards of mental health service delivery into the future. However, the risk of neglect for some patients who do not fit in to a developed strand as this Programme Plan is rolled out is obvious and the document does not acknowledge this and so does not propose any safety net to reduce this risk.

It is unclear from the document whether it is planned that CMHTs will be developed nationally to facilitate the strands or that the strands will be developed and the CMHTs will result but in an incremental fashion. The latter seems a more likely aspiration in the context of the statement that "resource restrictions prevent full team development at this time, either in size or in the range of therapists envisaged within the government policy document". This is disappointing and worrying as the focus should be on ensuring that service users have access to the fully resourced CMHTs nationally and this approach runs the risk of promoting the continued uneven nature of the service resources across the country.

Section 1.6 - Governance and Organisational Structures

Four layers are delineated: Local CMHTs; Health Area Specialist Services; Regional Specialist Services and Networks; and National Clinical Governance.

The Mental Health Service Directorate is not mentioned. No proposed governance structure for mental health services in Ireland can be valid within the policy of AVFC unless it has the Directorate as its lead. No Programme Plan can be valid without its functioning in such a structure and its relationship with the Directorate being delineated.

Putting this major omission to one side there is a lack of clarity on the governance of the Specialist Services and the CMHTs. It seems as if there is a proposal for a new type of team with team members doing work as members of a CMHT addressing the normal gamut of mental health problems presenting locally while also specialising in certain problems both within the local team and within a virtual Specialist Team across a Directorate. There is a lack of clarity here that is repeated in the discussion of the specialist programmes. After discussion with the NCL it appears as if it is proposed that mental health professionals will fill two roles: members of a local CMHT and Specialists for the Area Teams available for consultation, education and Specialist Team deliberation and leadership across a wider geographical area. It is difficult to see how this will be achieved with existing resources using already stretched professionals from already depleted CMHTs. This is especially so as many areas of the country do not have fully resourced CMHTs. The NCL, in the Document and in his meeting with the IMG, seemed to suggest that the structures outlined can make up for the lack of fully resourced CMHTs in some areas. The IMG remains unsure of how this can be done without further diluting existing service provision.

It is obvious from the document that little, if any, discussion has occurred with professional groups as regards the changes in work practice needed for this structure to be introduced. Though the IMG is supportive of imaginative proposals to maximise the impact of existing resources and understand the aspirations of the NCL, the IMG question the practicality of the solution proposed in this document but hope that the development of implementation plans which is currently in train will answer these concerns.

Sections 2, 3 and 4

These sections outline the Policy Context, Service Components, Objectives, Governance Structure, Interventions, IT Infrastructure, Resource and Education Requirements and Service Interfaces for three chosen clinical challenges:

1. Early Intervention in Psychosis
2. Early Detection in Eating Disorders
3. Management of Self – Harm among Service Users Presenting to Hospital Emergency Departments.

The IMG welcomes the plan to bring consistency to the service response to these issues and to outline targets. However, the governance structures proposed once again rely on the "Specialist within Generalist" model and, as previously stated, the IMG has concerns about this model. The IMG must await the deliberations of the Specialist Groups and the National Working Group and an implementation plan to hopefully put the IMG's concerns to rest.

Another concern is that this initial Programme declares a need for staff resources and for resources to educate staff and it is questionable that these are available at the current time. The IMG supports the call for such appointments of necessary staff and the dedication of resources to the training of staff.

Developments in 2012

As this may be the final report of the IMG it was considered important to clarify what developments have followed the publication of the initial Draft Programme Plan. Communications from the Programme Project Manager have been helpful in elucidating these. The initial Programme Plan was redrafted following consultations with the ICGP and the CPI leading to a further Draft Programme Plan document which was circulated for discussion in March of 2012. The main differences between the first and second drafts available are the accentuation of the key role of Primary Care as a partner in delivering an appropriate mental health service to the people of Ireland. The initial CPI Groups were formally established, in accordance with the National Clinical Programme Directorate model, in early 2012. This included nominations for various inputs from various stakeholders (including the NSUE. for service user representatives). The HSE Assistant National Director, Mental Health and the Assistant National Director, Primary Care are now members of the National Working Group. Clinical Leads and Co-Leads were also put in place in the three main sub-groups. These groups have a broader representation of stakeholders including service users and nurses. At the time of writing, the National Working Group with the three sub-groups is preparing the implementation process for the Programme Plan. A brief outline of the main interventions in each constituent programme is promised for June of this year (2012) with the detailed plans and metrics following in July. The four RDOs have endorsed the development of the Clinical Programme and have appointed an individual from each region to facilitate the implementation of the Programme through early engagement with the operational element of the HSE. A Training and Education Group has been established to ensure that all teams function properly and adhere to the same core principles. All training and education programmes will include service users and carers as tutors and

participants. This will ensure that all voices and views are heard. Recovery principles and care planning will be part of that training process.

Conclusion

The IMG welcomes the fact that mental health is being addressed within the structure of the HSE Clinical Strategy and Programmes Directorate. The Draft Programme Plan represents a bold effort to address specified needs to ensure uniform delivery of high standard services across the country. However, the governance structures outlined do not recognise the core AVFC proposal of a Mental Health Service Directorate. The IMG believes that a Directorate as proposed in AVFC is vital to the coherent and cohesive development of mental health services across Ireland. Therefore, though the IMG is excited by its broad sweep and innovative proposals, the Programme Plan as outlined cannot be seen as an alternative to the philosophies and structures proposed in AVFC. The IMG reiterates its core position that a Directorate as described in AVFC must be put in place to ensure the appropriate delivery of mental health services. The Document also proposes a governance and organisational structure for the implementation of the Programme and its constituent parts that requires a totally new way of working within and across health service structures. This requirement for a totally new way of working for individual staff and for teams was teased out in the IMG's meeting with the NCL and the PPM. They confirmed that successful implementation depends on all stake holders changing and expanding the way they work and interact without any new resources being provided. The IMG has concerns in relation to this proposition pending the production of an agreed, practicable implementation plan.

The IMG understands that new structures with wide representation of all stakeholders are in place to support the NCL and Co-Leads in developing this plan and a structure for its implementation. This development along with a reported commitment from the RDOs leads to hopes that 2012 will bring a practical and practicable implementation plan into the public domain.

Chapter 8

Recovery

Introduction

The Recovery ethos is enshrined as central to AVFC. Whilst the IMG does not underestimate the scale of the challenge involved in transforming mental health services, it is again disappointing to report that the progress necessary to embed recovery is worryingly slow. Consistently, submissions made to the IMG welcome the changes implied in adopting the recovery ethos but the challenge appears to be enabling principles to translate into recovery-oriented practice. A national implementation plan focussed on the transformation process required to embed recovery principles is urgently required if the agreed vision articulated in AVFC is to succeed.

Submissions to IMG

A review of the submissions to the IMG in 2011 would suggest that there is a growing engagement across the stakeholder groups. The initial scepticism that greeted the recovery ethos is slowly being eroded and replaced with more practical implementation concerns which include grappling with conceptual uncertainty and inconsistency regarding the meaning of recovery. This debate is a necessary precursor for change. Investing time in developing a shared vision of a recovery-oriented programme or service with all the stakeholders is to be welcomed.

The systemic changes identified in the submissions and presentations to ensure the cultural shift to recovery prioritise the need for attitude change if service delivery models underpinned by principles of service user and family involvement, advocacy, team working, recovery and respect for all are to be achieved. Submissions propose that the cultural change required can be achieved by embedding recovery principles in legislation, ensuring leadership is given both locally and nationally, designing recovery-oriented care planning involving service users and their families, mandating up-skilling in recovery approaches, and disseminating best practice across the country. Unanimously, all groups endorsed the principles and values of recovery but appear to be at different stages in interpreting recovery-oriented practice as it applies to them in their field of work/interest. Views held suggest that system change will require a new care philosophy in which recovery-oriented practice is incentivised. A commonly expressed view suggests that outcome measures and Key Performance Indicators are essential to capture progress and look at levels of community activation and participation.

One of the most comprehensive recovery focussed submissions received by the IMG came from Mental Health Reform who presented their "*Guiding A Vision for Change Manifesto*" to the group in addition to making a formal submission. This document, developed from an extensive national consultation process argues for the vision as articulated in AVFC "*of a humane, person focussed,*

accessible and responsive service, (p.4)". They suggest that implementing recovery-oriented services "*requires both structural and cultural change…….it requires a new set of values into mental health care delivery; it requires 'values-based practice' alongside 'evidence-based practice' (p.5).* Whilst Mental Health Reform expressed concern at the rate of implementation of AVFC, they acknowledge that modernisation is occurring and examples of good practice are evident nationally.

The transformation process implied by AVFC appears to be moving for some from an exploratory discussion phase into a broader consideration of implementation issues that need to be addressed. Whilst progress is disappointingly slow there does appear to be some momentum developing. One of the key drivers identified as necessary to enable the systematic change at national level is the appointment of a National Mental Health Service Directorate, as envisaged in AVFC. Whilst the announcement made by the Minister with responsibility for mental health, Kathleen Lynch, that this post will be developed was broadly welcomed in submissions, concerns remain that it will not be the Directorate as envisaged in AVFC which may diminish the opportunity to ensure recovery remains the keystone in both a values and evidence-based mental health service.

Care Planning

Promoting best practice in care planning is one of the critical factors that enables a paradigm shift to recovery focussed care. This was the central thrust behind the National Mental Health Services Collaborative, a project designed to ensure that best practice in care planning methodologies could be established in several participating services and the resultant learning used to provide an impetus for other services to follow suit.

One of the key principles in the national clinical care programme for mental health stresses the importance of the development of individual care strategies with a newly-defined relationship between service providers and service users at its core.

Mental Health Reform, in its submission, mentioned the need for appropriate care planning for those with dementia in inpatient services and the National Federation of Voluntary bodies called for people to be supported in making their own choices.

Mental Health Reform also emphasised the need to develop care planning that happens in partnership with service users, families and significant others and provides them with choice.

The results from the collaborative showed the difficulties inherent in attempting to change current practice, but the outcomes in participating sites were largely positive. What is less positive is the results from two surveys, the *Quality Framework for Mental Health Services in Ireland* survey on inpatient care, and the NSUE second opinions survey, which both came to similar conclusions: only about 50% of people currently feel they are fully involved in their care planning and a staggering one-third of those in the NSUE survey were either not involved at all, or did not even know what a care plan was. When this is allied to the relatively poor compliance levels of approved centres with the

regulation dealing with individual care planning, which expressly states, *"The registered proprietor shall ensure that each resident has an individual care plan"* then it is hard to avoid the conclusion reached in the NSUE "Second Opinions" report (section 7):

"Care planning is slow in evolving into a system that supports the individual's unique needs, goals and recovery journey."

