Evidence Review to Inform the Parameters
for a Refresh of *A Vision for Change* (AVFC)

A wide-angle international review of evidence and developments in mental health policy and practice

FINAL REPORT

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Summary

This report presents the results of an evidence review to inform the parameters of the planned refresh of mental health policy in Ireland ten years after the publication of the existing policy framework set out in *A Vision for Change (AVFC)*. The approach encompassed a stock-take of mental health developments in Ireland and a review of international developments, innovation, evidence and good practice. The review had a broad brief covering the various dimensions of the mental health terrain that might have relevance for informing the parameters of a refresh of mental health policy in Ireland. As the timeframe for the exercise was short (approximately 12 weeks) the review took a structured, but pragmatic, broad sweep or 'wide-angle' perspective and approach.

Methodology

The methodology mainly comprised desk research, augmented by some basic fact-finding from Irish stakeholders. For the stock-take of mental health developments in Ireland, the research team collated and reviewed evidence from published sources. These sources provide various stakeholders' assessments of progress against AVFC, and the study team did not review progress through primary research of their own. The study also sought to identify examples of promising initiatives and practice from Ireland. The report presents just an illustrative selection of these, and undoubtedly there exist many other important activities not mentioned.

For the international review, the team collated and reviewed evidence at a number of levels. This included publications of supranational agencies such as WHO, OECD and EU; reports and other sources providing multi-country material; more detailed review of available material from a selected set of countries; and broader thematic review of the policy, practice and research literatures in selected areas of the mental health field.

The report also presents a series of conceptual and mapping frames developed by the research team. These identify and locate key features of the mental health terrain in Ireland in a way that helps to contextualise the results of the review work. The combination of conceptual work and thematically organised collation of evidence, policy and practice may prove useful for informing the envisaged refresh of mental health policy.

Structure and contents of the report

The report covers the following main topics:

- Mental Health Situation, Policy and Services in Ireland today
- Prioritising Mental Health as a major Societal Issue
- Primary Prevention and Positive Mental Health
- Recovery, Social Inclusion and Living Well with Mental Illness
- Mental Healthcare Provision
- Mental Health System Governance and Financing
- Synthesis and Conclusions.

Results of the evidence review, and possible next steps

This report presents a broad overview and mapping of evidence and developments in the mental health area that may be helpful in guiding policy development and practice in Ireland. It provides an information resource and does not make recommendations as such. Nevertheless, it may be useful and appropriate to comment briefly on the relevance and possible approaches for taking forward the various issues raised in the report.

The Box below lists some of the key points arising from the evidence and practice review, and the following sections elaborate briefly on these. This might be helpful in the context of any operational follow-up, such as an Action Plan, to progress the policy agenda and improve services and other aspects of the mental health field in Ireland. It may be that sufficient consensus will emerge around key areas for action, and that an action plan underpinned by a light touch 'refresh' of AVFC might be an effective approach.

Key points from the evidence and practice review

Prioritisation of mental health as a major societal issue

- Recognition and strategic action to address the economic and social importance of mental health issues
- Establishment of concrete cross-sectoral actions
- Within healthcare system: parity of esteem; physical health co-morbidities

Primary prevention and positive mental health

- Perinatal and early years
- Educational settings
- Workplace
- Other target groups

Social inclusion/recovery

- Living well with mental illness
- Housing
- Employment
- Social inclusion & peer support

Mental healthcare services

- Addressing the spectrum of conditions and needs
- Balance of care and delivery systems: primary and secondary
- Recovery approaches in mental healthcare practice
- eMental health
- Inpatients and community residential settings
- Other areas: addiction/substance misuse; prisoners; non-nationals/minorities; carers.

Governance and financing

- Universality, public-private mix and equality/equity
- Quality assurance
- Innovation and change
- Research, statistics and evaluation.

Prioritisation of mental health as a major societal issue

The review found extensive evidence indicating the economic and social importance of mental health issues, as well as efforts in various countries to give more priority to mental health both within the healthcare system and by other relevant sectors. Attention focused on three aspects of this theme:

- Recognition and strategic action on addressing the economic and social importance
- Establishment of concrete cross-sectoral actions
- Within the healthcare system: parity of esteem and addressing co-morbidity issues.

Recognition and strategic action on the economic and social importance

There is strong evidence showing the economic and social importance of mental health disorders in Ireland and internationally. This includes the enormous human costs but also the very large economic costs. A large portion of these costs accrue to the social protection system, employers and the wider economy.

Studies have shown the substantial returns on investment that a broad range of prevention and treatment mental healthcare interventions can yield. This may include better outcomes for the mental health care sector and for the physical healthcare sector, cost-savings arising from prevention, and substantial cost-savings and other contributions across other areas of the public sector, economy and society.

Public spend on mental health - especially strategic 'upstream' investment in preventative, early intervention and community-based services - is therefore best viewed as an investment rather than a cost. Australia has clearly articulated this perspective to underpin government policy. Such investment can yield substantial 'downstream' savings from less utilisation of more expensive services / facilities and gains in other areas of public expenditure and the wider economy and society. For optimal economic and societal gains, this requires a visionary cross-sectoral perspective by government. Investments in one area of the public sector (such as mental healthcare treatment and prevention) may yield cost-saving and economic benefits in other areas of the public sector, sometimes in the short-term but also in the medium and longer term.

Establishment of concrete cross-sectoral actions

The review indicated the cross-sectoral nature of many of the issues in the mental health domain. The mental healthcare sector has important shared and overlapping responsibilities with other sectors, including the legal and judicial systems; the employment, education and housing sectors; and the social protection system.

There is recognition of this cross-sectoral dimension in Ireland, with some structures and activity emerging between mental health and sectors such as housing, employment and the judicial system. Other countries provide potentially useful examples of concrete inter-sectoral actions at governmental/ministerial levels and amongst key players at sectoral levels. Just some examples are the covenants and concordats with the police in England and the Netherlands, and the arrangements between mental healthcare services and employment services in the Netherlands.

Within the healthcare system: parity of esteem; physical health co-morbidities

Along with many other countries, Ireland appears to allocate a smaller proportion of the overall health budget to mental healthcare than its relative importance warrants because of disability burden, economic impact and potential for efficient use of scarce resources. Countries with better developed mental healthcare systems allocate proportionally greater amounts to this sector.

Some countries, such as England, frame the issue as one of 'parity of esteem', albeit sometimes experiencing challenges to realising this vision. Parity of esteem refers both to resourcing mental healthcare commensurate with its importance in the wider healthcare system and to broader issues around professional recognition for mental health care. There may be merit in developing this perspective in Ireland as well.

Another development since AVFC has been the increasing recognition and evidence base indicating the interplay between mental health conditions and physical health conditions. Apart from relatively independent co-morbidities, there are important interactions between mental health and physical health. These include causal associations (in either or both directions) as well as other interactions such as impacts of mental health conditions on management and outcomes of long-term physical health conditions. International studies consistently find mental disorders are associated with much higher risks of all-cause mortality compared to the general population, as well as increased risk of many health conditions and poorer outcomes with these.

Primary Prevention and Positive Mental Health

There is now a wide recognition of the importance of primary prevention and promotion of positive mental health. The review addressed a number of settings and target groups for prevention and mental health promotion:

- Perinatal and early years
- Educational settings
- Workforce
- Other target groups.

Perinatal and early years

The perinatal period (pregnancy to 1 year) brings risks of mental health problems for some women and is also an important period for early intervention and mental health promotion more generally. Screening is important but integration of services is also a key issue. The refresh of AVFC may wish to give attention to these aspects, in particular the integration of services (mental health, maternity, GP, public health nurses) and specialist perinatal mental health services. The approach in New Zealand provides an example of focused efforts in this area, addressing the challenge of developing effective provision of specialist perinatal mental healthcare inputs within the more general continuum of care over the perinatal and early parenting/childhood years.

Educational settings and young people

The government recently announced plans to roll out mental health promotion programmes as part of a school wellbeing curriculum in Ireland. The review identified potentially useful examples of approaches in other countries that may be helpful in this context, for example, NICE guidelines and programmes by the Department for Children, Schools and Families in England. Given that the youth focus now tends to extend to include the 18-25 year age group, the Irish approach might also consider the possibilities for engaging with the third level sector as well as primary and secondary level schools.

Initiatives tackling bullying and cyberbullying are also important. In 2013, the Oireachtas published a report on 'Addressing the Growth of Social Media and tackling Cyberbullying'. This might be re-visited in the refresh of AVFC.

Workplace

Extensive evidence is available showing the importance of mental health (and mental health promotion) in the workplace to address morbidity, absenteeism, reduced productivity and early retirement of skilled workers. Stress and other psychosocial factors at work can lead to mental health problems and mental health conditions can affect work performance. Some of the reviewed countries have a strong focus on workplace mental health, including legislative provisions and a range of sectoral programmes and initiatives. This is an area requiring more attention in Ireland.

Other groups

The review identified a range of programmes across other countries targeting particular at-risk groups, for example, unemployed people and older people. The refresh of AVFC may wish to give more detailed attention to mental healthcare issues and supports for these groupings. Given the timeframe, the review gave just brief attention to suicide prevention and initiatives addressing self-harm. These are clearly important areas for the refresh of AVFC.

Recovery, social inclusion and living well with mental illness

AVFC had a strong focus on recovery and on the social inclusion of people with mental health difficulties more generally. There has been progress in this area in Ireland, but many stakeholders feel there is a lot more to be done. The international review found examples of well-developed recovery oriented supports in some of the other countries. The review addressed a number of aspects of this, including:

- Living well with mental illness
- Housing
- Employment
- Social inclusion & peer support.

Living well with mental illness

It is increasingly recognised that mental illness and positive sense of wellbeing are not necessarily mutually exclusive. Some people with enduring mental illness may have good mental health in the sense of positive wellbeing, especially if they have the opportunity for fulfilment in their personal, social and working lives. The report introduces the notion of 'living well with mental illness' to encompass this perspective, borrowing from the perspective commonly applied in the dementia field. This is a central aspect of the recovery perspective.

Housing

Appropriate housing is essential for recovery and for living well with mental illness. This is a recognised area of responsibility for the public housing sector in Ireland, including provision of mainstream housing options for people currently residing in community hostels and other residential situations. However, progress appears slow in implementing practical supports and achieving stated policy goals.

The review identified some promising initiatives in Ireland based on floating support services that help people with mental health difficulties find suitable housing. This includes transition to independent living and support in managing tenancy-related and other aspects thereafter. Expansion of such services in Ireland could make an important contribution to delivering on this aspect of mental health policy. The international review found examples of well-developed approaches to this in a number of other countries.

Employment

Opportunities for employment can be very important for recovery and for living well with mental illness. Again, the review found examples of well-developed approaches to this in a number of other countries, such as the Netherlands, including structural linkages and operating procedures between mainstream employment-finding and support services and mental healthcare services. The Individual Placement and Support (IPS) model is an important approach in this field. Although there have been some recent initiatives in Ireland, the more mainstream linkages between the employment services and mental healthcare services remain under-developed. Again, expansion of this area of support in Ireland would be important for delivering on the recovery aspect of mental health policy.

Social inclusion and peer support

In addition to housing and employment opportunities, broader social inclusion supports may also be helpful for many people with mental health difficulties. Peer support initiatives have an important role in this, building or enhancing various forms of social capital. In Ireland, there has been public funding for some initiatives of this type and there may be value in considering further expansion of this approach.

Mental healthcare services

The review gave particular attention to good practice and innovation in mental healthcare services. This covered a number of aspects, including:

- Addressing the spectrum of conditions and needs
- Balance of care and delivery systems: primary and secondary care
- Recovery approaches in mental healthcare practice
- eMental health
- Inpatient and community residential settings
- Other themes - addiction/substance misuse; prisoners; non-nationals/minorities; carers.

Addressing the spectrum of conditions and needs

The spectrum of mental health conditions covers a very wide range of diagnostic categories which manifest themselves in a diversity of symptoms and associated impacts on functioning and well-being. Although we do not have a comprehensive profile of incidence and prevalence rates for the various conditions in Ireland, data from other countries can help to put some indicative scaling on prevalence across a range of conditions.

A crude extrapolation of Australian data to the Irish situation would give rough estimates of about 600,000 people with mild-to-moderate conditions (anxiety, depression, etc.); about 125,000 people with severe episodic/severe and persistent complex and chronic conditions (schizophrenia, bipolar, eating disorders, severe depression etc.); and about 13,000 with severe and persistent complex multi-agency needs and psychosocial disability. European prevalence data extrapolated to Ireland would indicate about 41,000 for psychotic disorders, 281,000 for mood disorders, 518,000 for anxiety disorders, and 141,000 for somatoform disorders. Other conditions worthy of note include Post-Traumatic Stress Disorder (PTSD), important in the context of historical sexual abuse and in the increased exposure to terrorist violence.

Depression and anxiety are particularly important due the scale of their impact in years lost to disability across the population. Across all health conditions, they rank high on the list in this regard and especially high in impacts on subjective wellbeing. The allocation of resources within the Irish mental healthcare sector must endeavour to cover the full spectrum of needs in an appropriate manner, including both the more common conditions and those less common but costlier to treat.

Balance of care and delivery systems: primary and secondary care

Ireland and other countries have recognised the challenge to put in place effective delivery systems and achieve an appropriate balance of care across this spectrum of mental health conditions and range of types and levels of support required. To support resource allocation in England, for example, the NHS has developed a clustering system and a non-mandatory tariff structure linked to this. The approach identifies a number of care clusters based on a combination of diagnostic category and level of associated disability.

The report develops an operational framework identifying relevant features of the Irish care ecosystem today. This includes primary care components (GPs, primary care centres, Counselling in Primary Care, independent psychosocial services and professional practices);

secondary/specialist care components (community & other ambulatory; hospitals and other residential; independent psychiatric and other psychosocial services and professional practices); and linkages between primary and secondary/specialist services (referral pathways and other linkages - liaison, consultative etc.).

The report presents examples of approaches to optimal utilisation of primary and secondary care services from a number of other countries. These include efforts to increase capacity and incentivise GPs to address common conditions and also to provide continuing care and care management for people with more severe and enduring conditions. Also important is early intervention in severe mental disorder, and the report presents evidence and examples of approaches in other countries that may provide useful insights for Ireland.

Crisis care and interworking with the police and judicial system is another important theme. The report presents examples of well developed approaches in this area, including the covenants and concordats with the police in England and the Netherlands.

Coverage across the stages of the lifecycle is also important. Due time constraints the review mainly focused on general adult mental healthcare services, with more limited attention to child and adolescent mental health and to specialist areas of mental healthcare for older people. It is likely that the refresh of AVFC will wish to give more detailed attention to these areas.

Recovery approaches in mental healthcare practice

Recovery perspectives and approaches have become increasingly influential in mental healthcare practice. In Ireland, AVFC espoused this approach and the HSE Mental Health Division has embraced the perspective, with various activities underway in this field. The report presents guidelines from Canada as an example of the development of this approach elsewhere.

As well as embracing recovery within mental healthcare service provision and practice, recovery is recognised as an intersectoral issue. Alongside clinical care, it requires inputs in areas such as housing, employment and more general social inclusion. This may involve the inclusion of skills in these wider areas of support within mental health teams, or coordinated inter-sectoral working arrangements between the mental healthcare sector, housing, employment and other relevant sectors. The FACT (Flexible Assertive Community Treatment) team approach in the Netherlands provides an example of the incorporation of a broad range of skillsets in mental healthcare teams.

In Ireland and internationally there has been increasing interest in the role that peer support can play in recovery for people with mental health difficulties. The HSE has published guidance to support formal services wishing to incorporate peer support. The report also presents a recent evaluation and analysis of peer support initiatives in Ireland that may provide useful insight and guidance for a refresh of AVFC.

eMental Health

One of the challenges facing the mental healthcare sector in Ireland and other countries concerns effective (and cost-effective) ways to reach the large numbers of people with common mental disorders. Some commentators suggest that eMental Health has the potential to be a game-changer in this field.

eMental health covers a broad spectrum, from formal delivery of therapy to self-help apps and online information. The scope includes:

- telephone-based delivery of therapy sessions, including telepsychiatry and telecounselling
- delivery of structured therapeutic protocols such as CBT, including eCBT (online) and cCBT (computer-based); approaches may vary in the involvement or not of human service professionals (i.e. whether 'blended' or not)
- mental health self-help applications, including mental health apps, online tools and other self-help tools; these may include formal services, such as medication reminders, ongoing supports in addiction treatments, and other applications
- online peer support through social media and other platforms (mental health '2.0'), either moderated (by professionals or peers) or unmoderated
- online information and psycho-education.

There is a broad body of emerging evidence on aspects of efficacy and cost-effectiveness across this spectrum. Systematic reviews have found some evidence of efficacy although also point to limitations in the methodologies of many of the reviewed studies. Overall, the indications are that well-developed applications can have comparable efficacy to traditional approaches when appropriately provided and in approriate delivery environments.

eMental health might merit focused attention in the refresh of AVFC policy in Ireland. It may be worth examining the extent to which eMental Health could be something of a 'game-changer' through provision of cost-effective ways of providing access to treatment and other supports and reaching more people who can benefit. In this context, it may be useful to look at approaches in other countries where eMental health in various forms is now actively incorporated as a component of the mainstream system and spectrum of available services. These include almost all the countries covered in some detail in our review.

In doing this, it is important to adopt a measured perspective and avoid blanket generalisations. This is a dynamically evolving domain, with inevitable hype. There may be risks of technology-push as well as unwarranted professional resistance, with neither in clients' interest. A considered and balanced perspective is required, through informed and organised mapping of the terrain and the evidence base, as well as the opportunities and risks presented in the Irish mental healthcare ecosystem.

Although eMental health services offer considerable potential, the internet and social media also bring new mental health issues and new challenges for mental healthcare services. These include cyberbullying, as well as a range of conditions and impact areas such as online grooming, excessive utilisation of online sexual material, online gambling, more general concerns about overuse of online media instead of face-to-face social interaction, and many

other issues. As mentioned already above, the Oireachtas published a report on 'Addressing the Growth of Social Media and tackling Cyberbullying' and the refresh of AVFC may wish to revisit this important theme.

Inpatient care and other residential settings

Given the timeframe available, the current study focused especially on community and other elements of ambulatory care, and adopted a lighter touch approach to inpatient care and other residential settings. The refresh of AVFC may wish to address these areas in a more detailed manner.

One issue is the adequacy or otherwise of the current stock of psychiatric inpatient beds now that the de-institutionalisation agenda has been extensively progressed. OECD data positions Ireland at a little below the OECD average in number of beds provided per capita. This is not necessarily a good or a bad thing, but there is need for a review of the current supply as regards the amount and mix of types of beds relative to need in the Irish context.

In Ireland, the Mental Health Commission monitors and reports on various aspects of inpatient mental healthcare, including use of restraint and seclusion. The Commission's Annual Report 2015 raises a number of issues. The review of other countries for this study found some examples of well-developed approaches to improving practice in the use of restraint and seclusion (England and the Netherlands), as well as extensive investment to upgrade inpatient infrastructures and patient facilities (England) and provision of advocacy for inpatients (Netherlands).

The Mental Health Commission has also pointed to a number of issues of concern in the current provision of community residential facilities for people with mental health conditions in Ireland. The AVFC report envisaged a major reduction in usage of community residential facilities and a re-focusing towards supporting independent living in the community. Progress appears to have been slow in this area, but there have been recent initiatives aiming to address this. The HSE and HAIL programmes mentioned earlier are important in this context, and the refresh of AVFC may wish to give further attention to the possibilities offered by this approach.

It may also be useful to look more broadly at the role that (upgraded and refurbished) community facilities might continue to play in the Irish situation. This could include a potential role in provision of short-term crisis care facilities, as well as in step-down and other interim or transitional arrangements for people discharged from psychiatric inpatient beds or other situations.

Other themes

The report also addressed some other specific mental healthcare themes:

- addiction/substance misuse
- prisoners
- non-nationals/minorities
- family carers.

Addiction and substance misue
Many commentators have suggested the need for better integration of addiction and substance misuse services within the mental healthcare system in Ireland. The HSE clinical programme on Dual Diagnosis should help improve the situation. The Netherlands provides an example of a country that has given a high importance to addiction and substance misuse within mental healthcare, with the scope encompassing addictions to nicotine, alcohol, drugs, and sedatives and tranquilisers.

Prisoners
A current focus in Ireland is on improving the mental healthcare provision for prisoners. Some elements of the approaches from other countries may provide useful insights in this context. Studies consistently show that the prevalence of mental disorders in prisons is far greater than in the general population. Suicide rates for male prisoners are much higher than the general population.

The research found variation across countries in whether funding and responsibility for prison mental health care is the responsibility of a Ministry of Justice (or similar ministry) or the Ministry of Health, with a shift towards mainstream health system responsibility in some countries in the last decade. In England there has been a shift from a Home Office commissioned prison health service to NHS commissioning of all health services for prisoners today. Specialist 'assertive community treatment teams' are also developing to operate in prisons and better recognise risk and provide support.

Non-nationals and minorities (including the Irish Traveller community)
The Irish population now includes a substantial number of non-nationals, including people from other EU countries and from further afield. The 2015 QNHS special module on health indicates that these may be an underserved group as regards access to mental healthcare services.

The Irish Traveller Community and the Roma are also important groups for attention. The All Ireland Traveller Health Study (AITHS) identified a disproportionate burden of mental health issues experienced by travellers, including excess suicide rates in comparison to the population overall. HSE has some services and has supported various initiatives in this field.

The refresh of AVFC may wish to address in more detail these issues of mental healthcare for non-nationals, Irish Travellers and other minority groups.

Family carers
In Ireland, the National Carers Strategy recognises the challenges faced by carers and emphasises the importance of supporting their physical, mental and emotional wellbeing needs. From the mental healthcare perspective, carers have a dual importance. They are key parties in the care and support for a family member with mental health problems, as well as having risk of mental and emotional wellbeing issues themselves because the strains of the caring role. There may also be impacts on employment and on education for young carers.

Surveys of carers in Ireland and other countries show that a substantial proportion of carers are caring for someone with mental health or behavioural problems. They are caring for people of all ages with mental health issues, including children with ADHD and other behavioural conditions, young adults developing psychosis, and adults and older people with a broad range of conditions. Recent Irish research and many anecdotal reports by carers

express concerns about professional reluctance to provide information to carers about the needs of the person they are caring for and the risks that this may pose. There appears to be a lack of consistency across the country and across individual practitioners in this regard. The refresh of AVFC may wish to address these important aspects of family caring for persons with mental health problems.

Governance and financing

The review also addressed issues of governance and financing of mental healthcare services. This covered a number of aspects, including:

- Universality, public-private mix and equality/equity
- Quality assurance
- Innovation and change
- Research, statistics and evaluation.

Universality, public-private mix and equality/equity issues

There is ongoing policy consideration of how best to achieve universality in Irish healthcare against the background of the public-private mix that currently prevails. One feature of the mix is the differential access to healthcare services for those with medical cards and those with private health insurance. Another feature is the range of public, private (for-profit) and non-profit organisations involved in the provision of services. The report develops a mapping of some of the many elements of this complex ecosystem as it applies in the mental healthcare field in Ireland today.

The public system provides much of the public mental healthcare services directly but also outsources (and/or funds in various ways) a considerable volume of service provision in the mental health domain. The HSE Mental Health division accounts for the largest share of public spending; other divisions also make important contributions, including Primary Care, Social Care, and Health and Wellbeing. HSE also provides or funds a substantial part of inpatient care, as well as a range of community-based residential settings.

Third sector service providers play a formal role in some parts of the public mental healthcare services. For example, a number of area-based services receive funding under Section 38 arrangements and a range of mental health activities are funded through Section 39 arrangements. HSE also outsources to the private sector in various ways, for example through the Counselling in Primary Care (CIPC) scheme (funding counselling services for medical card holders), and funds some high cost services for small numbers of clients in secure units in Ireland or abroad.

The private mental healthcare sector provides both institutional and community/ ambulatory services, and includes the private psychosocial practitioner sector (psychiatrists, psychologists, psychotherapists, counsellors, etc). Clients of these services may be covered by private health insurance and/or have to pay out-of-pocket (in addition to private health insurance premiums they may already be paying).

The refresh of AVFC may wish to consider how best to encompass this broad canvas in the articulation of an overarching policy framework and, where relevant, in practical governance arrangements. This perspective may also be helpful in seeking ways to effectively and

equitably cover the full population and to optimally leverage the available capacity and activity across the different elements and sectors.

Commissioning

There has been discussion of the potential offered by commissioning arrangements to address some of the challenges in the Irish healthcare system overall as well as in the mental healthcare system, although there have also been differences of perspective and opinion voiced in the political and broader stakeholder discourse. The ecosystem mapping in this report shows that 'commissioning' in various forms is already an established and long-standing element in some parts of public health and social care provision already in Ireland, with new applications emerging to support greater access and service improvements in various areas.

These types of arrangements may have relevance for the recruitment challenges that appear to be a significant barrier to service improvement in the public mental healthcare domain. They may also have relevance in the broader context of seeking ways to achieve more universality in the overall mental healthcare system in Ireland. The report presents examples of approaches in other countries that relate to a variety of elements of this 'commissioning' space, including approaches to incentivise GPs to provide primary mental healthcare as well as ongoing care management for people with enduring mental health conditions. These may provide useful insights for the refresh of AVFC and the more general elaboration of the mental health vision and policy in Ireland.

Differential access for public system users and private system users

The current de facto arrangements result in differential access for public system users and private system users of mental healthcare services. The data from the 2015 QNHS shows an inverse socio-economic gradient in need and in utilisation of mental healthcare services in Ireland. This underscores the importance of improving access to mental healthcare services for users following the public route. Initiatives such as CIPC are relevant in this context. Public oversight of the private route is also important. This applies currently in the public regulatory role of the private health insurance sector under the Minimum Benefit legislation. These issues of public-private mix and differentials also have relevance in the wider review of the Irish healthcare system as part of the ongoing efforts to design a more universal system. Studies conducted in this context have included mental health in their modelling of costings for various benefit 'Baskets'. The refresh of AVFC may also wish to give attention to this wider aspect of universality in mental healthcare in Ireland, including parity issues in the coverage of mental health care and physical health care.

Stakeholder roles and user organisation involvement

Given the mix of players in the current mental healthcare ecosystem in Ireland, the issue of stakeholder roles and involvement in the overall governance of the domain is important. This is a theme that the refresh of AVFC may wish to address.