It is abundantly clear that there is a major challenge in improving the care planning process in order to make a positive impact on the shift to the recovery paradigm in current Irish mental healthcare services.

Where is Change Happening?

The development of recovery-oriented practice nationally is evident to the IMG albeit that it appears to have occurred as a result of local/individual interest and endeavour and not as a result of a national strategic implementation plan. The IMG acknowledges the work of the NSUE in increasing its membership, raising capacity through the development of consumer panels, developing a new e-learning programme and the publication of their Second Opinions Survey conducted in 2011 and published in 2012. Through this range of activities, NSUE has maintained its momentum focussed on the need to keep the service user, their family and supporters and the community at the heart of all developments in mental health services.

In addition to the Mental Health Collaborative project, listening to service users was also a priority for the MHC who, in collaboration with the Irish Society for Quality and Safety in Healthcare published their Inpatient Satisfaction Survey 2011. Notwithstanding the acknowledged limitations of satisfaction surveys, their key findings categorised under 6 of the 8 themes in the *Quality Framework for Mental Health Services in Ireland*, record high levels of satisfaction by service users and provides a useful benchmark for assessing the impact of future interventions.

Capacity raising training activities also took place in 2011 with the Irish Advocacy Network developing new peer support and advocacy courses and reporting that peer support training at University College Cork was well received. Demonstrating the partnership concept at the heart of AVFC, the *Cooperative Learning and Leadership Course,* a collaboration between DCU and the HSE, has maintained a steady growth and momentum since its commencement in 2007. This project brings three stakeholders from local mental health services together to study and work on bringing about local service change. Groups are made up of a service user, carer/family member and a service provider and are focussed on developing leadership skills to enable new ways of working that are grounded firmly in recovery principles. Emerging from this initiative has come The Mental Health Irish Trialogue Network which is being steered and supported by a multiagency group including the Irish Advocacy Network and the National Service User Network, and is supported by the HSE National Mental Health Office and local HSE community services.

Training and implementation in Mary Ellen Copeland's Wellness Recovery Action Planning (WRAP) was reported by many and referenced as a valuable self-management tool for service users. Such developments broaden the range of recovery focussed strategies that can be offered by service providers and communities and are acknowledged by the IMG as being a vehicle to empower people to take ownership of their own wellness.

The transformation process required to develop new recovery-oriented ways of working by adult mental health services was acknowledged in submissions and meetings with the IMG as being at different stages of development nationally. Based on their 2011 member survey, NSUE awarded *Best Overall Service* to The Clifden Mental Health Service, the *Most Effective Supports* award went to The Mallow Mental Health Service and the *Most Improved Culture of Care* award went to The Carlow Mental Health Service. Both the HSE and Mental Health Reform cited developments in Castlebar where the rehabilitation team, in association with Shine, are testing a methodology for change within their service moving to a recovery-oriented approach as part of the Implementing Recovery through Organisational Change (IMROC). This project aims to improve the quality of local services to support people to more effectively lead meaningful and productive lives in their communities.

The IMG acknowledges and is aware of the various attempts by the HSE at local and regional level to introduce the concept of practice and recovery-oriented services. In its consideration of the HSE submission, the IMG was particularly impressed with the robust recovery-oriented services described by HSE South. The developments in the West Cork mental health services were cited in a number of submissions as exemplars of the changes to practice that occur when a local service commit to honouring recovery principles in all aspects of their practice and are captured in their report "*Moving West Cork Mental Health Service in a Recovery Direction*".

In addition, the HSE's submissions all report favourably on the development of local Jigsaw projects for which an additional €1m from Government was made available to fund an expansion programme. Jigsaw is an innovative community based support service for young people, which has been developed by Headstrong and is designed to promote systems of care that are accessible, youth-friendly, integrated, and engaging for young people. This allocation will be a recurring for 3 years from 2011. Jigsaw is currently in five sites around the country - Galway, Kerry, Ballymun in Dublin, Meath and Roscommon. An additional 6 sites were announced in 2011 – in Clondalkin, Tallaght, North Fingal, Dublin 15, Donegal and Offaly. Given the significant levels of investment in this initiative and expansion plans outlined, it is essential that the project is subject to a robust independent evaluation to assess its long term effectiveness.

Whilst there is now a sufficient body of literature and research describing what mental health services should look like from the recovery perspective, the IMG acknowledges the HSE's plans to localise practice per AVFC and develop a comprehensive Guidance Document on *Implementing Recovery in Practice* in 2012. The IMG notes and welcomes the recent publication by the HSE of Advancing Community Mental Health in Ireland Guidance Papers, developed in 2011, which have been "created to enable a high standard of service

provision to happen in the most effective and efficient way possible". It is imperative that the HSE continues to develop transparent, practical and user friendly structures and processes which are firmly rooted in the philosophy of recovery and the development of recovery competencies in all of its services.

In its submission to the IMG, the CPI reported on its work in Recovery. The IMG notes that CPI has established a forum for service users and family members, which they hope will inform future training and policies of the College. In discussion with the IMG, the CPI advised that they are engaging its membership in a dialogue on the implications of recovery orientated practice as evidenced in their recent Spring Conference in April 2012 on the theme of Social Psychiatry and Recovery. The IMG notes that CPI welcomes the opportunity to work actively with a new AVFC Mental Health Directorate and the implementation group in introducing AVFC.

The training of psychiatrists and indeed all mental health professionals has been highlighted by many contributors as a priority area needing a strong emphasis on the recovery ethos. The development of recovery competencies and the professional behaviour and actions consistent with recovery in practice needs urgent priority across all professional bodies and educational institutions.

It is argued by many that a recovery ethos applied to practice should lend itself to both qualitative and quantitative evaluation. Whilst the Mental Health Commission's Pillars of Recovery Service Audit Tool (Higgins, 2008) offers a methodology for auditing services against recovery principles, the Recovery Context Inventory developed by EVE was recently recommended for use (along with the INSPIRE measure) in Northern Ireland as a service user rated measure of recovery orientation (report commissioned by the Bamford Implementation Rapid Review Scheme 2011). The IMROC project in Castlebar was the only national project reported to the IMG that was implementing a systematic whole service approach, with accompanying evaluation. The results of this initiative should be considered carefully in the context of proposed re-configuration of local services.

As is evidenced in the submissions to the IMG, a growing body of evidence is accumulating which can inform future developments of recovery-oriented practice. It is essential that all future activities incorporate robust and preferably independent evaluation to support this ambition. Evidence based practice, when in the control of the service user, set in a values based context, has the potential to effectively support the individual achieve their own personal goals and enhance their recovery.

Factors that Promote a Culture of Recovery

Building on positive recovery practice is essential. Based on the experiences to date of recovery focussed projects and initiatives, it is important to acknowledge the responsibility that exists to design-in capacity in our mental health services to disseminate the positive learning that has been achieved to date and imbue courage and confidence that change is both possible and rewarding.

The IMG notes that there appears to be common characteristics which are present either whole or in part which contribute to creating a positive culture for change. These include:

- **Service User & Family Involvement** - where service users, families and service providers establish meaningful partnerships and dialogues, the reported quality of the service and recovery practice was noticeably higher. In areas where consumer panels are established, trialogues are present, where there is evidence of active community engagement with all stakeholder groups, cultural change is being achieved in line with AVFC and reported satisfaction levels are high.
- **Leadership** - this characteristic emerged at a number of different levels in the submissions and meetings with the IMG. Effective leadership by operational and/or clinical decision makers impacted powerfully on the capacity and willingness of services to implement significant changes at local levels. Leadership by statutory bodies exercising their mandate to drive change also brought about major developments that might not have occurred otherwise. Leadership shown in the voluntary sector has been a major driver of new and innovative practice both within the sector and in collaboration with statutory providers.
- **Culture and Attitudes** - the recovery ethos is often described in the context of an underpinning values and belief system. Where the local culture is based on a recovery ethos, be it organisational, institutional, or community-based, progress implementing recovery-oriented practice is evident.
- **Recovery Champions** - recovery champions are a key driver in the changes achieved to date and come in many guises. Champions were evident in organisational and institutional services, both within the statutory and voluntary sector. They have emerged from clinical and service user backgrounds, from families, from communities and all demonstrate a willingness to collaborate and harness the energy of the collective for the greater good. Whilst one can argue that developments achieved by recovery champions can be too "personality-driven" and not reflect a genuine systemic commitment to change, equally, the recovery champion can show the way, creating examples of good practice that can translate to other areas.
- **Community focus** - initiatives that have recognised the value of maximising opportunities for integration in the social and economic life of their communities have greatly enhanced the outcomes being achieved for service users. Delivering recovery-focussed services demands a pro-active engagement with the community and its stakeholders in order to create education, employment and social opportunities for people to re-connect and reclaim their citizenship. Good practice to date has harnessed the available "capital" with the community to the advantage of the service user and their families.
- **Commitment to re-configuration and transformation** - taking a measured decision to commit to delivering recovery-oriented services as envisaged in AVFC was a critical defining factor in those initiatives that have achieved momentum. Whilst AVFC is national policy, the IMG acknowledges that local services and stakeholder groups are at varying

stages in relation to implementation. Where the decision has been taken to commit and commence a transformation process, progress is achieved.

- **Funding enablers** - the presence of new sources of funding has been an independent stimulus for innovation and advocacy over the past 3-5 years. Initiatives funded from philanthropic sources have injected new momentum in the area of mental health advocacy and service provision. Blending philanthropic and statutory sector monies, GENIO has introduced a welcome level of strategic co-ordination and independence to the allocation of innovation funding that has prioritised recovery-oriented measures in line with AVFC.

Conclusion

In reflecting on the progress to date the IMG, whilst concerned at the pace of developments to date, is encouraged that there is evidence to suggest that the recovery ethos is slowly being adopted across the country. The imperative is now to create sustainable momentum in the development of recovery-oriented programmes and services that will be immune to the social, economic and political forces that may emerge over the remaining lifetime envisaged for the implementation of AVFC.