As an illustration, the arrangements in the Netherlands may provide insights useful for Ireland. The transition in 2006 to compulsory universal health insurance through a (regulated) competitive private insurance provider market required the development of appropriate governance and regulatory arrangements to reflect the various stakeholders in the system. The result is a system regarded as very transparent and underpinned by strong information systems that facilitate negotiation and agreement amongst the competing

interests. Those with formalised structural roles include the government, insurers, healthcare providers (including mental healthcare providers), professional organisations (including mental health professionals) and user/family organisations.

In the Irish context, national policy and the HSE strongly espouse the user role. This encompasses various levels of involvement, including a mandated involvement in the composition of the Mental Health Commission and the significant efforts and investments by the HSE in this area. However, the strong involvement of user (and family) organisations at a structural level in the Netherlands is noteworthy and may provide useful insights for a refresh of AVFC.

Public System

Resource allocation

Based on official data, the current percentage allocation to mental health in Ireland seems to be around 6% of overall health spend, although the percentage varies depending on which elements of overall health expenditure are taken into account as well as what elements of healthcare are included within the mental health allocation (e.g. relevant parts of the social care allocation, and of dementia care services). AVFC proposed a target of 8% for mental health spending from the overall health allocation and other commentators have suggested higher figures. AVFC also presented data showing that the relative spend on mental health had declined considerably in the twenty-year period leading up to the report in 2006. A comparative positioning of Ireland internationally suggests that the percentage resource allocation today is around the median level across EU countries, and lower than in some of the countries with better developed and better performing mental healthcare systems.

Equally important is the allocation of resources (and costs) within the mental healthcare sector itself. Data from other countries suggest that large proportions of expenditure are consumed by a relatively small number of high cost clients and that, despite the de-institutionalisation agenda, there has not been commensurate shifting of resources to the community/ambulatory sector.

Manpower and skills mix and sufficiency

The issue of professional manpower and skills mix and sufficiency is another theme in mental healthcare in Ireland today. Much of the focus has been on the quantitative yardsticks proposed in AVFC. On the aggregate, the available data suggests that the manpower levels in the HSE's community/ambulatory services have been increasing, with levels now about seventy-five per cent of the AVFC targets. The refresh of AVFC might wish to re-examine the basis for the original targets in today's environment, as well as whether it is possible to develop needs-based or other approaches to complement the population-based perspective.

Available HSE data on staffing profiles in adult mental health teams show variation across CHOs in the manpower mix in key professional categories - psychiatric/medical (consultant psychiatrists, senior registrars, registrars, SHOs); nurses; and allied professionals (psychologists, occupational therapists, social workers, addiction counsellors). Although this data is instructive it is also important to consider the underlying skills mix that the staffing profiles encompass, as well as the extent to which particular skills are actually applied. For example, there have been many developments in the skills profile of nursing staff in the

mental health field in Ireland and many nurses may be operating, or at least skilled to operate, in areas (such as psychosocial intervention) that might traditionally have been the preserve of other disciplines.

A focus on quantitative profiling of staffing numbers and on numbers of teams has tended to dominate the presentation of developments in community mental healthcare services in Ireland. It is less clear how the relatively large number of teams actually operate. This makes it difficult to gain a picture of the levels of service available across the country, where they operate from, and the scope of the services they provide.

The refresh of AVFC may wish to give attention to this aspect, including the need for a qualitative mapping of existing community based services / teams in their structural and operating characteristics and in the service portfolios that they offer. In regard to service portfolios on offer, the issue of choice may also be a topic for attention. A recurrent theme in the wider discourse has been variation across the country in the therapeutic options available, such as in orientations towards medication or talking therapies. This is an issue for consideration in quality assurance of mental healthcare in Ireland.

Quality assurance

There are many important elements to quality assurance. These include timely access to appropriate services, and choice between therapeutic approaches where relevant and desired. Consistent provision of services across the country is another aspect requiring consideration.

There are a number of HSE initiatives addressing quality assurance, including the clinical programmes and standard operating procedures introduced. The Mental Health Commission also developed a series of quality tools as well as an overall quality framework which maps to the contents of AVFC. Other countries covered in the review have developed service and clinical guidelines for practice in mental healthcare. These include NICE guidelines in England and a range of multidisciplinary guidelines on mental health in the Netherlands. The refresh of AVFC may wish to giver further attention to this area.

Innovation and Change

There are a number of current HSE and other programmes to promote and accelerate innovation and necessary change in mental healthcare in Ireland. The HSE has established a transformation programme and the Service Reform Fund programme with Genio is underway. The refresh of AVFC will likely seek to align with these areas of activity where relevant.

Approaches in other countries may also be of interest in this context, such as the Breakthrough Quality Collaboratives (QICS) in the Netherlands. Such initiatives to promote rapid change and progress in priority areas might be helpful in the Irish context, to support achievement of relatively quick-fixes in relevant areas alongside the slower and more transformational change processes.

Research, Statistics and Evaluation

The issue of parity of esteem for mental health within the wider healthcare domain applies also to health research funding. In Ireland, apart from suicide research and mental health promotion, there has been a limited volume of research on mental healthcare issues. There are many gaps in knowledge on the prevalence of mental health conditions and their impacts, and on how the mental healthcare system is performing in addressing these needs. Service development and resource allocation requires good underpinning evidence. The refresh of AVFC may wish to consider the development and commensurate funding of a research strategy on mental health, including basic research as well as research that can directly support policy, system and service developments.

Linked to this is the development of an adequate statistical profile of the mental health situation in Ireland today. The current focus tends to be towards key performance indicators addressing operational features of the system and services. Other countries, such as the Netherlands and England, have developed more elaborate statistical and monitoring systems, including efforts to produce more meaningful operational performance data, as well as detailed data on prevalence and need, and on outcomes.

1 Introduction

This report presents the results of an evidence review to inform the parameters of the planned refresh of mental health policy in Ireland ten years after the publication of the policy framework set out in *A Vision for Change (AVFC)* [1]. The approach encompassed a stock-take of mental health developments in Ireland and a review of international developments, innovation, evidence and good practice. The review had a broad brief covering the various dimensions of the mental health terrain that might have relevance for informing the parameters of a refresh of mental health policy in Ireland. As the timeframe for the exercise was short (approximately 12 weeks) the review took a structured, but pragmatic, broad sweep or 'wide-angle' perspective and approach.

Methodology

The methodology mainly comprised desk research, augmented by some basic fact-finding from Irish stakeholders. For the stock-take of mental health developments in Ireland, the research team collated and reviewed evidence from published sources. These sources provide various stakeholders' assessments of progress against AVFC, and the study team did not review progress through primary research of their own. The study also sought to identify some illustrative examples of promising initiatives and practice from Ireland. This is just an illustrative selection, and undoubtedly there exist many excellent activities which are not mentioned in the report.

For the international review, the team collated and reviewed evidence at a number of levels. This included: publications of supranational agencies such as WHO, OECD and EU; reports and other sources providing multi-country material; more detailed review of available material from a selected set of countries; and broader thematic review of the policy, practice and research literatures in selected areas of the mental health field.

The report also presents a series of conceptual and mapping frames developed by the research team. These identify and locate key features of the mental health terrain in Ireland in a way that helps to contextualise the results of the review work. The combination of conceptual work and thematically organised collation of evidence, policy and practice may prove useful for informing the envisaged refresh of mental health policy.

Structure and contents of the report

The main body of the report is structured into eight Chapters:

Chapter 2: Mental Health Situation, Policy and Services in Ireland Today

Chapter 3: Prioritising Mental Health as a major societal issue

Chapter 4: Primary prevention and Positive mental health

Chapter 5: Recovery, Social Inclusion and Living Well with Mental Illness

Chapter 6: Mental Healthcare Provision

Chapter 7: Mental Health System Governance and Financing

Chapter 8: Synthesis and Conclusions.

2 Mental Health Situation, Policy and Services in Ireland Today

This Chapter presents an overview of some important features of the mental health terrain in Ireland today. Within the study, the overview helped to inform and guide the approach to the wider international review reported in other chapters. In its own right, the material is also helpful in identifying some guiding themes and insights to support the forthcoming review and refresh of *A Vision for Change* (AVFC).

2.1 View from the inside

The study team reviewed material providing an internal (Irish) view of the mental health terrain in Ireland today. The review focused on two main aspects - progress on A Vision for Change policy and the current mental health situation in Ireland.

2.1.1 Progress on *A Vision for Change* (AVFC) policy

A number of sources provide material and evidence to inform a stock-take of progress on mental health policy goals as articulated in AVFC. These include reports from statutory bodies such as the Mental Health Commission, reviews prepared by stakeholders such as Mental Health Reform, and relevant mental health and service statistics.

Overall, there is agreement across the stakeholders on the need for a lot more progress to make the vision of AVFC a reality, along with a range of views on the priorities for attention and the nature and scale of reform required. The Mental Health Commission's Annual report for 2015 presents a succinct statement of its appraisal of progress [2] (Box 2.1).

Box 2.1: Mental Health Commission: Annual Report (2015) – Extracted excerpts
Policy • Now a degree of congruence between national mental health policy and the aspirations and objectives of the HSE Mental Health Division Operational Plan • Considerable commitment to the policy both at national and regional level. This commitment is evident in the statutory, voluntary and independent sectors • Implementation of policy to date is still reliant on innovative and imaginative leadership at regional and local level • There is a great deal of activity, clinically and administratively, and all levels of service provision need to work towards adherence to the Vision for Change policy • Much needs to be done to ensure the delivery of consistent, timely and high quality services in all geographic regions and across the full range of clinical programmes and age groups.
Source: Extracted excerpts from Mental Health Commission Annual Report 2015

Box 2.1: Mental Health Commission: Annual Report (2015) – Extracted excerpts (contd.)
Resources • €35 million budget allocation in 2015 for revenue spending on the development of additional mental health services with an emphasis on supporting the development of specialist community mental health teams • Current level of expenditure on mental health as a proportion of overall health expenditure is less that the 8.24% target (based on 2005 figures) envisioned in Vision for Change • HSE Mental Health Division Operational Plans show services operating at about 75% of recommended staffing numbers in Vision for Change • Continuing recruitment difficulties for specific specialist staff; this requires action as a matter of urgency • Commission stresses the need for the continued development of community mental health services to replace traditional models of inpatient care **Recovery services** • Now well understood, but implementation of it is uneven • Stated commitment by the HSE Mental Health Division to the Advancing Recovery in Ireland programme and the Service User, Family and Carer Engagement Action • But Commission information points to a serious deficiency in the development and provision of recovery oriented mental health services • Service delivery is still largely delivered by psychiatric and mental health nursing staff. There is still a significant absence of psychology, social work, occupational therapy and other multidisciplinary team members • ...there needs to be a cultural shift in how we deliver services away from a linear medical model towards a more holistic bio-psychosocial one.
Source: Extracted excerpts from Mental Health Commission Annual Report 2015

Over the years, the Mental Health Commission has also prepared a range of sectoral or thematic overviews of progress against various elements of AVFC. A number of other sectoral bodies have also presented their members' perspectives in various ways, including psychiatrists, GPs and psychiatric nurses. They indicate a certain degree of consensus on issues facing the mental health field in Ireland but also divergence across the professional groupings on key issues and priorities.

Mental Health Reform also recently published an extensive evidence-based review of progress against each key theme of AVFC [3] (Box 2.2). This assessment rates progress on some aspects as more advanced than others, although no area is fully developed so far.

Box 2.2 Mental Health Reform's Evidence-based review of progress against AVFC	
AVFC Topic	**MHR Progress Rating**
Service User Involvement	
Social Inclusion	
Mental health promotion/mental wellbeing	
Mental health in primary care	
Adult mental health services	
Children and adolescents	
Older people	
Mental health services for people in the criminal justice system	
Special categories of service provision	
Accountability, governance, manpower	
Source: [3]	

Although stakeholders agree on the need for a lot more progress, they do point to a range of areas where there has been substantial progress and to specific examples of promising innovation and good practice (Box 2.3). Genio have also supported over 100 innovative projects in the mental health field, with about €8 million of funding. They are also leading

on the implementation of a new Service Reform Fund to improve capacity and effectiveness in community mental health services.

Box 2.3: Illustrative Areas of Progress and Examples of Innovation / Good Practice

• HSE establishment of Mental Health Division; subsequent progression of structural and service improvements aligned with AVFC and other relevant policy; initiative to improve manpower situation and enhance skills mix; substantial change programme initiated
• Publication of *Connecting for Life,* the new national strategy to reduce suicide 2015-2020
• Establishment of National Taskforce on Youth Mental Health; Pathfinder project on youth mental health; other programmes and many initiatives in youth mental health since AVFC, including early childhood, JigSaw etc.
• HSE has established or is in the process of setting up Clinical programmes in mental health
  ○ National Clinical Care Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm
  ○ Early Intervention for people developing First Episode Psychosis
  ○ Eating Disorders Service spanning Child and Adolescent and Adult Mental Health Services
  ○ ADHD in Adults and Children
  ○ Dual Diagnosis (Mental Illness and Substance Misuse).
• Development of a number of Standard Operating Procedures (SOP), models of care and other quality frameworks for a range of HSE mental health services
• HSE progression of user involvement agenda
• Establishment of Counselling in Primary Care (CIPC) programme
• Support for other pilot initiatives on access to mental health professional services (e.g. APSI in Roscommon)
• Development of HSE's National Recovery Framework; establishment of recovery / peer support initiatives (e.g. Gateway, Aras Follain, ARI)
• Initiatives to promote positive mental health via integrated media campaign (#littlethings)
• Expert Group report to review Mental Health Act 2001
• Range of improvements to National Forensic Mental Health Services (NFMHS) underway

Sources: collated by research team from various sources

2.1.2 Mental health situation in Ireland – trends and current situation

Data on the mental health situation in Ireland also provides evidence and insights to inform the parameters of a refresh of AVFC. Statistics published by the Department of Health and the Health Research Board show a number of trends since 2006. These include: continued decline in the rates of admission to psychiatric hospitals, with about 2,400 in-patients at any one time in 2013; suicide rates and absolute numbers seem not to have changed much over the period; and there has been a substantial increase in the numbers in drug treatment. These figures indicate just some of the themes that may need attention in a refresh of mental health policy.

Historically there has been an absence of population-based mental health morbidity data in Ireland. A number of sources have helped to improve the situation, although our review did find examples of approaches in some of the other countries that show the types of further enhancement possible in this area in Ireland.

The HRB National Psychological Wellbeing and Distress Survey (NPWDS) provides a considerable body of evidence and analysis that remains relevant today [4]. Box 2.4 presents some of the main conclusions of the survey. These include the substantial prevalence of psychological distress (12% of the Irish adult population) and the implications of this for mental health policy (including encouragement of self-help, mental health promotion, developing the skills of GPs in this area, and putting in place effective referral pathways to secondary care when required).

Box 2.4: HRB National Psychological Wellbeing and Distress Survey 2005-2006

The NPWDS found that approximately 12% of the Irish adult population were currently experiencing psychological distress – a figure which is similar to that found in other countries (ESEMeD/MHEDEA 2000 Investigators, 2004). It is evident that formal services as currently provided cannot respond to the demand for support and it may not be appropriate that they do so in all cases. The decision to seek help can depend on a number of health beliefs such as the perceived need for help, the perceived efficacy of treatment and the barriers and facilitators to seeking help.

There is an evident need to develop new models of support for persons experiencing psychological distress – many of these could be informal and inexpensive, operating at individual (recognition and ownership of stress/distress), interpersonal (seeking informal support from family, friends) and societal (mental health promotion programmes, development of social capital in communities) levels in a wide range of situational contexts (schools, homes, resident associations). Individuals and communities need to be provided with strategies aimed at reducing or coping with psychological distress so as to reduce the chances of symptoms reaching diagnostic criteria. This would, of course, reduce the chances of the symptoms requiring formal health care services.

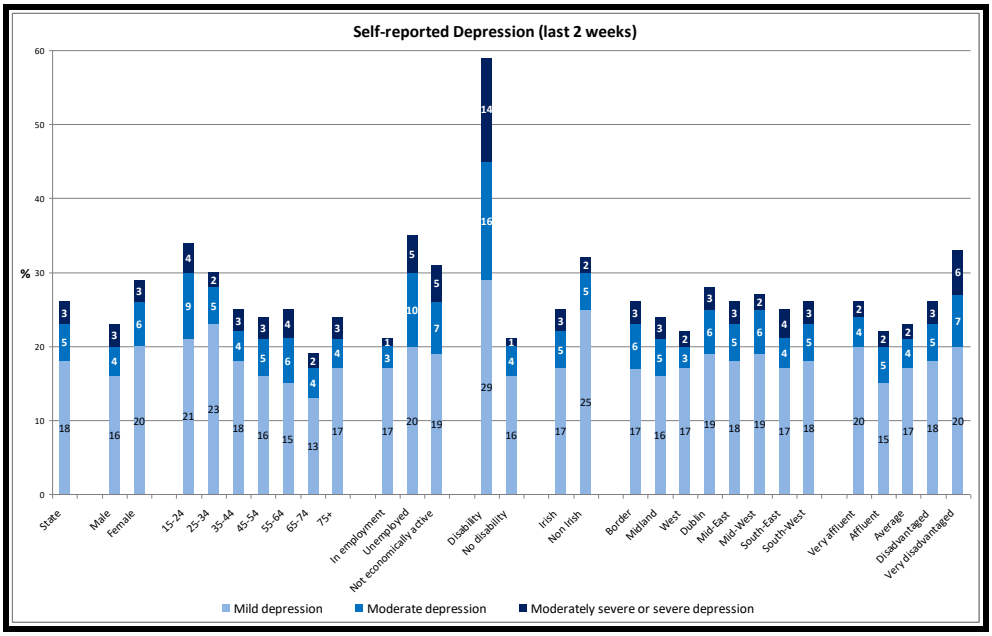
With regard to formal supports, this survey has highlighted the important role the GP plays in the assessment and treatment of mental health problems. GPs are often the first and only port of call for those seeking help and are also the primary gatekeepers to specialised mental health services. These findings raise a number of important issues relating to the assessment and treatment of both short-term mental health problems to more enduring mental health problems within the primary care setting. There is a need for training in mental health care for GPs and those working within the primary care setting. Importantly, there is a need for mental health professionals within the primary care network who can provide a range of psychological therapies. And finally, the interface between primary care and secondary mental health services needs to be developed so there is a continuity of care for those who require specialised mental health services.

Source: [4]

More recently, the special module on health from the Quarterly National Household Survey (QNHS) in 2015 provides a useful picture of prevalence of self-reported depression in Ireland [5]. The results show a substantial prevalence (in last 2 weeks) – mild (18%); moderate (5%); and moderately severe or severe (3%) (Figure 2.1). The published data also show a variety of

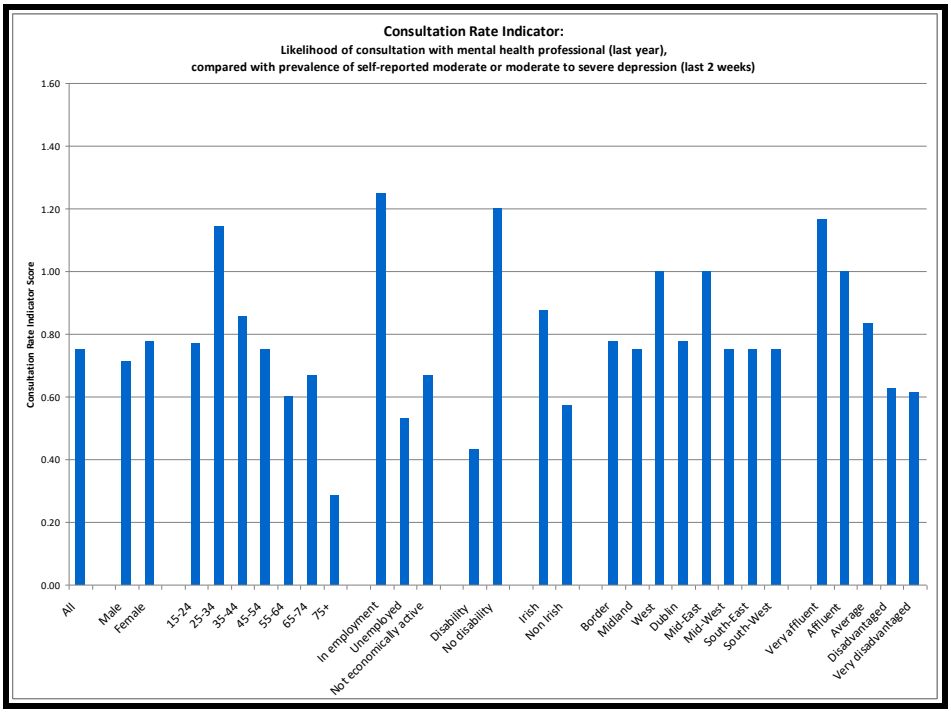
socio-demographic and socio-economic patterns in prevalence, as well as in broader patterns of consultation with specialist mental health professionals (such as a psychiatrist, psychologist, psychotherapist) (Figure 2.2). In practice, GPs are typically the key initial point of contact for people with symptoms of depression. Analysis of the microdata from the survey would be necessary in order to examine this aspect.

Figure 2.1 Prevalence of self-reported depression (last 2 weeks) - QNHS 2015



Source: derived from data presented in CSO (2016)

Figure 2.2 Consultation Rates across socio-demographic groups (past year) - QNHS 2015



Source: own calculations based on data from CSO (2016) Note: the published CSO data is presented as percentages rounded to nearest whole number; therefore, the indicator scores are cruder and less accurate than would be the case using un-rounded values

The data shows that people who consider themselves to have a disability report much higher levels of depression. Other notable features are the higher rates amongst women, younger age groups, the unemployed, non-Irish and the less affluent, especially the very disadvantaged. Based on the published data it is possible to construct a crude indicator of consultation rates with specialist mental health practitioners (although consultation patterns with GPs would require analysis of the survey microdata), relative to need, across the different groups. This shows likelihood of consultation declines with age; people in employment are much more likely to consult than unemployed or inactive persons; people without disability are much more likely to have consulted in past year; and a strong inverse gradient according to the affluence/disadvantage dimension.

2.2 Ireland in an international perspective

In the international context, Ireland has a unique public-private mix that characterises the overall healthcare system and also the mental healthcare component of this. A challenge for the refresh of AVFC will be to find ways to accelerate progress now (within the current system structure) whilst also addressing mental healthcare reform within any wider reform of the overall healthcare system.

Whilst recognising the complexities of meaningfully comparing mental health care systems across countries, the evidence review also looked at available data enabling some degree of comparative positioning of Ireland against other countries. This was important for guiding the more focused international evidence and good practice review. It may also provide a useful starting point for any future comparative benchmarking of Ireland in the context of the planned refresh of AVFC. The approach included a cross-country (comparative) perspective and more detailed examination of a number of selected countries.

2.2.1 Cross-country (comparative) perspective

A Eurobarometer survey conducted in 2010 provides some comparative data on mental health related service usage in Ireland and other European countries [6]. One aspect concerns rates of consultation with a professional (in the last 12 months) for a psychological or emotional problem. The Irish rate of 12% is a little lower than the EU average of 15%. As in other European countries, general practitioners were the most frequently consulted in Ireland. Rates of consultation with psychiatrists and psychologists in Ireland were about the European average, although rates of consultation with a psychologist were considerably lower than some other countries (particularly Denmark, Sweden, Netherlands and Spain).

The Eurobarometer survey also presents reported rates of antidepressant consumption in last 12 months. It shows the Irish rate (6%) as just a little below the EU average (7%). Other data from the Eurobarometer survey present reported patterns of usage - regularly for a period of at least a 4 week period; regularly for a period of less than 4 weeks; and took from time to time when felt the need to. The survey also provides data on reported reasons for taking the medication - chronic pain; depression; and anxiety. For future surveys it would be useful to collect data on use of brief psychological therapies as well.

More generally, the cross-country review covered material available from international agencies (especially WHO and OECD) as well as other useful sources. Material from this part

of the work is drawn-upon extensively in later sections of the report. Box 2.5 presents some high level themes against which to position the current Irish situation.

Box 2.5: Positioning Ireland in an International perspective
• Over the years there has been increasing recognition in Ireland of the **cross-cutting importance of mental health**, and the mental health care system, **across many aspects of social and economic policy**; however there have been just a few cross-departmental efforts so far, and a number of other countries have addressed this in concrete ways that may provide insights for enhancing this aspect of Irish policy. • In line with many other countries, the **de-institutionalisation agenda** has significantly progessed in Ireland, although various aspects require further attention (such as ensuring the appropriate level of availability of in-patient beds, reinforcing efforts to provide alternatives to admission where desirable, and improving the quality of care and experience for in-patients). • The **community and broader ambulatory care system for mental health disorders** has been developing since AVFC, and guided by the AVFC vision; however, the current system is still under-developed in comparison to better functioning systems in a number of other countries. • The **proportion of overall public health spend allocated to mental health** in Ireland is relatively modest, especially when compared to countries considered amongst the better performers in mental healthcare service provision; although difficult to measure and even more difficult to make direct international comparisons, Ireland would appear to have a middle ranking in a European league table on this aspect, as well as remaining below the targets set in AVFC.
Source: the authors, based on the international review

2.2.2 Closer examination of selected countries

To provide a more differentiated perspective, the evidence review also prepared short profiles of mental healthcare systems in selected countries. The selection aimed to cover countries generally recognised, or known to the research team, as examples of well developed systems some of which have also recently considered significant reform. These countries provide useful illustration of approaches and innovations that may have potential in the Irish context. Guided by this, a pragmatic approach was also applied in country selection, especially as regards ready availability of appropriate system descriptions. The profiles cover eight countries - England; Scotland; Northern Ireland; the Netherlands; Sweden; Italy; Canada; and Australia. These provide a mix of UK countries, other European countries with quite different mental health care systems, and two English-speaking countries from further afield.

Box 2.6 presents an overview of some of the relevant features in these countries. Annex 1 presents more detailed profiles of each country.