Driving the changes required to embed recovery principles in practice in our mental health services is contingent on an effective implementation plan driven by a Mental Health Service Directorate as envisaged in AVFC - *"The National Mental Health Service Directorate will be of central importance in facilitating the modernisation of the Irish mental health services*".

Based on the submissions to date, the IMG suggests that translating recovery principles into practice is possible, where the will and commitment exists. Whilst the process of change can be slow and not without challenge, the benefits to the service user, the families, carers and the community are acknowledged by all, including the mental health services.

Chapter 9

Overview of progress on implementation since 2006

The focus of this Chapter is on providing a general overview of the themes which have emerged over period 2006 – 2012 arising out of a consideration of the five IMG reports produced. Copies of the IMG annual reports and accompanying documentation are available at http://www.dohc.ie/publications/

1. The Staffing of Mental Health Services

All mental health care services by their nature rely heavily on the delivery of comprehensive care and interventions by professionally competent staff. There is little or no reliance on technology in the provision of mental health care.

Since the launch of AVFC, there have been significant challenges in providing the type of staffing required due to the implementation of the HSE's Recruitment Embargo and the Public Service Moratorium from 2009 – to date.

The HSE Embargo and Public Service Moratorium on staff recruitment have been effective in driving down the overall cost of mental health services but are rather a blunt instrument making it extremely difficult to reshape and reallocate mental health service resources as envisaged in AVFC. Consequently, there has been very slow progress in fully staffing CMHTs in all areas of mental health services. Many submissions to the IMG have stressed that mental health services have taken proportionally a much greater reduction in staff numbers than other areas of the health service.

The blunt nature of the embargo/moratorium means that it is ultimately and practically impossible to put in place a proactive and progressive manpower plan. The unpredictability of retirements and resignations under the various exit schemes has resulted in a haphazard and uneven distribution of remaining staff across the 26 counties. There are manpower shortages in nursing, psychology, occupational therapy, social work, junior hospital doctors (related to supply issue) which make it extremely difficult to populate mental health teams. Additionally, there has been a trend in recent years to depopulate community facilities in favour of preserving staffing levels in residential facilities (Approved Centres). This has resulted in the reduction of staff in day hospitals, day centres, group homes and CMHTs. As referred to earlier, there appears to be a de-prioritisation of rehabilitation and recovery teams in favour of acute adult mental health teams.

Despite the derogation for 200 Psychiatric Nursing and Allied Health Professional posts in 2010 and 2011 there is an overall gross reduction in the availability of professional staff to address the type of service envisaged in AVFC. The IMG is encouraged by the plans for the additional allied health professional posts arising out of the 2012 Budget allocation, detailed in Chapter 3.

2. Financial Resource Allocation

AVFC recommendation

> *"Substantial extra funding is required to finance this new Mental Health Policy. A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services".*

AVFC envisaged the additional allocation of capital and revenue funding to mental health services to allow the development of supports for AVFC. Additionally, AVFC spoke of freeing up existing resources by way of transforming old models of service to community models. This would involve the closure of outmoded 'unfit for purpose' services in favour of more locally based comprehensive community services and the consequent transfer of staff.

In reality during 2006 and 2007, the Minister of State with responsibility for Mental Health allocated additional resources of €26.2 million in 2006 and €25 million in 2007 recurring. In 2008, the Minister of State announced that he could not allocate additional resources until he was assured that the resources already allocated were utilised appropriately. Subsequently, Freedom of Information reports confirmed that in fact the majority of the additional funding allocated in 2006 and 2007 was either not spent or reallocated to other health programmes. In 2009 and 2010 nominal additional amounts were allocated against the backdrop of top sliced reductions in allocations – 2010 – 3%; 2011 - 1.8%; 2012 – 1% *(net of 2012 Budget allocation)*. In respect of 2011, the IMG acknowledges that the 1.8% reduction applied to mental health expenditure was a specific exception to the overall health reduction of 5%.

The IMG also acknowledges the allocation of an additional €35 million to mental health services in the 2012 Budget and notes that this is specifically targetted towards the filling of vacant posts in CMHTs. Details of the new posts arising from this allocation are detailed in Chapter 3.

Notwithstanding the above, the IMG notes that the 2012 Budget reduced overall mental health revenue expenditure by €41 million. The net effect, taking into account the allocation of €35 million, is a 1% reduction in 2012.

The expected capital investment also failed to materialise despite a commitment by Government to invest mental health monies generated from the sales of un-required lands and buildings. The Government's commitment was to allocate up to €50 million per annum for capital investment, the amount to be recouped from the sale of lands. In reality due to the collapse of property and land prices a sum of €37million was recouped from sale of lands.

As a consequence of the embargo, moratorium, reduced revenue and reduced capital expenditure the related expenditure on mental health services has fallen to 5.3% of all health expenditure far short of the figure of 8.4% envisaged in AVFC. The IMG is of the view that full implementation of AVFC will require additional revenue and capital allocations.

3. HSE reconfiguration and organisational structures

In 2004, the Health Act created the HSE following-on from the dissolution of the Regional Health Boards. The first five years of the HSE was dominated by transformation and reconfiguration programmes. During this time there were constantly changing management structures, models of service delivery, redrawing of service boundaries and cathment areas across the entire HSE structure. In the early years, there was little clarity on the nature of these structural changes. In 2006, AVFC was launched by the Government and adopted fully by the HSE Board as policy for the provision of mental health care services into the future. The IMG is of the view that despite this commitment by Government and the HSE, the dominance of the transformation and reconfiguration programmes made it extremely difficult to implement AVFC. From the evidence available to IMG, it is clear that little or no significant progress was made on the implementation of AVFC in the early years.

AVFC envisaged that the leadership for its implementation would come from the creation of a National Mental Health Service Directorate which would be of central importance in the modernisation of our mental health services. Full details of the responsibilities and structure of the Directorate are detailed in Chapter 16 of AVFC. Year on year, many submissions and all previous IMG Reports have called for the creation of this National Directorate which should be fully staffed, have authority to shape services in line with AVFC and have control over existing resources and any new resources made available to mental health services. The absence of a Directorate significantly reduces accountability for the delivery of AVFC.

Despite the preponderance of calls for such a Directorate, the HSE has not responded. Instead, it has put in place the Office of Assistant National Director for Mental Health which is focussed on the strategic development of mental heath care services and which carries additional responsibilities beyond AVFC. The IMG is of the view that this Office is under resourced and does not have the authority to lead the implementation of AVFC. The absence of a full implementation plan makes it difficult to assess the value of the current Office of the Assistant National Director Mental Health.

Presently the authority and control of resource allocation in mental health services rests with the four RDOs, who report directly to the National Director of the Integrated Services Directorate. Over the last few years the posts of ECDs have been created within the HSE system. The rational for the creation of ECDs in mental health has been to support a more appropriate clinical management structure for the delivery of AVFC. In the context of implementation, however, it is unclear what precisely are the role and responsibilities of ECDs in mental health services and what is the scope and limitations of their authority.

The IMG is aware of recent Ministerial announcements in relation to the preparation of the Heads of a Bill for the appointment of Directors of Programmes to replace the present HSE Board. There is no detail available to the IMG or publicly about how such structures will operate. The IMG is concerned to make the distinction between an overall "Director" of Mental

Health Services and a Directorate to support the implementation of AVFC. The Director of Mental Health Services and AVFC Directorate are not synonymous.

4. Implementation Plan

Despite consistent recommendations from the IMG and from many other stakeholder organisations there has been a failure to produce annualised or indeed multi-annual implementation plans which are objective-based, costed and time-lined. The absence of such an implementation plan is seen by the IMG as a significant barrier to the full implementation of AVFC. In 2010, the MHC produced an analysis of policy implementation entitled *Vision into Action* and the IMG is still of the view that the advice described in this analysis should be utilised by the HSE.

5. Cultural Change

It is widely acknowledged that organisational change requires not only structural and process change but also cultural change. Organisational culture is a term often used to describe the processes in an organisation that are not easily identified or visible. These processes include personal attitude, personal interests, dislikes, unwritten policies and agreements, philosophical biases, historical precedent and practices.

It is imperative that these cultural issues are addressed in any policy implementation process.

AVFC clearly sets out the principles which underlie a modern mental health service. It is essential that organisational culture matches these principles. Changes in culture can be evidenced by changes in how services are delivered, professional work practices, care management practices, communication styles and perception of services.

6. Development of Specialist Services

A consistent finding from IMG Reports and the theme consistently repeated in submissions to the IMG is the lack of progress in developing specialist mental health care services. There has been a worrying absence of development of appropriate mental health care services as envisaged in AVFC in the areas of intellectual disability, old age, eating disorders, borderline personality disorders, rehabilitation and recovery, co-morbid severe mental illness and substance abuse problems.

The IMG acknowledges the progress made in the development of additional residential places for children and adolescents and the commitment of the HSE to reduce and eliminate the inappropriate admission of children and adolescents to adult units. In addition, the IMG notes that staffing of the 56 existing teams is only at 63.8% of the recommended level, a decrease on the 70% level reported in the 2009 – 2010 Annual Report on CAMHS.

The IMG welcomes the production of the comprehensive Annual Reports for CAMHS, first published in 2009, and recommends that a similar report should be produced by other mental health services.

In respect of forensic mental health services, the IMG acknowledges the long awaited policy decisions and planning for the development of a new forensic mental health care service to replace the existing CMH at Dundrum. Despite the protracted delay arising out of disagreements about location, the IMG welcomes the plan to build a facility at Portrane, which will accommodate adult forensic mental health services, children's forensic mental health services and forensic services for people with intellectual disability and in addition, the provision of four regional intensive care rehabilitation units.

Additionally, the IMG notes the proactive development of prison in-reach teams and court diversion services for prisoners on remand. Such services need to be expanded to cover all prison locations.

The IMG congratulates the Irish Prison Service and the HSE's Forensic Mental Health Service on winning the World Health Organisation's "*Health in Prison – Best Practice* Award for the High Support Unit in Mountjoy Prison.

A major development in 2011 was the coming into operation of the Criminal Law Insanity Act 2010 which amended the 2006 Act. The new Act gave the Review Board the authority to make orders for the discharge of patients subject to such conditions as the Board considers appropriate, including conditions relating to outpatient treatment or supervision or both. In 2011, the Board approved the conditional discharge of seven patients from the CMH.

The IMG has grave concerns that the National Mental Health Programme Plan, which has as a core principal the "Specialist within Generalist" framework, will further delay and perhaps stagnate the development of comprehensive specialist CMHTs. This matter is dealt with more fully in Chapter 7.