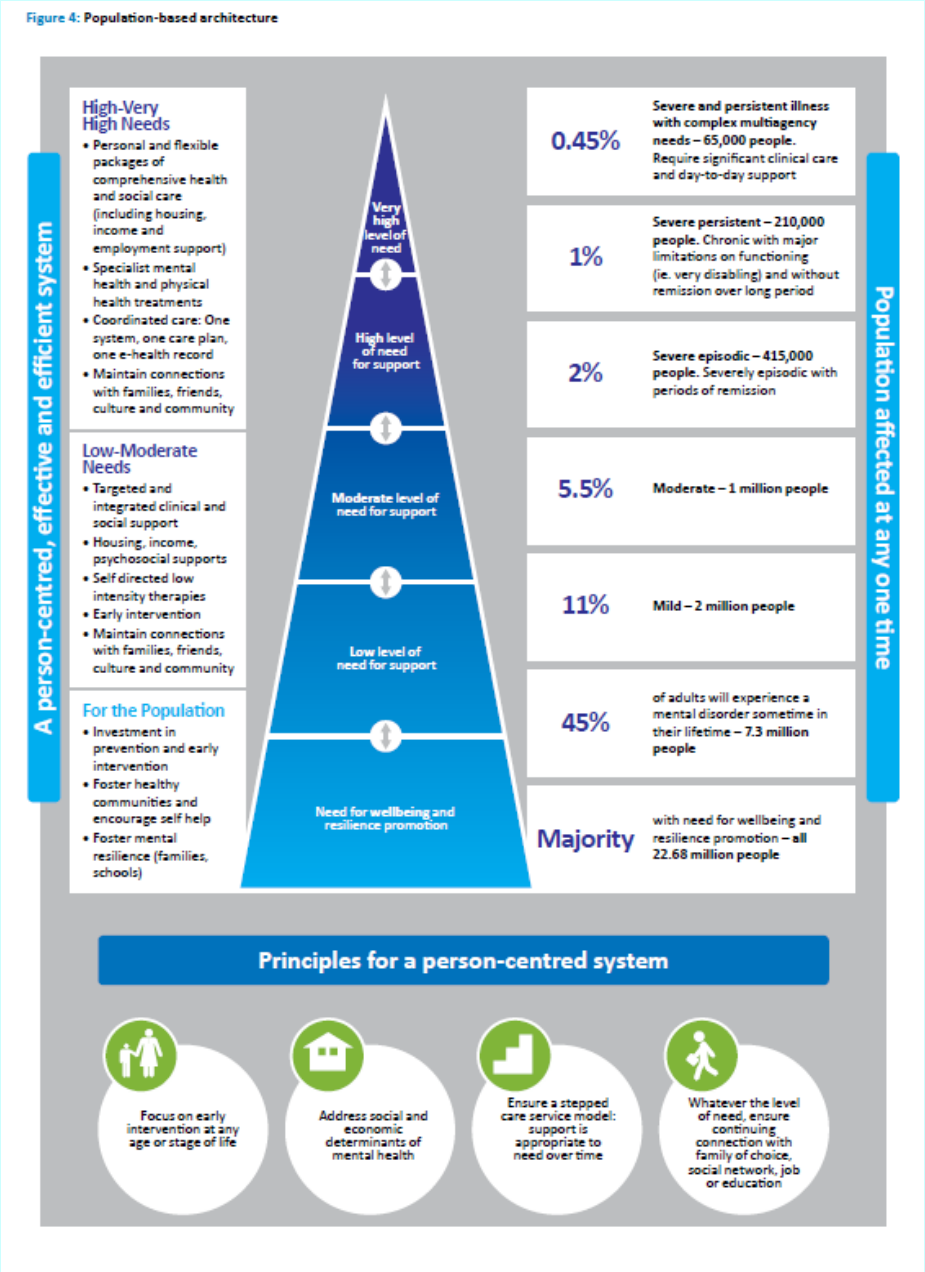
Box 2.6: Illustration of some relevant features of mental healthcare in other countries
England: One aspect of interest in England is the development and utilisation of mental health outcome measures in making decisions about public sector commissioning of mental health services. Outcome-based frameworks include the NHS Outcomes Framework, Clinical Commissioning Group (CCQ) Outcomes Indicator Set, and Quality and Outcomes Framework (QOF). Parity of esteem for mental health within the wider healthcare system is also a recent policy focus. More generally, there has been a very strong focus on mental health promotion and wellbeing services, and on intersectoral work, for instance with schools, employers and the police. At the strategic level there is also a five year mental health forward view from 2016 prepared by an NHS task force. A national Benchmarking system on mental health services has also been established, making it easier to identify mental health spending at local level. In June 2016, the Secretary of State for Health, rather than a junior minister, became responsible for mental health.
Scotland: Various reforms are outlined in a planned 10 year mental health strategy from 2017, including an emphasis on transforming the way primary care works to incorporate new approaches to responding to mental health problems. This will include helping people manage their own health. Link workers will direct people to non-clinical services and support them to stay in employment, contribute to the economy, and access employment opportunities. There will also be more focus on the premature mortality of people with mental health problems, tackling preventable physical health problems within an overall approach to population health. More generally there is a strong focus on early intervention for young people, including the creation of early intervention for psychosis services and a national roll out of parenting programmes by 2020. A whole-of-government approach to parity between physical and mental health is also planned.
Northern Ireland: The Executive's response to the 2007 Bamford Review of Mental Health and Learning Disability has dominated reform in the last decade. The Bamford Report envisaged a 10-15 year timescale for full implementation of its recommendations. The Transforming Your Care (TYC) review of progress in 2011 may be of interest in the context of a refresh of AVFC in Ireland, and also a more recent review of developments for the Northern Ireland Assembly [7]. The 2012-2105 Bamford Action plan included a commitment to a programme to facilitate an enhanced culture of recovery across all mental health services. It also included actions to develop early intervention services, including psychological therapy services, and to build up some highly specialist services including eating disorders and perinatal mental health. Goals for more promotion, including school based promotion, were also included. By 2014, Pilot Primary Care Talking Therapy Hubs had been set-up in each Trust and over 5,000 people had signed up for the computerised CBT *Beating the Blues* programme.
Netherlands: The Dutch model of health (and mental health) care delivery through universal health insurance provides insights for Ireland. Its arrangement requiring that all insurers offer a basic benefit package at an agreed price applies also for mental health care services. Strong information systems and transparency underpin this system, facilitated by meaningful involvement of and influence by all stakeholder groups. These include patient/family groups, mental health professional groups, service providers, insurers, and an overall government regulatory role. There is also a wide network of early intervention in psychosis teams around the country. The Dutch model of Flexible Assertive Community Treatment (FACT) is a good example of integrated care for people with enduring mental illness, delivered in a flexible manner by multidisciplinary teams to meet changing needs, as well as managing crises if they occur. FACT teams include a broad range of professionals such as psychologists, psychiatrists, addiction specialists, nurses, peer counsellors, and employment placement service specialists. Also of interest in the Netherlands is that employers are responsible for long term sick leave and there have been many employer initiatives to promote mental health at work and help in return to work.

Box 2.6: Illustration of some relevant features of mental healthcare in other countries (continued)
Sweden: A multidimensional quality framework – Good Care – has been developed to monitor the performance of the mental health care system. Dimensions covered include safety, effectiveness, patient centeredness, equity, efficiency, and timeliness, and allow for comparisons between regions and patient groups. Other relevant innovations include internet-based cognitive behavioural therapy (CBT), suicide reporting initiative (Lex Maria), and the national strategy for parental support targeting early mental health wellbeing.
Italy: One recent initiative has focused on reducing the number of forensic psychiatric hospitals and the transition of resources to newly established small-scale residential facilities or community-based care arrangements with less restrictive security environments. There have also been a variety of mental health initiatives in the regions. One example in northern Italy focuses on early intervention in psychosis implemented through routine mental health services. It provides multi-component psycho-social interventions and case management for people with First-Episode Psychosis. Rather than continue to expand specialist teams (which have not had much traction in Italy), it was financially more attractive to re-train existing mental health staff to provide the service.
Canada: Recent developments have been informed by an extensive examination of mental health in Canada by the Mental Health Commission of Canada (MHCC). One interesting aspect of the Canadian approach is the development and application of quite elaborate reimbursement schemes to incentivise GPs. In addition to recognising the longer time that consultations with people with mental health difficulties may take, there are initiatives focusing on reimbursement regimes to encourage GPs to adopt an ongoing care management role for people with enduring mental health problems. Within the mental healthcare services, the Mental Health Commission of Canada (MHCC) has developed Guidelines for Recovery-Based Practice to support the adoption of the recovery approach. The MHCC's Canadian Recovery Inventory supports knowledge sharing in this area.
Australia: A current policy focus is to shift resources from 'downstream' areas (such as un-necessary hospitalisation or mental health related disability benefits) to 'upstream' areas such as mental health promotion, prevention, early intervention and community-based services. There are also major initiatives around the development of Headspace, a national foundation targeted at young people to address general mental health and wellbeing issues and also provide early intervention for psychosis. Other innovations include actions on vocational rehabilitation and on physical health improvement for people with mental health problems. There has also been innovation in eMental Health services. The government has set up a Virtual Clinic providing real-time online counselling or phone-based counselling services by a trained CBT counsellor, with this seen as one of the alternative cost-effective therapy options to traditional face-to-face offline services.
Source: the authors, based on the international review

2.3 Frameworks underpinning the wider evidence and good practice review

A number of frameworks helped to guide and support the work on the wider evidence and good practice review. At an overarching level, a population architecture perspective guided the approach and underpins the various aspects of mental health policy and practice addressed in the report. Box 2.7 presents an example of this perspective from Australia.

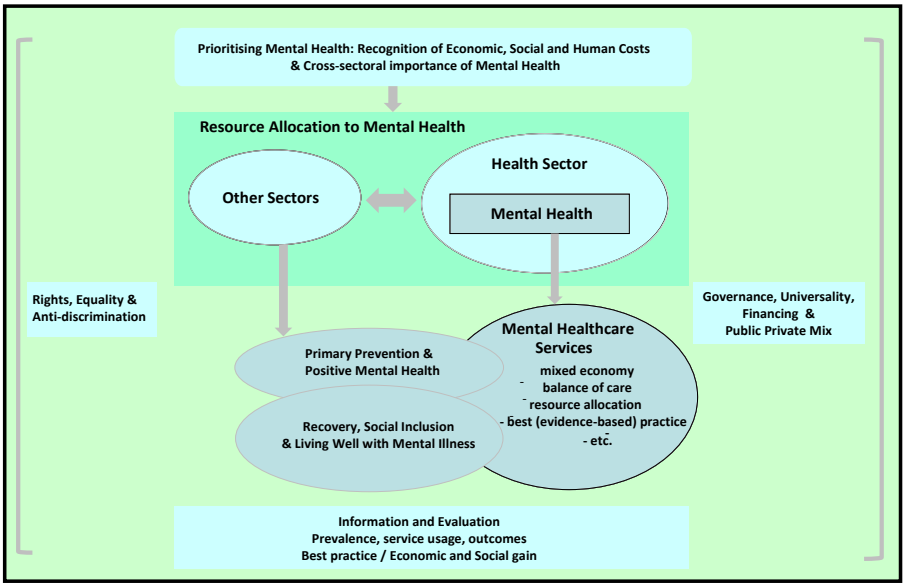
Box 2.7: A population-based architecture for mental health interventions



Source: [8]

The research team also developed some more operational frameworks to identify key themes and help focus the review work. Figure 2.3 presents the general framework employed for this purpose. Chapter 3 addresses the issues around prioritising mental health as a major societal issue and the cross-sectoral roles and responsibilities in this area.

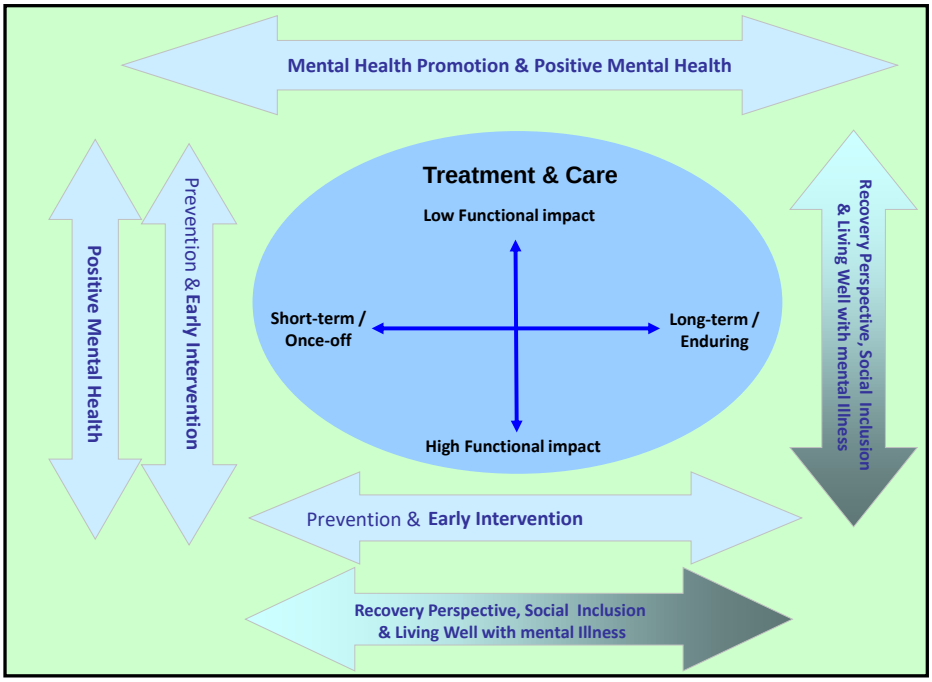
Figure 2.3 General framework for wider evidence and good practive review



Source: the authors

Figure 2.4 presents a more focused conceptual framework that helps to map the terrain addressed in Chapters 4, 5 and 6. This includes primary prevention and positive mental health, recovery and social inclusion, and mental healthcare treatment and care services.