7. Closure of Old Hospitals

The IMG acknowledges and welcomes the continuing process of closure of outdated and not fit for purpose institutions. The IMG notes that the closures have been a combination of policy initiatives by the HSE and the imposition of conditions on registration by the MHC, following inspections. AVFC proposed that outdated and inappropriate services should be closed and that people would be re-accommodated in more appropriate based services. The IMG strongly encourages the continued closure of inappropriate care settings.

AVFC proposes that outdated and inappropriate facilitates should not be closed before people are re-accommodated in more appropriate services. There has been a planned transfer based on clinical assessment into community nursing units and private nursing homes. In some instances there is planning and development of new 50-bed units. While understanding the need for such developments, the IMG is concerned that these new community based units, may, because of size, develop as miniature institutions within the community. The IMG recommends that the HSE ensure that there are models of personalised care in place which will reduce the risk of institutionalisation.

8. Relationship with Independent Mental Health Service Providers

In previous reports, the IMG stated the need for a proactive relationship to be developed between the statutory and independent health service providers. From submissions received to date, the IMG is not aware of any significant progress in this area.

Given the volume of activity of the independent providers, the IMG recommends as a matter of urgency that formal relationships are established which might include, for example, memoranda of understanding or contracts for shared service provision, in other words, that there is clear evidence of service planning and cooperation.

9. Relationship with the voluntary sector

The IMG is aware of the long history of the voluntary sector in Irish mental health services. The IMG wishes to acknowledge the valuable work being done by the voluntary sector and recommends the proactive partnership already formed should be developed further to enhance full implementation of AVFC.

The policies, services, and practices agreed with the HSE and delivered by the voluntary organisations should be aligned fully to AVFC.

In this respect, the IMG acknowledges the importance given to the voluntary sector in the recently published AVFC Guidance documents.

10. Manpower, Education and Training

AVFC makes twenty eight recommendations as regards Manpower, Education and Training. It is disappointing to observe that little progress seems to have occurred. Though it is obvious that the economic situation and resource issues will impact on these three areas, little effort seems to have been made to introduce a governance and implementation structure that would make maximum use of the resources available. Once again the IMG must point to the key role the National Mental Health Service Directorate as envisaged in AVFC would play in the planning of manpower, education and training. Both the centralisation of planning and funding of education and training and the development of a multi-profession manpower plan are not beyond the scope of the stakeholders despite the very straitened economic circumstances the country is in.

Many of the discussions in relation to education and training that took place during IMG meetings this year unfortunately gravitated towards a traditional model both of the method of education and of the roles of the various professionals. It seems as if little opportunity for multidisciplinary training is sought out. The training of doctors seems to continue mainly in the mode of brief encounters either at outpatient clinics or in hospitals. This would seem to be less than satisfactory for service users and for trainees. As referred to in other chapters in this Report several key issues need to be addressed which include: the need to ingrain the philosophy and practice of Recovery in the education of all clinicians involved in delivering mental health care; the need to ensure all mental health professionals are trained in the biological,

psychological and social factors and in multidisciplinary work; the need to ensure that all training involves service users and carers; and the need to ensure that all health professionals have a sound knowledge of the appropriate use and possible side-effects of medications used in treating mental illness.

Currently, certain professionals have funding delegated to them in their contracts for personal training and development (i.e. Doctors) while other professionals are reliant on their employers or their own resources to take part in such activities. AVFC recommended that *"A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services"*. The move to a community based service brings ongoing training requirements for staff. Especially in a time of limited resources the best use must be made of available funding to ensure a practical impact on outcomes for service users. The establishment of a properly functioning centralised Education and Training (E&T) Authority as part of the National Mental Health Service Directorate working with the relevant professional bodies could ensure that this is the outcome. A strong case can be made that such an approach would maximise value and ensure that the aspiration of AVFC that *"E&T should be directed towards improving services as a primary goal and must have the welfare of service users as its ultimate objective"*.

The ongoing support for the training of Clinical Psychologists by the HSE is vital and the call in AVFC for expansion of these programmes is still relevant. In view of the fact that the majority of first contacts by service users are with primary care the IMG welcomes efforts by the ICGP to include mental health in its training themes and recommends that this be a core of specialist training and continuing professional development programmes. The IMG welcomes the development by the ICGP and the CPI of training in mental health issues for GPs and acknowledges the work done by the CPI in developing a new curriculum and training programme for psychiatrists. The IMG also welcomes the continued delivery and expansion of advocacy training across the country. Training for service users is essential to ensure that those who wish to actively engage with the services can represent themselves and others. There remains a need for formalised training for volunteers nationally and taking into account the valuable contribution of voluntary groups, co-ordination of their training should be a priority. The IMG emphasises the continuing need for training in care planning for all mental health service staff, including management.

Several issues recurred in the submissions and discussions on manpower. The primary ones were the HSE embargo and the Government moratorium. These along with the shortage of Non-Consultant Hospital Doctors (NCHDs) and the planned early retirement scheme coming into play in early 2012 were forecast to have negative effects on a wide range of services. It seems as if much was happening in a piecemeal way and, once again, the need for a National Manpower Plan and a body to co-ordinate it would seem even more important in these times. The IMG were told on several occasions that it was open to the HSE to apply to Government for exceptions from the moratorium in specified cases. The IMG received little evidence that this was happening in a productive way.

As regards recruitment of NCHDs, the IMG would see current problems as an opportunity to change the way mental health services are delivered and the way training is delivered to NCHDs. While it is becoming very difficult to fill the NCHD posts in Psychiatry nationally, the current number of these posts is beyond that required in AVFC. This taken with the evidence that service users desire to have more continuity in their care and not be subject to the lack of continuity brought about by the rotational nature of NCHDs work placements should cause pause for thought on the continuation of a model of service delivery where the NCHD has the pivotal role. An appropriately structured community mental health service must make use of a variety of professionals in a variety of roles. Examples of options include the development of the roles of Advanced Nurse Practitioners and Clinical Nurse Specialists in order to improve continuity of care and access to clinical decision making.

The IMG proposes that urgent attention be given to reviewing the training, registration and roles of various mental health professionals in line with international models. The IMG believes that the call in AVFC that *"Future manpower requirements must be driven by service requirements rather than historical factors and should not be wedded to the perceived needs of any single discipline"* is more relevant than ever. A co-ordinated approach to manpower planning is an urgent requirement and should be led by a properly functioning Mental Health Service Directorate.

To ensure quality of psychological interventions, it is important that the Government pursues the statutory regulation of psychotherapy and counselling. The IMG notes that the Government is presently legislating for the statutory regulation of professions designated in the Health and Social Care Professionals Act 2005 which does not include psychotherapy and counselling.

Notwithstanding the above, the Government could look at innovative ways of engaging accredited therapists presently working in the community to support the development of multiple interventions in mental health care services.

11. Quality Mental Health Services

The principles and values which should underpin mental health services in Ireland are outlined in the first recommendation of AVFC. One of the key principles identified is the quality principle which states that mental health services and the treatment and care offered in them should be of the highest standard. The Mental Health Commission is the statutory body tasked with setting and monitoring standards in mental health care. The Commission has established a range of regulations and standards and assesses adherence to these standards through its annual inspection process. The IMG is concerned that none of the submissions from the HSE mental health services discusses compliance ratings with the Commission's standards and regulations. The MHC's Annual Report identifies that, in 2011, only three centres run by an independent service provider were fully compliant with the standards and regulations. The IMG recommends that the HSE develop an action plan to ensure all existing mental health services become fully compliant with the current regulations and standards.

12. Developments in research and information

In Chapter 6, the IMG acknowledges the changes in the relationship between the CPI and the Pharmaceutical industry in respect of research.

AVFC envisaged that mental health research would be funded independently of vested interests. The IMG encourages such research by the CPI, HRB, MHC, and relevant third level institutions.

In respect of information and data collection, the IMG encourages the development of comprehensive systems which allow for the measurement of inputs, processes, and outcomes of service delivery leading to a more systematic evaluation of mental health services. Research and information gathering should focus on both quantitative and qualitative data capturing the subjective experiences and narratives of service users, carers and families.

The involvement of service user researchers is an essential component of an inclusive recovery-oriented research strategy. Investment will be required to ensure that competencies and capacity are developed to support this ambition.

Chapter 10

Consultation process – comparisons between 2004 and 2012 process

In 2004, the Expert Group on Mental Health Policy hosted two one day seminars (Limerick and Dublin). A range of issues were discussed under the broad headings of medication and community based services. The feedback from these seminars was included in a report *What We Heard* along with other data collected by survey and submissions received. A copy of this report is available **http://www.dohc.ie/publications/**

Given that this is the final report of the IMG as presently constituted, the IMG repeated the one day seminars in Dublin and Limerick as an exercise in comparing attitudes in 2012. The seminars were primarily attended by service users and their family members. The 2012 seminar were replicas of 2004 in terms of workshop topics. The results of both 2012 events are attached at Appendix 6.

The main themes that emerged are as follows:

- Many people reported receiving a service that is still largely medicalised with little or no access to psychologists or social workers.
- There was a sense that while there was lots of talk about AVFC there was little change in the actual service delivered.
- There is a perception that services are inconsistent across the country such that the type of service received was often determined by where you lived.
- Many people complained that there was a poor response to mental ill health until the situation escalated into a crisis.
- There is a paucity of either crisis interventions or respite care.
- There is little evidence that the patient is central to services.
- There is very poor involvement of family members in the care process.
- There is a perception that day and community services were being reduced in favour of residential services.

Chapter 11

Implementation and Monitoring

The appointment of the Independent Monitoring Group was one of the first recommendations of AVFC to be implemented in 2006 and details on the membership of the 1st and 2nd Monitoring Group are listed in Chapter 1. The term of the appointment was for three years. The appointment and work of the IMG is outlined in AVFC and states as follows:

*"It is recommended that an **independent monitoring group** be appointed by the Minister of Health and Children to oversee the implementation of this mental health policy. While other bodies are involved in the operation, management and inspection of mental health services, the sole function of this group will be to oversee the implementation of this mental health policy. This will help ensure a continuous focus on the implementation process. The Monitoring Group should have also a role in the annual assessment of the plans to close psychiatric hospitals.*
This Monitoring Group should have an independent chairperson and 4–5 members, some of whom should be members of the Expert Group. The inclusion of members of the Expert Group will ensure continuity and clarity in this process. This Monitoring Group should be required to meet at least bi-annually and produce annual reports for the Minister for Health and Children, and these reports should be published. The implementation should be reviewed formally after seven years in the light of what has been implemented and the changing needs and priorities for service provision, and a final report issued. It is important that the Monitoring Group should engage with and listen to the stakeholder groups and support them throughout the change process. This independent Monitoring Group should be established as soon as this policy has been adopted by government.

Recommendation 20.5: An independent monitoring group should be appointed by the Minister of Health and Children to oversee the implementation of this mental health policy".

As can be seen, AVFC suggests that implementation of AVFC should be reviewed formally after seven years (2013) in the light of what has been implemented and other changing needs and priorities for service provision and a final report issued. AVFC is silent on what body should conduct this review and write the final report.

The following options are presented:-

1. The mandate of the present IMG should be extended to 2013 to allow it to conduct a comprehensive seven-year review.
2. Authority be given to the MHC to conduct the seven year review in 2013 and to conduct yearly monitoring for the following three years.

To enhance the work of the National Mental Health Service Directorate, a Special Delivery Unit for mental health should be established within the Department of Health.

Regardless of the mechanism for monitoring it is clear given the inconsistent and slow pace of implementation to date that formal external monitoring of implementation of AVFC is essential.

The IMG is aware of the current review of the Mental Health Act 2001 and is conscious of the terms of reference used in the consultation process as follows: "…the extent to which the recommendations of 'A *Vision for Change*' could or should be underpinned by legislation…". The IMG is of the view that the implementation of AVFC could be strengthened by the provision of legislation which obliges Government and health service providers to plan, develop and deliver mental health care services in accordance with the policy of AVFC.

Chapter 12

Recommendations

In light of the above, the IMG makes the following recommendations:

12.1 Recommendations – Health Service Executive

- A National Mental Health Service Directorate as envisaged by AVFC must be established.
- Staffing of CMHTs should be continued as described in AVFC.
- A comprehensive, time-lined and costed Implementation Plan should be developed.
- Cultural issues such as personal attitude, professional policies and attitudes, philosophical biases, historical precedent and practice, should be addressed in any policy implementation process.
- Team working and shared planning should involve the service user and where appropriate family members.
- There should be a consistent national approach to the development and support of service users and family members.
- All mental health care services should be based on the fundamental principles and practices of recovery.
- In order to develop recovery oriented mental health services, all future activities should incorporate robust and independent evaluation.
- There is a need to ingrain the philosophy and practice of Recovery in the education of all clinicians involved in delivering mental health care.
- There us a need to ensure all mental health professionals are trained in the biological, psychological and social factors as well as in multidisciplinary work.
- There is a continuing need for training in care planning for all staff working in the area of mental health services.
- There is a need to ensure that all training involves service users and carers.
- There is a need to ensure that all health professionals have a sound knowledge of the appropriate use and possible side-effects of medications used in treating mental illness.
- The development of specialist mental health services in Psychiatry of Old Age, Intellectual Disability, Liaison Psychiatry, Eating Disorder, Co-morbid Substance Abuse and Mental Illness, Neuropsychiatry, Borderline Personality Disorder should be prioritised as a matter of urgency.

- Comprehensive annual reports for all mental health specialties should be developed on the lines of the CAMHS annual report.
- Rehabilitation and recovery mental health teams, as envisaged in AVFC, should be resourced and additional teams developed.
- The ICGP, CPI and health service providers should work to develop collaborative working relationships between primary care and mental health care services.
- A comprehensive social inclusion strategy with implementation timelines should be developed for those with mental health problems, as a priority
- Prison In-Reach teams and court diversion services for prisoners on remand should be developed nationally.
- The IMG strongly encourages the continued closure of inappropriate care settings.
- Models of personalised care should be developed in the new community based units which will reduce the risk of institutionalisation.
- A formal working relationship should be established with the independent mental health service providers.
- The proactive partnership between the HSE and the voluntary sector should be developed further to achieve full implementation of AVFC.
- The policies, services and practices agreed with the HSE and delivered by the voluntary sector should be aligned fully to AVFC.
- An action plan should be developed by the HSE to ensure that all existing mental health services become fully compliant with the current standards and regulations.

12.2 Recommendations - Government Departments

- Government Departments, other than the Department of Health and Department of Environment, Community and Local Government need to focus on their responsibilities for the implementation of AVFC.
- To ensure quality of psychological interventions, it is important that the Government pursues the statutory regulation of psychotherapy and counselling.
- An advocacy service which specifically responds to the needs of children and adolescents should be established by the Department of Social Protection in consultation with the Department of Children and Youth Affairs.
- Prison In-Reach teams and court diversion services for prisoners on remand should be developed nationally.

12.3 Addressing the biological, psychological and social factors that contribute to mental health problems

- The work of the National Mental Health Services Collaborative on Care Planning should be continued and extended by the Partners to ensure the concept of care planning is embedded in all mental health services.
- Equal priority should be given to filling vacant allied health professional posts on multidisciplinary teams.
- The Department of Health with support from all relevant stakeholders including service users, carers, CPI, ICGP and Pharmaceutical Society of Ireland should develop a robust strategy to monitor, audit and report on the use and side-effects of drugs used in mental health treatment on a regional and national basis.
- The relationship between the medical profession (and to a certain extent the mental health nursing profession) and the pharmaceutical industry should be carefully monitored to ensure that undue influence does not arise.
- Future research in mental health services should be funded through non-pharmaceutical sources.
- Training of GPs, psychiatrists and, indeed, all multidisciplinary members should be funded from non-pharmaceutical sources and training of all clinicians involved in the delivery of mental health services be along biopsychosocial lines with particular emphasis on multidisciplinary working, service user involvement and the concept of recovery.

12.4 Recommendations – National Mental Health Programme (Clinical Programmes)

- The Principle of "Specialist within Generalist" Framework should be revised to ensure the development of separate specialist teams.
- The necessary staff resources and training should be made available to implement the National Mental Health Programme.
- The IMG would like to see a greater emphasis on Recovery as a core concept informing the Clinical Programme as it evolves and is rolled out.
- The National Clinical Lead and the GP Co-Lead should be full time posts.
- The Programme Plan should be further developed to ensure that it is fully consistent with AVFC.

12.5 Recommendations – Recovery

- A Mental Health Service Directorate should be established with responsibility for the development and effective implementation of a plan to transform the mental health services in accordance with AVFC.
- The Directorate should prioritise the development of recovery-oriented practice in mental health services and should engage with all the stakeholder groups to agree a national co-ordinated strategy and implementation plan to achieve this objective.
- The strategy to achieve service and system level transformation must focus on the introduction of recovery-oriented practice in the key areas of service design and delivery, governance, training and evaluation.
- 'Recovery-proofing' the Human Resource practice within our mental health services is an essential component of transformation. The protocol for the recruitment of staff must clearly signal a commitment to recovery practice in the design of job descriptions and the inclusion of trained service users on the interview boards for staff recruitment.
- Monitoring of the implementation of AVFC must incorporate on-site assessment of reported activities to quality assure claims of recovery-oriented practice and provide a measure of accountability for both funders and service users.
- Evidence-based/informed practice and values-based practice must become the bedrock of a transformed service model focussed on the implementation of recovery-oriented practice in mental health services.
- Service users and their families must be afforded the opportunity to avail of evidence-based/informed recovery-oriented programmes if they wish to use these tools to support their own recovery.
- Independent evaluation of programmes must be conducted by qualified personnel/bodies to support the development of a national evidence-base for recovery-oriented programmes and services in an Irish context.
- Care planning must develop into a system that can support service users unique needs, goals and recovery journey.
- Standardised outcome measures must be introduced to capture recovery as an outcome goal for services with consideration given to the introduction of recovery-oriented key performance indicators for services. The measures introduced must reflect a holistic perspective extending beyond symptom management to evaluating progress in respect of housing, employment, education and citizenship.
- Standardised tools to support the assessment of recovery outcomes and facilitate recovery planning with the service user must be integrated into the Clinical Care Pathways and the care planning process.
- Recovery champions need to be encouraged, incentivised and empowered to drive change at national level and ensure they have the authority to achieve what is expected of them.

- Marketing the positive achievements of services, their staff, the service user and the broader community in adopting recovery practice is a priority.
- At national level, there is a need to formally recognise that the change to recovery practice is dependent on shifting beliefs, attitudes and behaviours. A range of measure will be required to support this evolving paradigm. Capacity-raising measures need to be a focal point in the recommended implementation plan for the new AVFC Mental Health Directorate. This should be supported by creating a dialogue internally within systems to enable a transformation process
- The area of training needs to be developed strategically and incorporated into the Implementation Plan of the AVFC Mental Health Directorate. Whilst recognising the need for broad competency-based training in many areas, training in the principles and practice of recovery needs to be incorporated into all in-house training in the HSE and in the professional training for students and professionals in the medical and allied health professional training courses run by professional bodies and universities including continuing professional development programmes.
- With appropriate training available, we recommend the introduction of the post of peer support worker within the HSE to ensure the expertise that people with self-experience is valued and not presume that this expertise will always be "volunteered". Where opportunities arise to recruit new staff, the HSE should consider adopting practice from other jurisdictions where groups of employees have been explicitly recruited for their personal qualities rather than professional qualifications, which includes valuing their personal experience of mental health problems and services.
- The good practice and learning to date needs to generalise within the mental health services. Systems and processes to cascade the learning through the HSE must be established by the new AVFC Mental Health Directorate to ensure we standardise practice nationally.
- The publication of Guidance Papers by the HSE should continue as a practical support to local communities seeking to implement AVFC. These documents should seek to address the reported conceptual uncertainty and inconsistency regarding the meaning of recovery as it applies to practice in terms of delivering mental health services.
- Opportunities to embed recovery principles in the current review of the Mental Health Act 2001, Criminal Law (Insanity) Act 2006 and future capacity legislation need to be fully explored.

12.6 Recommendations – Monitoring of Implementation

The following options should be considered:

- The mandate of the present IMG should be extended to end of 2013 to allow it to conduct a comprehensive seven-year review.

- Authority be given to the MHC to conduct the seven year review in 2013 and to conduct yearly monitoring for the following three years.
- To enhance the work of the National Mental Health Service Directorate, a Special Delivery Unit for mental health should be established within the Department of Health.
- The implementation of AVFC should be strengthened by the provision of legislation which obliges Government and health service providers to plan, develop and deliver mental health care services in accordance with the policy of AVFC.