Figure 2.4 Conceptual Framework underpinning Chapters 4, 5 and 6



Source: the authors

3 Prioritising Mental Health as a major societal issue

Since the publication of AVFC in 2006 there have been growing calls, both at home and abroad, for enhancing the policy priority given to mental health. In a recent report - *Making Mental Health Count* - the OECD compiled extensive evidence on the case for prioritising mental health.

> *"Despite the enormous epidemiological, social and economic burden of mental ill-health, mental health care is still not a priority in most health systems. The current weak state of mental health care is unacceptable. More must be done to make mental health count and improve the lives of those suffering from mental ill-health: policy makers must give mental health the importance it demands in terms of resources and policy prioritisation."* [9]

An Irish economic analysis conducted two years after the publication of AVFC echoes this:

> *"Given the multi-faceted impact of mental health problems and the many and damaging consequences of poor mental health, it is surprising how little attention has been focused in Ireland on the economic and social returns to greater investment in mental health. The evidence suggests that it is possible to impact on many of the elements that contribute to the development of mental health problems if the political will exists to direct more resources towards mental health. Although per capita expenditure on mental health care has increased in recent decades in Ireland, spending as a proportion of GNP remains low in comparison with similarly developed countries in Europe. Clearly, we have not yet made the connection between increased public spending on mental health care and individual and societal gains. Making mental health a national health priority in Ireland would be an important first step in realising the potential gains associated with increased spending on mental health. As part of that prioritisation, we should set a target of 10 per cent for mental health care expenditure as a proportion of overall health expenditure, to be realised over a five year period."* [10]

This Chapter presents an overview of evidence on the case for prioritising mental health, focusing on three aspects:

- quantifying the economic and wellbeing dimensions of mental health
- mental health as a cross-sectoral concern
- mental health in the wider healthcare system.

3.1 Quantifying the Economic and Wellbeing dimensions of Mental Health

There is now convincing evidence of the economic and human costs of mental health disorders. This includes Irish evidence [10] and a large body of evidence from international agencies and other countries.

3.1.1 Economic costs

The economic costs of mental health disorders are enormous, with figures suggesting this may amount to as much as 4% or more of GDP in some countries. Although substantial costs accrue to mental healthcare systems, the main economic costs are located in the labour market and social protection systems, not just for those experiencing poor mental health but

also impacts for other family members. Box 3.1 presents some illustrative data on economic costs of mental health problems as a whole.

Box 3.1: Wider economic costs are greater than mental health care system costs

Ireland

- Estimated that the overall economic cost of mental health problems was just over €3 billion in 2006, equivalent to 2 per cent of GNP at that time; this does not include the significant human and social costs associated with mental health problems (such as pain, suffering, stigma, reduction in quality of life and suicide)
- The health care system accounted for less than one quarter of overall costs; the main economic costs are located in the labour market (lost employment, absenteeism, lost productivity and premature retirement).

Source: [10]

International

- Mental health costs can be 4% or more of GDP in some countries

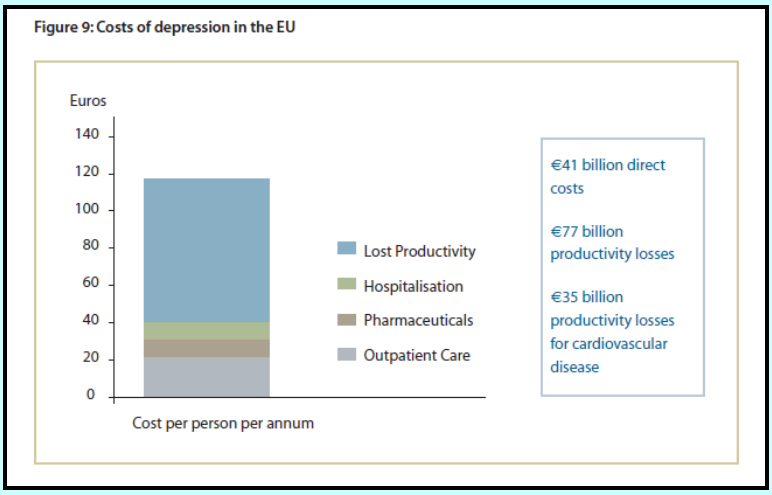
Country, year	Direct costs[1] (billions)	Indirect costs[1] (billions)	Total costs (billions)	% of GDP
Canada, 2011	CAD 42.3	CAD 6.3	CAD 48.6	4.40
England, 2009/10	GBP 21.3	GBP 30.3	GBP 51.6	4.10
France, 2007	EUR 22.8	EUR 21.3	EUR 44.1	2.30
Global, 2010	USD 823	USD 1 670	USD 2 493	

Sources:[9, 11]

Box 3.2 presents some data on the economic costs of specific disorders – depression, schizophrenia, and conduct disorders.

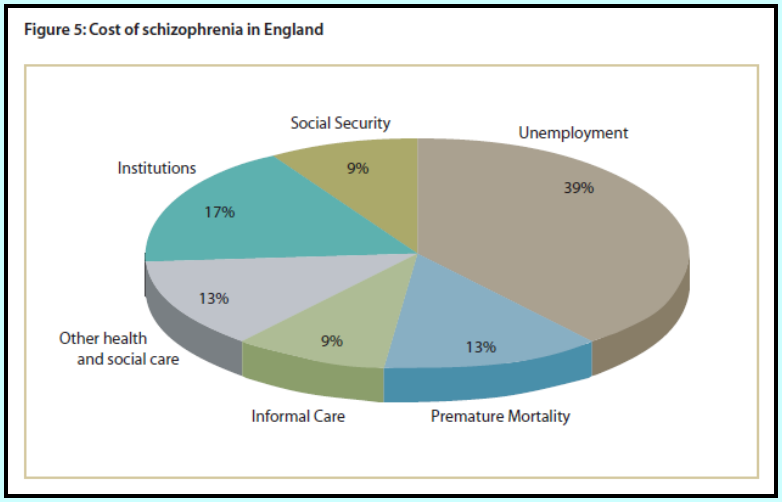
Box 3.2: Costs of specific mental health disorders

Cost of depression in the EU

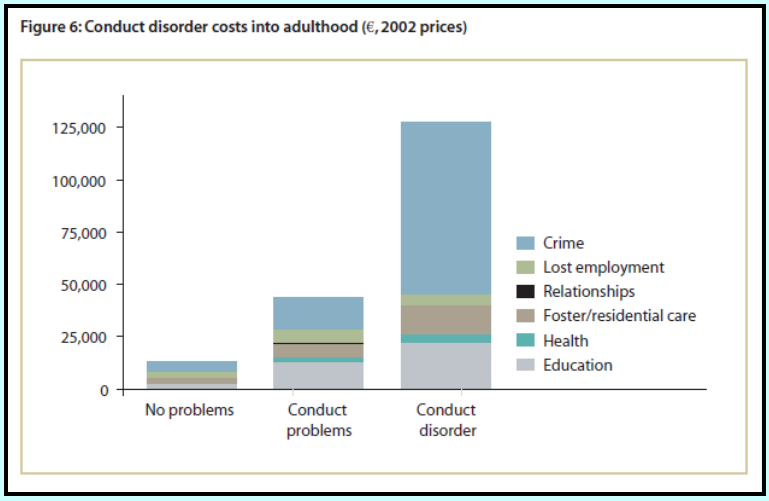


Box 3.2 (continued): Costs of specific mental health disorders

Cost of schizophrenia in England



Cost of conduct disorder in England



Source: [12]

3.1.2 Human costs

Of greater importance, of course, is the human cost. As well as the distress and suffering experienced by people with mental disorders, and often their families, there is increasing work expressing the human costs in quantitative/monetary terms. International data (Box 3.3) show that, in high income countries (such as Ireland), depression and anxiety are amongst the top ranked contributors to years lived with disability. Other ways of quantifying costs, including QALYs and more recent subjective wellbeing approaches also show the enormous human costs of disorders such as anxiety and depression, both in absolute terms and relative to other physical health conditions.

Studies using QALY approaches give estimates for France and UK of between €50 and €65 billion [9]. UK data using an approach that monetises subjective wellbeing impacts of mental health and other conditions found that, of eleven health conditions covered, having either

depression or anxiety is around 5 times worse than the worst physical health condition; and depression and anxiety are over 10 times worse that the average of all other physical conditions [13].

Box 3.3: Quantifying the human costs of mental health disorders

High income countries – Leading causes of Years Lived with Disability 2015

Cause	YLD (millions)	% of total YLDs
Low back pain	12.1	9.21
Neck pain	7.4	5.62
Major depression	7.2	5.48
Other hearing loss	7.1	5.39
Diabetes	6.1	4.62
Migraine	5.5	4.19
Other musculoskeletal	5.4	4.13
Anxiety Disorders	4.8	3.69
Iron-deficiency anaemia	3.6	2.74
Falls	3.5	2.26

Source: [14]

Quality adjusted life years (QALYs) and similar approaches

Health condition	Monetary equivalent
Depression, anxiety	-£44,237
Stomach/liver/kidneys or digestive problems	-£5,556
Migraine or frequent headaches	-£3,336
Difficulty in seeing (other than needing glasses to read)	-£2,791
Epilepsy	-£2,698
Chest/breathing problems, asthma, bronchitis	-£2,052
Heart/blood pressure or blood circulation problems	-£1,422
Problems connected with: arms, legs, hand, feet, back	-£1,201
Skin conditions/allergies	-£895

Source:[13]

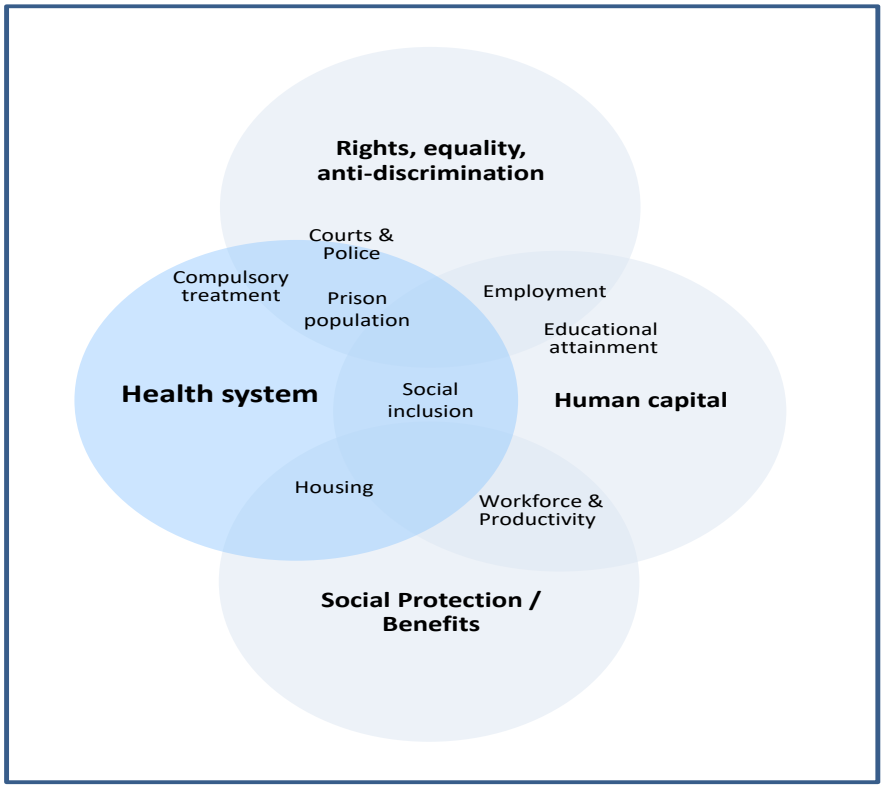
3.2 A Cross-sectoral Issue for Government

There is a strong case for giving as much priority as possible to reducing the burden of mental health problems. In addition, there is growing appreciation of the cross-sectoral nature of the issue for government, as well as understanding of the roles that different sectors have in this sphere. Figure 3.1 shows some of the important sectors and how they relate to the overall ecosystem within which mental health issues manifest themselves and have relevance. As discussed in later Chapters, cross-sectoral actions are essential to underpin the recovery model now espoused in mental health policy and practice in Ireland and elsewhere.

3.2.1 Rights, equality, anti-discrimination

Rights issues in the mental health field are addressed in a number of ways. This includes: specific sectoral legislation (such as the Mental Health Act [15]) and measures in the wider forensic mental health area; equality and anti-discrimination legislation (such as the Equal Status and Employment Equality Acts [16, 17]), and associated measures in this field (including the Disabilty Act [18]); and broader social inclusion policy and measures.

Figure 3.1 Cross-sectoral relevance of mental health issues



Source: the authors

There is ongoing review of mental health legislation in Ireland, including the recent report from the Expert Group [19]. This is an expert field, and our review did not give focused attention on this area. The collation of international material did find some potentially useful inputs to the current work in Ireland. These include a recent report from the Mental Welfare Commission in Scotland (Mental Welfare Commission, 2015) and an earlier review in Northern Ireland from a human rights perspective (Northern Ireland Human Rights Commission, 2003). These are useful in highlighting broader equality perspectives that apply as well as the core legal issues about rights in relation to treatment and capacity to consent.