Appendix 1

List of submissions received from Agencies/Voluntary Groups

1. Amnesty International Ireland
2. Association of Occupational Therapists
3. Children's Mental Health Coalition
4. Disability Federation of Ireland
5. Headstrong - The National Centre for Youth Mental Health
6. Health Research Board
7. Irish Advocacy Network
8. Irish Association of Social Workers
9. Irish College of General Practitioners
10. Mental Health Commission
11. Mental Health Reform
12. National Disability Authority
13. National Federation of Voluntary Bodies
14. National Service Users Executive
15. The Pharmaceutical Society of Ireland
16. The College of Psychiatry of Ireland

Appendix 2

GENIO FUNDED MENTAL HEALTH PROJECTS (as at July 2011)

Organisation	Project Title	Grant Allocated in 2011
HSE Area Dublin North City	The Doras Project: Transitioning from institutional hostel care to independent living	€100,000
HSE Dublin West South West Mental Health Services	Making "A Home"	€100,000
HSE Limerick Mental Health Services	Moving On Project	€30,000
HSE Wicklow	RESTART	€129,320
HSE, Clare Mental Health Services, Rehabilitation and Recovery Services.	Independent Living – My Recovery	€49,000
HSE, Laois/Offaly Mental Health Rehabilitation Recovery Service	Community Living Project	€62,572
HSE Mayo Recovery Consortium	Peer Support to Promote Recovery (Pros- Per): Community Inclusion	€195,600
South Lee Social Inclusion Group	Glenmalure Social Inclusion Project	€28,000
HSE West Cork Mental Health Services	Family Support West Cork	€54,500
HSE, Balbriggan Community Mental Health service	Home Respite for individual	€26,100
HSE, North Dublin Mental Health Service	North Dublin Adult Mental Health Support & Respite project	€30,211
HSE St. Lukes Hospital Clonmel	Home Based respite Service for Psychiatry of Later Life (POLL) Service Users provided by Carer Peer Support Worker (CPSW)	€35,000
North Tipperary Mental Health Service in partnership with Aras Follain	Peer Support Community Respite (RnR Project)	€75,000
Total Mental Health Innovation Grants in 2011		€915,303

Appendix 3

NATIONAL PRIORITY LISTING OF MAJOR MENTAL HEALTH CAPITAL PROJECTS (at November 2011)

Project	Region / Location	Status	Rationale
New 120 Bed National Forensic Hospital	**National / DNE** *(relocating from DML)*	Announced Nov 2011	National Policy & MHC Concerns
10 bed Forensic CAMHS	**National / DNE**	Announced Nov 2011	National Policy & MHC Concerns
10 bed Forensic ID	**National / DNE**	Announced Nov 2011	National Policy & MHC Concerns
30 Bed ICRU	**DNE** – Location TBC	Announced Nov 2011	National Policy & MHC Concerns
30 Bed ICRU	**South** – Location TBC	Announced Nov 2011	National Policy & MHC Concerns
30 Bed ICRU	**West** – Location TBC	Announced Nov 2011	National Policy & MHC Concerns
High Observation Refurb	**South** Kerry (*Tralee*)	Listed	Closure Order pending
High Dependency Unit	**South** Replace St Finan's	Listed	Closure Order pending
Acute Unit Drogheda	**DNE** Drogheda	Announced Mar 2010	Facilitate Closure
20 Bed CMAHS	**DML** Cherry Orchard	Listed	National Policy Requirement
Acute Unit Sligo	**West** Sligo	Listed	Replace inadequate, dated facility
Acute Unit Mater	**DNE** Mater Hospital	Listed	Replace inadequate, dated facility
20 bed CAMHS	**National** Paediatric Hospital	Announced Nov 2011	National policy & required
Acute Unit Refurb	**West** Limerick Unit 5B	Announced Mar 2010	Required by Policy
Acute Unit Galway	**West** UCHG –	Funded under Cancer Control	Replace inadequate, dated facility
Acute Unit Cork	**South** UNHC	Funded under Cancer Control	Replace inadequate, dated facility

Shaded Projects relate to the Government announcements of Nov 2011

Appendix 4

Other significant Mental Health projects currently in train (at November 2011)

Project	Region / Location	Status	Rational
Acute Unit	**DNE** Beaumont Hospital	Sod Turned Nov 21 2011	Replace inadequate, dated facility
Low Secure Unit	**DNE** St Brendan's Hospital	Under construction	Replace inadequate, dated facility
Interim Works	**DNE** St Ita's Campus	listed	Facilitate closure
ACNU	**South** Wexford	Under construction	Facilitate closure
ACNU	**South** Clonmel	Under construction	Facilitate closure
ACNU	**DML** St Mary's Mullingar	Under construction	Facilitate closure
CMHC	**South** Clonmel	Under construction	Facilitate closure
CAMH Day Hospital	**DML** Cherry Orchard	Under construction	Required by Policy
Low Secure	**DML** Mullingar	Under construction	Facilitate closure
CAMHS Inpatient	**DNE** St Vincent's Fairview	Under construction	Required by Policy & MHC
CMHC + Primary Care	**DML** Ballyfermot	Under construction	Required by Policy
Residential	**DML** Ballyfermot	Under construction	Required by Policy
Residential	**DML** St Loman's Rd	Under construction	Required by Policy
Day Hospital	**South** Dungarvan	Under construction	Required by Policy
Acute Unit Refurb.	**South** Waterford	Planned for 2012	Required by Policy
Day Centre	**South** Waterford	Planned for 2012	Required by Policy
ID Residential	**South** Wexford	Planned for 2012	Required by Policy
Crisis House	**South** Clonmel	Planned for 2012	Required by Policy
Day Centre	**West** Clare	Planned for 2012	Required by Policy
CMHC	**West** Ballinasloe	Planned for 2012	Required by Policy
Day Hospital	**West** Galway	Planned for 2012	Required by Policy
Residential	**DML** Governor Rd	Planned for 2101	Required by Policy

Appendix 5

Closure and replacement of the traditional Psychiatric Hospitals - at Dec 2011

Hospital	County	Built	Replaced by
St Brendan's	Dublin	1814	Acute Units at Connolly Hospital + new 54 bed Unit under construction at Grangegorman (*due 2013*).
St Ita's	Dublin	1902	Acute Admissions to interim unit at St Vincent's Fairview, 44 Acute Unit at Beaumont under construction (2013). Knockamann Units opened in 2010 for Service Users with an Intellectual Disability (St Joseph's ID Service)
St Loman's*	Dublin	1950	Acute units at AMiNCH, Tallaght opened in 1998. Last patients left St Loman's campus in 2011.
CMH Dundrum	Dublin	1850	Funding approved for a new 120 bed facility at Portrane. Plus 10 beds for Forensic CAMHS & MHID & related ICRUs (project to complete 2016)
Newcastle*	Wicklow	1896	Admissions continue at Newcastle Hospital, Co Wicklow
St Dymphna's	Carlow	1832	Admissions to Acute Unit to Department of Psychiatry in St Luke's Acute Hospital in Kilkenny. Also 29 bed unit at Naas General Hospital
St Loman's	Westmeath	1855	2 Replacement Capital projects under construction. 22 Bed Acute facility and 50 bed Continuing care at Mullingar
St Finnian's	Laoise	1833	Acute Unit at Portlaoise General Hospital
St Canice's	Kilkenny	1852	Acute admissions to Department of Psychiatry at St Luke's, Kilkenny
St Luke's	Tipperary	1834	Continuing care & CMHC facilities under construction in Clonmel. Acute admissions to Department of Psychiatry at St Luke's, Kilkenny from March 2012

St Senan's	Wexford	1868	Acute admissions to Department of Psychiatry at Waterford Regional Hospital. Capital works providing alternate continuing care facilities.
St Otteran's	Waterford	1835	Acute admissions to Department of Psychiatry at Waterford Regional Hospital
Our Lady's	Cork	1852	Acute admissions to Cork University Hospital
St Finan's	Kerry	1852	Acute admissions at Kerry General Tralee. Replacement continuing care facilities commence construction in 2012
St Joseph's	Limerick	1827	Acute admissions to Unit 5B at Limerick Regional, redevelopment capital programme in train
Our Lady's	Clare	1868	Acute admissions to Acute Psychiatric Unit at Ennis General
St Brigids	Ballinasloe	1833	St Brendan's Continuing Care facility opened Dec 2010. New 50 bed Acute unit approved by UCH Galway
St Mary's	Castlebar	1866	Acute admissions to Acute Psychiatric Unit at Mayo General
St Patrick's	Roscommon	1940	Acute admissions to Acute Psychiatric Unit at Roscommon General
St Columba's	Sligo	1855	Acute unit at St Columba's, replacement unit in planning
St Conal's	Donegal	1866	New Acute unit at Letterkenny General opened in Autumn 2011
St Davnet's	Monaghan	1869	Admissions to Acute Unit at Cavan General
St Brigid's	Louth	1935	Admissions at Ardee and Navan General Hospital. New acute unit planned for Louth / Meath at Drogehda

Appendix 6

Independent Monitoring Group

Consultation meeting in Limerick on 16th April 2012

Summary of findings

Offering More than Medication

Lack of choice in HSE services.

No alternatives, e.g. counselling, psychology, Occupational Therapy (OT), breathing exercises, listening ear, relaxation techniques, CBT, massage, (counselling and psychology most often mentioned)

Lack of information on medication

No support for families, excluded by psychiatrists, not listened to, confidentiality used as a barrier. Lack of trust in psychiatrists, hard to change your psychiatrist, poor levels of engagement by psychiatrists, uncaring services, drugs only approach and medical model only. Lack of equality. Service user voice not listened to nor encouraged.

Current gaps in service provision, services disappearing, deteriorating rapidly. No information about, or promotion of, recovery. Recovery may not suit psychiatrists. Stigma and stress due to economic climate.

Some good work being done by voluntary groups, lack of employment initiatives, carer groups are available, but too many support groups - (e.g. 87 suicide support groups registered in Ireland vs. 2 in U.S.) Consumer panels need to link with CMHT.

"Medication will keep you from drowning, but it won't teach you how to swim"

Building a Community-based service

Two differing strands

There are signs of it. Inconsistent spread of community resources. Only achieved in parts of the country - it is not enough. Good foundations in Clonmel. Club Houses offer peer support. Turning point would be community based services, but need to increase CMHTs. Should be 24 hour. phone service. Attitudes need change, friendliness, openness, "smile in the street".

Mental health Directorate needed.

Tipperary being stripped of services, NSUE not enough clout; St. Michael's should stay open. Treatment stops at the hospital. No Occupational Therapists in the community. "No money, no choice". Very little public awareness of CMHTs, key workers etc. Physical health neglected in mental health services. No services in country areas, and no contacts. Hard to find help in the community. Activities are gone, no more lunches, downgrading of services Galway and Ennis. No follow-up after hospital, professionals won't travel. Beds being reduced but nothing put into community services, transfer from

hospital unsuitable because if no services available where you live means what type of care you get. Some have had no experience of community services.

Mental health care through primary care. More funding, early intervention, more youth services. Suicide increasing but help not available.

No initiatives on jobs, training, employment and recovery. Need more nursing attention to recovery.

"What about community mental health teams? - Never heard of them!"

What people would like to see.

Joining of community groups.

More psychological training.

Direct access to services. Where do you go in crisis?

More family involvement.

Same level of services across the board.

Final Comments from the floor:

What assurances do we have that another minister in power will not just scrap VFC and start another 10 year plan. Some service users are institutionalised from outside the institutions. Sign language interpreters should be available in services. WRAP training available, but who is supposed to use it, where does it fit in? Serious concerns about Clonmel and services going to Kilkenny (suggestion of political interference) Galway services going backward, physical barriers to access in the last three years, appalled at what is happening in Ennis, 20 suicides last 6 months, only 40 beds. Instead of going forwards we are going back. Sli Eile has to source counselling from the rape crisis centre. Bed based model continued but also support people in their own beds and homes. People with psychiatric difficulties aren't dangerous. A lot of societal problems are not down to mental health issues. Prisoners should be in private rooms. Stigma is huge, attitudes may not change.

What happens if VFC isn't implemented by the deadline? What happens next? Disconnect between minister and people around mental health issues. People in sheltered housing for the elderly have no evening care, need legislation over 600 homes. We need home carers and we need security. No legislation to enable HIQA to investigate homes for the elderly. Psychiatrists may not push recovery for their own benefit.

Response from the podium

VFC not a bad policy, it is the implementation that is bad. HSE due to close 153 more beds this year, must replace them with services in the community.

Attitudes have to switch everywhere. Resources needed, but just pumping money into systems won't work.

Suicide won't just go away, it needs to be addressed. Complement the HSE for avoiding political influence. They want policy implementation not political persuasion.

Need to grapple with the issue of translating recovery into practice, show them what it means.

Consultation Meeting in Dublin on Monday 30th April 2012

Notes from Workshops

Workshop 1 Medication

Question 1 What alternatives to medication have been offered to you through the mental health services

- ***Talking therapies?***
- ***Have you had contact with a social worker, an occupational therapist, a psychologist, or a community mental health nurse.***

- There are plenty of treatments which could be used in tandem or as an alternative to medication such as Psychotherapy, Counselling, Social Work and Group Support.
- Respect is very important to the patient receiving services and health professionals need to be mindful of their body language for example make eye contact when speaking to patients.
- There is a feeling that we are seeing many meetings and a lot of talk but that action on implementing change and recommendations is not visible.
- There is a need for the development of more services across certain parts of the country and that services should be uniform in their operation and have the interpretation of what recovery means.
- A greater provision of information is needed on what types of services are available and on the use of medication.
- Greater involvement of patients is required by health professionals in developing patient care plans.
- In some areas there is openness to new therapies this needs to be repeated across the entire country.
- Sometimes in crisis situations there is a lack of appropriate risk assessment and management of patient with self harm or suicidal ideation.
- We need to build a mental health care system that is rooted in the community that involves family and carers and move away from one to one treatment.

- Psychotherapy rarely, if ever offered
- Social workers ✓
- Community mental health nurse ✓
- Talking therapy – 2 year wait (to put people off?) "On hold to the Samaritans"
- High fees for CBT
- No last minute/urgent access to psychotherapy
- Day hospital – no psychologist there
- Have to shout loudly
- Key workers essential

- Grow – voluntary group, offering social outlet, tips/sayings that help
- Lack of occupational therapy – need more in community e.g. Day Centres, for workshops etc in order to keep occupied/meaningful activity/rewarding activity
- Art therapy would also provide same (above point)

- Counselling services – use of those external to HSE e.g. Genesis (private) – offering programmes e.g. bi-polar programme that increase awareness and knowledge of individuals diagnosis and triggers etc. (CBT based).
- Drama therapy – found useful but stopped provision
- Important that GPs have knowledge of local services and voluntary organisations so that more can be offered than medication. More choice.
- Medication is just dulling feelings not offering ways of coping/therapy which for some e.g . first time depressive episode could prevent further relapse and shorten duration of illness.
- Sense of threat if you don't use medication – i.e. condition will get much worse – admission to inpatient unit, ECT. Therefore feel there is no option.
- Befriender social service – voluntary group – wonderful social outlet, referred through Day Hospital, more of this needed.
- No one in the group ever had access to a psychologist or CBT therapist.
- Central Mental Hospital WRAP group – holistic approach seen as excellent.
- Isolation loneliness is very common, more groups needed for social support, activation, structure.
- Inpatient unit offered relaxation therapy/walking instead of tranquillisers made a huge difference to quality of care and experience in the unit
- Other clients chatting together etc.

- Occupational therapy
- New Horizons course
- Women's clubs social & community
- Roslyn Park College
- No contact with social work
- Integrated groups
- Day Hospital services
- More in Dublin

- Have been offered
    - Exercise
    - Art
    - Bingo and other activities
    - Nursing home place
- Best thing was getting weaned off medication – no help from mental health services for this – and home help was key
- Empowerment is missing but I took it for myself
- In 2003 – son told me he needed medication for life – left services and is now medication free, family helped and GP
- On no medication but at a rehab centre – non HSE and that gives me support, found out about it from Advocacy Officer in Eve
- Changing due to consumer panel no consultant reaching out to community services
- Funding for Development Worker was important, funding for groups important
- Yes have had help from Social Worker sorting out benefits.
- Bad experience with social worker.
- Psychologist – one person had therapy and it was helpful but limited to 6 weeks.

- No psychologist Cherry Orchard
    - Nurse trained as cognitive therapist
- Carlow – service being cut – had a very good service and now seeing it cut back
    - Waiting list for psychology
    - Social worker – left – not replaced
    - Rehab team closed
    - Steer training linking with HSE
    - Day Hospital was 8.30 – 8.00, now to 5pm
    - Trying to access local community service - They are also under stress
    - Hard to access psychiatrist
    - 8 bed unit – nurse withdrawn
    - If peer support is there keeps people well.
    - Beds reducing, community services being cut back
- NE Dublin
    - Change psychiatrist every 6 months an issue – including Rehab Team
    - Clinic improved, better system for appointments
    - Unless you ask, alternatives are not offered
    - Nurses are aware
    - Psychiatrist suspicious of people asking for psychologist – expect should be in primary care only
    - Access to multidisciplinary team limited
- AVFC – what future – time of implementation a problem
- AVFC - ok for largely populated area – not for rural areas.
- Mileage/travel effecting home visits

Question 2 – What supports have you had outside the mental health services for your mental health?

- There are many voluntary and community groups that not only provide mental health support but also organisation like MABS or addiction services that should be utilised in support of patients.
- Service need to be sensitive to the needs and culture of minority group for example the Traveller Community.
- We need to develop Regional Network System that is aware of the organisation within their community and promote referrals across those organisations.
- We need to challenge current barriers to such community cooperation such as resource issues and protection of funding.
- There is a lack of knowledge of what services are available in communities and how to access such service.
- There is a challenge to developing home based supports in rural area with regard to the value for money aspect. A therapist could spend more time in travelling to appointments than a therapist in an urban area.
- There were reports of discrimination by a minority of health professional towards minority groups.
- GPs and A&E staff are key gatekeepers for access to mental health services and therefore need to be appropriately trained and ensure that they develop experience in the management of mental ill health cases.

- Patients' choice is important and affords the patient many rights. It can also act against the patient with regard to patients who do not follow their care plan or allow family to become involved to support them in their recovery.
- Models of early intervention must be supported for example, Jigsaw or the DETECT project.
- Mental Health Promotion should be delivered by specialists and not teachers in schools.
- A panel of experts should be available to the media to discuss mental health issues. This panel should be briefed on mental health issues and support in their work with the media so as to avoid the media sensationalising the issue.

- Private counselling
- Sought out own alternatives, crafts etc but small budget
- Aware
- No extra supports offered because family gives extra support?
- Gateway
- HSE Rehab guidance service.
- FAS vocational specialist training – on offer but low awareness.

Re: Medication

- Easy to get
- No communication about side effects/Cost of medication versus cost of talking therapy – labour intensive?

- Family best friend
- Counselling
- recovery
- Partners
- Family support
- Better services in Dublin
- Poorer services in country

- Aware/Grow, not informed through the mental health service, could use a list of services
- NLN psychosocial programme – a lot of people coming in don't know about community supports
- HOPS Centre – Westland Square, art, creative writing, drama, martial arts
- If computer classes had been cut, if not for this centre, I would have ended up in hospital
- Exercise S/b provided and recommended by psychiatrist
- Why can't mental health services get access to mainstream leisure and sports facilities like swimming pools, etc.

- Clubhouse access every day gives purpose
- NLN services helpful
- FAI helpful: skills training, sports, funding, tickets
- Northside Suicide Prevention (Dublin) , info on organisations/information days
- Near FM (Community Radio) gives good coverage to local clubhouse

- Finance – Dept of Social Protection asking people to appeal to landlord for reductions in rent – not liaising with mental health services, putting people under pressure
- People are making up the difference in rent and the landlord is saying its reduced.
- See Change positive
- €35 million positive
- Ballinasloe – GPs charging for blood tests
- Medication – people expect that psychiatrist will give medication
- Example, 3 family members/ for 20 years : No alternatives to medication/no psychology etc
- Recovery – meds part of the package, is meds the package?
- Fear of coming off meds
- Out of hours back up not there
- Rapid service only Monday, referral back to GP

Workshop 2 Building a Community Based Service

Question 1 – Your local mental health service should include access to a hospital in-patient service, a clinic, day services and home based support. To what extent has this been your experience?