The broader equality legislation is also very relevant for the mental health field. In Ireland it provides protections for people with mental health problems under the disability grounds. The Equality Authority has produced guidance material in this area [20]. Disability legislation also places sectoral obligations on various public bodies [18]. More generally, mental health falls within the scope of social inclusion policy and of all public bodies with a role to play in promotion of social inclusion. The refresh of AVFC may wish to consider how these different angles on rights and equality may be coherently leveraged to progress the agenda on this aspect of the mental health field in Ireland.

There is also an Interdepartmental Group between the Departments of Justice and Health. The First Interim Report was published in 2016 and focuses on first point of contact with An Garda Siochana to the point where the courts pass sentence after a trial. A second phase is further developing other aspects of this domain, including improving links between the judicial system and the HSE national forensic mental health system as well as other relevant parts of the HSE services.

3.2.2 Housing, Employment, Education and Social Protection

The evidence on the economic and human costs of mental health problems shows the strong relationships between mental health promotion/care systems and other domains, including education and employment (human capital), housing, and the social protection system. In the employment field, for example, recent OECD reports collate a convincing body of international evidence showing the substantial impacts of mental health difficulties for employment rates and unemployment, as well as increasing absenteeism and reducing productivity amongst those working [9, 11]. Employment and housing opportunities are central to recovery for many people with mental illness. Chapter 5 addresses these elements of recovery support in more detail.

3.2.3 The Case for Investment in Mental Health

There has also been considerable innovation in the assessment of the impacts of interventions in the mental health field and of the value for money they can provide for the healthcare sector and for other sectors in the public sphere, as well as for wider aspects of the economy and society. Box 3.4 presents a collation of such studies, illustrating the very substantial return on investments for many different types of intervention and target group [21].

3.3 Mental Health in the wider Healthcare System

In addition to the cross-sectoral implications of mental health concerns it is also important to consider the position and relevance of mental health care within the wider healthcare system of which it is a part. This section addresses two aspects of this issue - parity of esteem for mental health; and co-morbidity and joining-up mental health and physical health care.

3.3.1 Parity of Esteem for Mental Health

AVFC addressed the resource allocation issue in Ireland, suggesting a target yardstick of 8% for mental health from the overall health allocation. Other commentators have suggested higher figures (e.g. [10]). AVFC also presented data showing that the relative spend on mental health had declined considerably in the twenty year period leading up to the report in 2006.

There has been a steady if modest increase in the overall gross non-capital mental health budget funding over the 2012-2017 period. Based on official data, the current percentage budget allocation to mental health seems to be around 6% of overall health allocation, although the percentage varies depending on which elements of overall health expenditure are taken into account as well as what elements of healthcare are included within the mental health allocation (e.g. relevant parts of the social care allocation, and of dementia care services). Chapter 7 of the report addresses these issues in a little more detail. It also presents a comparative positioning of Ireland internationally, suggesting that the percentage resource allocation is lower than in some of the countries with better developed and better performing mental healthcare systems.

Box 3.4: Returns on investment for a range of interventions

Table 13: Total returns on investment (all years): economic pay-offs per £1 expenditure [a]

	NHS	Other public sector	Non-public sector	Total
Early identification and intervention as soon as mental disorder arises				
Early intervention for conduct disorder	1.08	1.78	5.03	7.89
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.33
Early intervention for medically unexplained symptoms [b]	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Early intervention in psychosis	9.68	0.27	8.02	17.97
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45
Promotion of mental health and prevention of mental disorder				
Prevention of conduct disorder through social and emotional learning programmes	9.42	17.02	57.29	83.73
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	–	–	9.69	9.69
Addressing social determinants and consequences of mental disorder				
Debt advice services	0.34	0.58	2.63	3.55
Befriending for older adults	0.44	–	–	0.44

Notes:

a Returns on investment calculated as gross economic pay-offs divided by expenditure on the intervention. Depending on the availability of data, these returns may be calculated over different time periods for different interventions; see Section 2 and Tables 14–16 for details. Returns and expenditures discounted back to present values, expressed in 2009/10 prices.

b For e-learning of GPs, plus CBT for all people with somatoform conditions (including sub-threshold cases as well as those with full somatoform disorders).

Source: [10]

The notion of 'parity of esteem' has become a focus of attention in England and some of the other UK countries (Box 3.5). It encompasses resource allocation issues as well as broader aspects such as professional recognition.

Box 3.5: Parity of esteem for mental health – perspective from England
• Mental illness (including dementia) is responsible for 23% of England's total burden of disease, but receives only 13% of NHS health expenditures (Centre for Economic Performance, 2012). • The 2011 mental health policy for England called for *"No Health Without Mental Health"* • Since then the Government's commitment to parity of esteem was made explicit in legislation (*NHS Mandate 2012*), and in 2014 the action plan for mental health *Closing the gap: priorities for essential change* (HM Government 2014) and the five-year plan for mental health, *Achieving Better Access to Mental Health Services by 2020* (HM Government 2014), were published.
Source: [22]

Although the issue of an appropriate overall resource allocation to mental health in Ireland is important, there may be merit in placing this in the wider frame provided by the parity of esteem perspective.

3.3.2 Co morbidity and Joining-up Mental and Physical Healthcare systems

Another development since AVFC has been the increasing recognition and evidence base indicating the interplay between mental health conditions and physical health conditions. Apart from relatively independent co-morbidities, there are important interactions between mental health and physical health. These include causal associations (in either or both directions) as well as other interactions such as impacts of mental health conditions on management and outcomes of long-term physical health conditions. International studies consistently find mental disorders are associated with much higher risks of all-cause mortality compared to the general population. One recent review reported years of life lost compared to the general population of between 7 and 23 years for different conditions [23].

In England, it is estimated that approximately 30% of people living with a long-term physical health condition also have comorbid mental health problems [24]. This source cites international studies suggesting that co-morbid mental health problems increase the cost of care for long-term conditions by at least 45% [9] and go uncounted in the estimation of the NHS mental health spending. It also cites a UK study suggesting that, in England, between 12 and 18 per cent of all NHS expenditure on long-term conditions is due to poor mental health, representing between £8 and £13 billion each year.

The Healthy Active Lives (HeAL) programme is an example of a targeted initiative aiming to help prevent development of physical health co-morbidities in young people with psychosis (Box 3.6). An associated programme has developed algorithms addressing cardiometabolic issues arising in medication treatment for psychoses (Box 3.7).

Box 3.6 Healthy Active Lives (HeAL): Addressing co-morbidities in youth with psychosis
Originating in Australia, HeAL has published an international consensus statement on a set of key principles, processes and standards. It aims to combat the stigma, discrimination and prejudice that prevent young people experiencing psychosis from leading healthy active lives, and confront the perception that poor physical health is inevitable. Compared to their peers who have not experienced psychosis, young people with psychosis face a number of preventable health inequalities: a lifespan shortened by about 15-20 years; two to three times the likelihood of developing cardiovascular disease making it the single most common cause of premature death (more so than suicide); two to three times the likelihood of developing type 2 diabetes; three to four times the likelihood of being a smoker.
Source: [25]

Box 3.7: Cardiometabolic Risk Management: Antipsychotics (Mood Stabilizers & Antidepressants) - Canada

Monitoring: How Often and What to Do

Applies to patients prescribed antipsychotics and metabolically active mood stabilizers and antidepressants

Frequency: As a minimum review those prescribed a new agent at baseline and at least once after 3 months. Weight should be assessed monthly in the first 3 months of taking a new antipsychotic as rapid early weight gain may predict severe weight gain in the longer term. Subsequent review should take place annually unless an abnormality of physical health emerges, which should then prompt appropriate action and/or continuing review at least every 3 months.

	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually
Personal/FHx	X					X
Lifestyle Review[1]	X	X	X	X	X	X
Weight/WC	X	X	X	X	X	X
BP	X			X		X
FPG/HbA1C	X			X		X
Lipid Profile[2]	X			X		X

History: Ask about family history (diabetes, obesity, CVD in first degree relatives <60 yrs), gestational diabetes. Note ethnicity.

[1]Smoking, diet, and physical activity [2]If fasting lipid profile cannot be obtained, a non-fasting sample is satisfactory

Derived from consensus guidelines 2004, j clin. psych 65:2

Review of Antipsychotic Medication

Choose lower metabolic liability medication first-line when possible. Response in first episode psychosis is robust independent of agent.

Changing or discontinuing antipsychotic requires careful clinical judgment, balancing metabolic benefits against relapse risk. Ideally psychiatrist supervised. Should be a priority if there is:
- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causative role in these abnormalities and, if so, whether an alternative regimen could be expected to offer less adverse effect:

If clinical judgment and patient preference support continuing with the same treatment then ensure appropriate further monitoring and clinical considerations.
Avoid antipsychotic polypharmacy when possible; Avoid off-label use of antipsychotics.

Specific Adjunctive Pharmalogical Interventions

For mitigation of excess weight gain associated with antipsychotic use, the strongest evidence is for off-label use of Metformin and Topiramate (Mayan, 2010). Consider Metformin first due to better tolerability profile unless there is a co-morbid binge-eating disorder (McElroy, SI, 2009). Please be advised that off-label use requires documented informed consent. Discontinue if no sign of efficacy (continuing weight gain if used for weight loss or stabilization) after 3 months at therapeutic dose.

Metformin:
Weight Gain & Primary Prevention of Diabetes : Start 250 mg po BID, titrate every 1-2 weeks as clinically indicated and tolerated. Dose range is 750 mg - 2 Gm/day

Caution with renal or hepatic impairment. Avoid excessive alcohol use. Monitor for GI side effects. Monitor for B12 deficiency.

Topiramate:
Weight Gain: Start 12.5 mg po BID; titrate by 25-50 mg per day in divided doses every 1-2 weeks as tolerated to a maximum of 100 mg po BID.

Caution with renal or hepatic impairment. Avoid excessive alcohol use. Monitor for cognitive changes. Parasthesias are common but generally well-tolerated.

DON'T JUST SCREEN: INTERVENE!

FOR ALL PATIENTS IN THE *DANGER ZONE*

The primary care provider and psychiatrist will work together to ensure appropriate monitoring and interventions are provided and communicated to avoid over or under monitoring. The primary care provider will usually lead on supervising the provision of physical health interventions. The psychiatrist will usually lead on decisions to significantly change antipsychotic medicines.

The | Le Royal — Mental Health - Care & Research / Santé mentale - Soins et recherche

Ontario Shores — Centre for Mental Health Sciences

The Ottawa Hospital | L'Hôpital d'Ottawa

Waypoint — Centre for Mental Health Care / Centre de soins de santé mentale

camh — Centre for Addiction and Mental Health

Adapted for use by the Ontario Metabolic Task Force. With permission from Curtis J, Newall H, Samaras K. © HETI 2011; Shiers, D et al

Source: [26]

4 Primary Prevention and Positive Mental Health

Mental health issues are pervasive across the population and at all stages of the lifecycle, with a very broad spectrum of manifestations, impacts and requirements for support. Both in Ireland and internationally, increasing attention is given to primary prevention of mental health disorder, mental health promotion, and positive mental health.

The fields of primary prevention and mental health promotion encompass both universal actions delivered to the general population or everyone in a specific setting, e.g. in a school, as well as selective actions targeted at specific population groups identified as at higher risk of developing mental health problems, such as those in insecure employment or the long term unemployed. Irish researchers are quite prominent in research on the promotion of mental health and wellbeing, for example in programmes targeting young people.

The concept of 'positive' mental health has gained traction in recent years. Concepts like resilience are relevant in this domain, referring to capacity to cope with the ups and downs of life without succumbing to mental health problems. This is increasingly incorporated into mental health promotion programmes, including those targeting school settings. The Eurobarometer survey in 2010 provides some comparative data on aspects of positive mental health [6]. The data suggest that Ireland fares above average on a number of indicators of positive mental health or wellbeing, although somewhat less well in terms of frequency of feeling worn out or tired.

The positive mental health perspective also brings to the fore the idea that 'mental health' is not just an absence of 'mental illness' but is a separable, albeit often linked characteristic focusing on positive wellbeing. This is very relevant in the recovery context, with an emerging evidence-base showing that some people with significant enduring mental health conditions can have good mental well-being (e.g. [27, 28]). Chapter 5 takes up this theme from the perspective of 'living well with mental illness'.

There are variety of policy approaches to primary prevention and mental health promotion in Ireland and internationally. Mental health promotion may be a component of broader mental health policy or focused on health promotion for different age groups (e.g. children) or sectors (e.g. workplaces), or addressed through separate standalone mental health promotion / disorder prevention policies. Funding may come from the mental healthcare sector, from sectors such as education or employment, or from some combination of sectors. This material in this section of the report draws on a forthcoming international review of this field [29]. It covers a number of areas:

- Perinatal mental health
- Infants, children and young people
- Initiatives in educational settings
- Workplace mental health promotion
- Unemployed persons
- Older people
- Suicide prevention and initiatives addressing self-harm.

4.1 Perinatal mental health

The perinatal period (pregnancy to 1 year) brings risks of mental health problems for some women and is also an important period for early intervention and mental health promotion more generally. While there has been a debate about the merits of universal rather than targeted screening in the perinatal period, some major guidelines, such as the 2016 guidance of the US Preventive Services Task Force, recommend routine depression screening in women in the perinatal period [30]. Australia is among countries introducing universal screening programmes for perinatal depression (Box 4.1).