- There is a lack of knowledge of what services are available in communities and how to access such service.
- There is a challenge to developing home based supports in rural areas with regard to the value for money aspect. A therapist could spend more time in travelling to appointments than a therapist in an urban area.
- There were reports of discrimination by a minority of health professional towards minority groups.
- Patients' choice is important and affords the patient many rights. It can also act against the patient with regard to patients who do not follow their care plan or allow family to become involved to support them in their recovery.
- Models of early intervention must be supported for example, Jigsaw or the DETECT project.
- Mental Health Promotion should be delivered by specialist and not teachers in schools.
- A panel of experts should be available to the media to discuss mental health issues. This panel should be briefed on mental health issues and support in their work with the media so as to avoid the media sensationalising the issue.

Inpatient

- Widely available through GP referral or A & E (8 hour wait)
- Traumatic experiences in A & E
- Disrespectful treatment, lack of access to clothes, phone, hospital facilities, forced medication

Clinic

- Can be poorly resourced – long wait, short time with doctor, inappropriate setting, disempowering, dehumanising

Day Services

- Generally available

Home Based

- None available. Most psychiatrist community nurses don't do outreach.

Private psychotherapy

- Paid for by self – should be a grant available.

Other Issues

- Mental health issues can happen to anyone
- Stigma of always having that label
- No clear information for service users on their rights, what's available
- Lack of clear communication
- Medication issues – the "easy option", no monitoring of side effects
- Vetting of counsellors
- Advertising standards in hospitals – drug company clocks, pens etc.

- Day centre (Phoenix (run by EVE not HSE) gone very medical, used to provide more activities/occupational work (3 people in the group attend the day centre)
  - Social trips
  - Social contact but more structure/activities needed.
- Problem with Day Centres – they are 9 – 5 Monday to Friday and are closed around holidays which are a very lonely time for service users. Increased access would be beneficial.
- Community services
- Very poor services in country as in Dublin
- After care for private than in public
- Sheagh House has daily service
- Daily services access to all services
- Hospital aftercare is needed as it would help to get better.

- Daughter has all of it but not in Dublin, nurse morning and evening but services are cut and cut and staff are paying for things out of their own pockets. If she had been in Dublin, she would be dead.
- Care given recently by nurses has been amazing
- Community based service is one size fits all – not personalised
- Day centre setting not attractive for younger service users
- More local autonomy for all involved in services
- Not good idea to have psychiatrists in charge.
- Attitudes need to change
- Communities can come together to fill gaps/address deficits
- Different components of service available for some, but by no means all.
- Extra supports for practical problems e.g. housing
- Theory of chemical imbalance not proven

- Carlow – did have clinics now cut back – example : due appointment – not seen, 2 appointments cancelled, relying on GP, consultant sick/on leave
- NE Dublin – don't know of home service

- Galway – has good range of services
- Carlow – Day Service – visit 2/3 times weekly – excellent nurses
- Galway – have day centres and access mainstream services
- Carlow – range of services in place – however very tight on staffing ; if any staff are missing will topple it.
- Out of Hours – Care doc only
- Reducing community service to staff hospital - closing Day Centres
- No choice of doctor - Lack of choice is a problem
- A & E not suitable to access service out of hours - stigma

Question 2
How connected is your GP to the Mental Health Service?

- GP's and A&E staff are key gatekeepers for access to mental health services and therefore need to be appropriately trained and ensure that they develop experience in the management of mental ill health cases.
- Not all trained in psychiatric option
- Younger GP sometimes more tuned in
- Very mixed experiences of GPs
- Hospitals sometimes don't liaise with GP

- Group felt that there was very little connection between their GP and their Mental Health Service.
- Many had been attending the same consultant psychiatrist for several years but do not see them unless they make a special request – registrar seen instead.
- Some continuity but can be frustrating if seen by different people as registrars change every 6 months.
- Home based support – e.g. community psychiatric nurses (CPN) – some experienced that if they need it, it is provided. Some expressed that the level of input from CPNs depends on the attitude of the consultant psychiatrist – some see the benefits more than others.
- CPNs great support outside of Community Group hours.
- Outside of work hours – where does support come from
    1. Family
    2. Ring hospital ask to speak with psychiatric nurse
    3. Samaritans used by some – <u>useful</u>
    4. Ring a friend
- Acute involuntary admittance
    - Some felt it was needed and appropriate
    - Others that such extreme treatment was not necessary – that sub-acute would he been more appropriate – right to go to Mass and buy the paper taken away.
    - Dignity and respect.
- GPs just do what they're told – not able to question psychiatrist
- GPs not able to address prescribing/over prescribing
- Some GPs who prescribe are not always accepted by mental health services
- Lack of communication – no shared care with GP
- GPs probably know the individuals better than the psychiatrist.
- Psychiatrists no time to look at physical health problems

- Mother had a physical condition for years, not picked up, attributed to mental illness until ended up in A & E
- I had a physical difficulty – very bad for years but ignored until ended up in hospital and only then got a doctor who gave proper assessment and treatment through non mental health services
- My daughter started using alcohol and every time she was in detox. I asked the psychiatrist to look behind it, but was always told it was only behaviour. Only when moved to different area, did doctor give a mental health diagnosis and care.

- Carlow – good, referral 3 to 4 month wait
- Depends on GP
- Support group – GPs don't understand mental health or tolerate it?
- Care Doc after 6 pm
- Galway – weekend service 9-5 from Day Hospital
- Aware and Grow-recovery, get out what you put in, supportive, insight into other people
- Clubhouse – brilliant, should be one in every part of Ireland (accredited USA)
- Peer support
- Need social side
- Carers committee in Carlow
- VIP need for an Out of Hours service
- Link NLN and Skillbase Carlow

Open Discussion – other issues

Contributions from the floor

:

Inpatient treatment, medication and alternatives:

- Training is needed for GPs. They often cannot think of anything other than medication, to treat someone who is having mental health difficulties. There should be a menu of options available to the service user, offering a range of treatments like talking therapies and massage treatment. GPs should not presume to know what a person needs. If the person cannot decide on the treatment they want, the GP should ask some clarifying questions.
- One person's experience: access to a psychologist is not routinely offered. This person was only offered access to a psychologist because they vehemently refused medication.
- The medical model has ruled for so long that people are not aware of other options.
- The mental health services are failing people, especially outside of Dublin. There is no ambition in terms of achieving AVFC.
- Comment that the HSE has a vested interest in the pharmaceutical industry.
- One person's experience: Given forced injections and medication in hospital. Not informed of any rights, for example the right to go to church, to buy a newspaper, etc. No respect for free will. Sleeping tablets given, even if not needed.

- Comment that the first workshop should have addressed how to come off medication, and that psychiatrists tend to simply renew prescriptions.
- Issue was raised of inpatient beds being cut in Waterford. Although in line with AVFC, this is dangerous if no provision is made for alternative care/treatments.
- Issue raised that the HSE has had to freeze recruitment due to budget cuts but that there seems to be no shortage of money for expensive drug treatments.
- One person's experience: Issue of private versus public treatment of bi-polar disorder – "If I had been in the public service, I wouldn't be here now."

Funding

- Over a 10-15 year period, the mental health budget has dropped from 12% to 5% of the overall health budget. This is disproportionately low compared to Northern Ireland, England, Scotland and Australia. No political will to implement AVFC.
- Comment: funding is not coming, there is no money. Need to look at different ways to work around the system, to get people involved in their community. A lot of people are walking around with lots of "nothings" in their lives – the challenge is to turn those "nothings" into "somethings".
- When funding was cut from the mental health budget in the past, it was diverted into other areas of the heath service. Now, it is a matter of taking that money back from the other parts of the health service and using it for mental health, where it was originally supposed to be spent.
- The HSE is able to fund private companies to provide mental health services. Why not divert this money into public services?
- Comment: If any other area of health lost such a large percentage of funding, it would be all over the newspapers. It is not okay to slash budgets in this way.

Lobbying

- There is a perceived fear of speaking out because organisations get their funding from the HSE. Need for an independent lobby group to fight for funding. What use are reports of the IMG?
- Question about NSUE's role and some expectation that NSUE would be a powerful lobby for service users/families. Answer from John Redican, NSUE: NSUE works behind the scenes.
- Need to lobby for advance directives. They are mentioned within AVFC but there is no way to access them. Similarly, people are not able to contribute to their own care plans. Without advance directives being part of legislation, there is a power imbalance and people are very vulnerable. Feedback from one participant's TD that advance directives will not be included in forthcoming Capacity Bill.

- Comment about lobbying: Much easier to use the internet to stay in touch and to build a powerful lobby. Need to move this conversation outside this room and into the public arena.

Recovery

- Comment on the patronising attitude of "inviting people to participate" in their own recovery, when actually they are the only person whose life depends on their recovery, they are the biggest stakeholder in their own recovery. Need to treat service users with respect.
- Question about what training is given to those in the health services on the recovery model, given that the bio-medical model is so prevalent. Answer from John Redican: Training on recovery is going to be an integral part of training for community mental health teams.
- Comment: Hospitals can be comfort zones for people. It's important to get people out of hospitals and into the community. The result will be two-fold: freeing up beds and improving people's lives.
- Comment: St. Patrick's Hospital has the WRAP Programme (Wellness recovery Action Plan), an 8-week programme in which the service user designs a care plan in advance of becoming unwell again.

Comment on AVFC

- AVFC is 200+ pages – there's a need for a pocket version of the document, so that service users can easily explain it to others. Request for NSUE to raise this issue with the Department.
- Comment from Respond Housing Association: AVFC talks about interagency work, but it is not always clear how Respond should be linking to the HSE. Services are so stretched that there is no space to look at innovative ways of working together.
- Comment: Although the participant felt this was a worthwhile day, this consultation should not be necessary in order to ensure AVFC is implemented. The original consultation already happened, pre-AVFC, so there is nothing to delay implementation.

Consultation

- Issue raised about consultation: The majority of people affected by these issues, including advance directives, are in hospital at the moment. Not consulted, treated badly, forced into ECT and medication. Where are those voices? Their human rights are being ignored and we have an obligation to them.
- Comment: workshop questions were a bit limited and didn't give the space to discuss the issues people ended up raising.

Other issues

- Comment from a mental health social worker: Need to adopt a community development approach to mental health. There are lots of things out there, people need to be flexible and work within communities.

- Suggestion to try and ensure St. John's Wort be made available again over the counter.
- Family support groups should be more widespread. They are free and really help.
- Need to spread culture of respect for the person. Example given of health care professionals talking over the person's head.