Box 4.1: The National Perinatal Depression Initiative in Australia
This initiative includes routine and universal screening for depression for women during the perinatal period (once during pregnancy and again about four to six weeks after the birth) by a range of primary and maternal health care professionals. Health care professionals receive training to help screen and identify women with perinatal depression. Appropriate follow up treatment for women with, or at risk of perinatal depression, include focused psychological treatment, counselling services, networks of support groups for new mothers, acute inpatient mental health care and community-based care and support. In total $120 million from all state and territory jurisdictions has been invested in the scheme to support the roll out of the service. Specific additional Commonwealth funding of $2m over four years (until 2016-17) was allocated to the national depression initiative beyondblue to continue to provide on-line training for health professionals and to raise community awareness about perinatal depression nationally.
Source: [29]

Other countries which have expanded activities to address perinatal depression include England, where NICE guidelines on the management of perinatal mental health recommend having a general discussion about mental health and wellbeing with all women upon first contact with primary care (or her booking visit) and during the early postnatal period. There are also several national training initiatives, including the Health Visitor Champions training and the Perinatal Mental Health Training for midwives in England.

A similar role is played by health visitors in Denmark and Finland. Finnish first time parents may also participate in one of the many Parents First groups in the country [31]. The scheme, which is free for parents, promotes better attachment between parents and their infants, and their mental strengths to cope with parenting.

Much of the focus of perinatal mental health has been on depression, and commensurate attention is needed for other mental health problems, to include anxiety (rates may be high and often missed or inaccurately diagnosed) and psychosis. More generally, screening is important but integration of services is also a key issue. The refresh of AVFC may wish to give attention to these aspects, in particular the integration of services (mental health, maternity, GPs, and public health nurses) and development of specialist perinatal mental health services. The approaches in New Zealand provide an example of focused efforts in this area. This recognises the challenge of developing an effective approach to provide specialist perinatal mental healthcare inputs within the more general continuum of care over

the perinatal and early parenting/childhood years. A ministry report reviewed evidence and current services and explored different options for developing perinatal and infant mental health services in New Zealand (Box 4.2)

Box 4.2: Continuum of perinatal and infant mental health services across universal, primary and secondary health services

Configuration	Opportunities	Challenges
OPTION ONE: Develop specialist maternal and infant mental health and AOD expertise within existing CAMHS or maternal mental health services	• Potential for faster and less expensive implementation • Builds on existing networks	• Difficult to develop a specialist service with orientation to both mothers and infants within the dominant clinical culture of an existing service • Lack of existing linkages and collaboration with key providers in the continuum of care eg, CAMHS with LMCs or maternal mental health with paediatric services • Maternal mental health services are not set up for older infants and preschoolers up to their fourth birthday
OPTION TWO: 'Virtual team' comprised of specialist staff members from both CAMHS (infant mental health) and maternal mental health (or adult community mental health and AOD) services co-working in dedicated clinics	• Flexible configuration that allows dedicated time and development of specialist expertise in clinicians with some other responsibilities • Suits smaller DHBs that cannot support a full-time service • Flexibility of coverage from pregnancy to infant's fourth birthday	• Logistics of organising clinics when other clinical priorities intrude • Difficult to establish permanent clinical staff for virtual teams • Risk that vacancies or lack of commitment from one team impacts on the other • More difficult for part-time teams to communicate and collaborate with referrers and other agencies
OPTION THREE: Stand-alone specialist infant and maternal mental health service that combines infant, maternal and family mental health (including AOD)	• Provides opportunity to develop expertise and own 'new' and 'joined up' clinical culture and networks • Ideal configuration for larger DHBs with support responsibilities for smaller DHBs • Flexibility of coverage – pregnancy to infant's fourth birthday	• Proliferation of specialist services increases interfaces and potentially exacerbates boundary issues • Risk of de-skilling of generic secondary MH/AOD services that always defer to specialist service • Self-contained specialist MH/AOD service becomes less engaged with the rest of Health
OPTION FOUR: The service configuration in option two or three working within perinatal or Well Child / Tamariki Ora services	• Potentially strengthens collaboration with critical non-mental health/AOD services • Reduces stigma for service users • Simplifies service user clinical pathway by facilitating access through existing service providers with which they have already engaged	• Risk of professional isolation for mental health and AOD clinicians working in a predominantly physical health environment • Over time, collaboration with mental health and AOD services may diminish • Perinatal services are not set up for older infants and preschoolers up to their fourth birthday

Source: [32]

4.2 Infants, children and young people

Good mental health in the first few years of life is associated with better long-term mental, physical and social outcomes. A growing body of literature highlights the importance of early intervention and prevention programmes for the prevention and treatment of early

childhood behavioural problems and promotion of child mental health and wellbeing [33]. Effective interventions include support for maternal mental health during the perinatal period, parenting support programmes in both infancy and pre-school years, and specialist parent support programmes for very high risk groups, where parents may have severe mental health problems or may be neglecting their children [34].

Parenting programmes have attracted national and/or regional governmental support in many jurisdictions including Ireland, England, Australia and Germany. In England, for example, the Parenting Early Intervention Programme provided funding from the Department for Education to deliver evidence-based parenting programmes in all local authorities [35] and local authorities across the country continue to offer parenting programmes.

Many high-income countries support websites and other sources of information and advice on parenting. In Ireland, the NGO Barnardo's operates a database providing information on parenting courses that are available around the country. The government's Child and Family Agency has a strong focus on helping positive parenting, with online information for parents of children of all ages; this advice covers topics including communication, bonding and attachment, dealing with stress and bullying. It also has a guide on how to help parents help their children to cope with the emotional impact of the recent recession.

Children whose parents have mental health problems are at increased risk of poor mental health themselves. Multi-component programmes are emerging that identify and then support these children to protect their mental health. Examples of these initiatives can be seen in Finland, Norway and the UK.

4.3 Educational settings

Adverse experience and poor psychological wellbeing in childhood may have long-lasting and profound consequences, which not only last into adulthood but affect future generations. There is already an evidence base showing that a range of interventions can be delivered in school for the benefit of mental health, as well as social, emotional and educational outcomes [36]. Many of these interventions focus on developing social, emotional and mental health literacy skills and instilling good behaviours in children, with increasingly strong evidence on the economic case for action.

For instance, KidsMatter in Australia is a national multicomponent programme targeted at primary school aged children that teaches children skills for good social and emotional development. It received $A61 million from the Australian government between 2012 and 2016 in addition to funding from the BeyondBlue initiative on depression and anxiety. For older children, MindMatters provides teacher training and resources to increase the capacity of secondary schools (11-18 years) to implement a 'whole-school' approach to mental health promotion, prevention and early intervention. In England, mental health literacy and resilience programmes may be delivered as part of the Personal Social and Health curriculum delivered in schools. It is up to schools to determine the content of this curriculum and they differ in their approaches.

In Ireland, the Minister for Mental Health and Older People has recently announced a new mental health plan for secondary school students to act as a preventive measure. This is

linked to the Department of Education's plans to roll out a new health and well-being programme with a focus on three age groups: 0-12, 13-18 and 19-25. In England, there have been a number of initiatives in the field over the past few years (Box 4.3)

Box 4.3: Addressing mental health in schools - England
• ***No Health Without Mental Health*** (2010) stresses the importance of preventing mental ill health, and points out that nearly 50% of lifetime mental ill health, excluding dementia, is evident by age 14. Early intervention, including intervention at preschool and school age, has therefore been placed at the forefront of the current government approach to mental health. • Schools are also expected to promote good mental health for students, and remain alert to mental health concerns; ***NICE Public Health recommendation 12 (NICE, 2008***), for example, offers guidelines on social and emotional well-being in primary education, stating that "schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems. They should be able to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed". • The ***Targeted Mental Health in Schools (TaMHS)*** initiative, which ran between 2008 and 2011, was backed with GBP 60 million of funding from the Department for Children, Schools and Families. The programme aimed to tackle emotional and mental health support delivery in schools for children aged 5 to 13, and was found to have had mixed results at the end of the three-year programme. TaMHS provision was found to have led to a decrease in the onset of problems in primary aged children (aged 5-11), but not at secondary level, or for pupils who had emotional and behavioural difficulties prior to the establishment of the scheme. For further information see ***"Guidance on commissioning targeted mental health and emotional well-being services in schools"*** (Department for Education, 2010a) and ***"Me and My School"*** (Department for Education, 2010b).
Source: [29]

Tackling / preventing bullying and Cyberbullying

Schools also provide an opportunity to address bullying, a phenomenon that can affect children and young people of all ages. It includes both direct aggressive behaviour (e.g., physical intimidation, verbal threats) and indirect aggressive behaviour (e.g. exclusion, rejection). Intense bullying in childhood is associated with adverse impacts throughout the life course, including higher rates of mental illness and poorer rates of employment / career opportunities.

For example, recent analysis in Denmark for children born between 1990 and 1992 looked at the association between being bullied by age 10 – 12 on education, health and crime outcomes by age 18 [37]. This found higher educational outcomes, lower rates of teenage pregnancy, lower body weight and lower use of psychopharmacological medications for children who had not been bullied. It also identified a higher probability of criminal convictions in children who had been bullied and then become perpetrators of bullying themselves. One example of a promising approach which addresses all types of bullying in and beyond school, including cyberbullying, is the KiVa programme in Finland (Box 4.4).

Box 4.4: The KiVa programme in Finland
KiVa has been developed and now is implemented in more than 90% of all schools in Finland for children between the ages of 8 and 16. KiVa addresses all types of bullying in and beyond school, including cyberbullying. In a non-randomised trial involving more than 150,000 students, participants in the control group were 22% more likely to be victims and 18% more likely to be perpetrators of bullying during the first 9 months of the study (Karna et al., 2011). In another large cluster randomised trial in Finland there was also a small but significant reduction, specifically in cyberbullying, among KIVA participants whose mean age was below 12.87 years. KiVa has also been implemented in multiple countries in Europe and beyond. It is currently the subject of evaluation in Wales.
Source: [29]

In England, state schools must have a behaviour policy in place that includes measures to prevent bullying among pupils. The Department of Education also recommends that all forms of bullying (including cyberbullying) should be handled as a community issue for the whole school. Independent schools are also required to ensure that an effective anti-bullying strategy is drawn up and implemented.

In France, the Ministry of Education now supports a free national telephone helpline to address physical and cyber bullying, as well as a website advice service. By the end of 2016 1,500 trainers were to be in place to reach more than 300,000 people. November 5, 2015 was also the first national day of action against bullying in school and it is also mandatory for schools to have prevention plans in place [38].

Cyberbullying and other new problems associated with the internet and social media

A number of the programmes mentioned above address cyberbullying. However, although there is growing evidence on the prevalence and impacts of cyberbullying on children and adolescents (e.g. [39]) there is less evidence demonstrating the effectiveness of measures to address this phenomenon [40, 41].

In Ireland, there is an Oireachtas report on *Addressing the Growth of Social Media and tackling Cyberbullying* (Joint Committee on Transport and Communications, 2013).
Box 4.5 presents the recommendations made in the report. The refresh of AVFC may wish to revisit this important theme.

In addition to cyberbullying, per se, there are a range of new problems created by technology (e.g. grooming, online gambling, sexual addiction, etc). All of these will require new forms of response from the mental health service and new ways of conceptualising prevention and health promotion. Chapter 6 addresses this topic in a little more detail.

Box 4.5: Oireachtas report on Addressing the Growth of Social Media and tackling Cyberbullying: Recommendations

Recommendation 1
Despite age restrictions put in place by social media companies, many children are opening accounts on social media platforms. The Committee recommends that, where this has been identified, the relevant company must be swift in closing the account and taking down all information in relation to it. Also, parents should be made more aware of their responsibilities in this regard.

Recommendation 2
The Committee recommends that Child Protection Guidelines incorporate guidance for all professionals working with children, to aid them if they encounter issues relating to cyberbullying and inappropriate use of social media.

Recommendation 3
The Committee recommends supporting and reiterating the recommendation contained in the Action Plan on Bullying that the definition of bullying in the new national procedures for schools should include a specific reference to cyberbullying. Also, guidelines specific to cyberbullying should be put in place, so that school principals, who are dealing with instances of cyberbullying, have a clear protocol to follow.

Recommendation 4
The Committee recommends that employers be made aware of the importance of introducing a social media policy, i.e. outlining what constitutes cyberbullying and what actions will be taken if there is a breach of such a policy. Employers should be aware that cyberbullying falls within the term 'harassment' and Section 10 of the Non-fatal Offences Against the Person Act 1997 may apply in such cases.

Recommendation 5
The Committee recommends that a review of international best practice in relation to the registration of prepaid SIM cards be carried out by the Government, with a view to exploring the feasibility of preventing use of these cards for malicious and/or illegal purposes.

Recommendation 6
It is the Committee's view that the Office for Internet Safety does not adequately deal with cyberbullying or with the traceability of tweets and other social media. The Committee recommends that a single body be given responsibility for co-ordinating the regulation of social media content. Funding and organisational models for this agency should be agreed with the industry. It is noted that other examples of industry-led partnerships between stakeholders and government have been established in other sectors in recent years.

Recommendation 7
The Committee recommends continuous professional development for public officials working in criminal justice so that they are given clear guidance on how to deal with cases of bullying and cyberbullying.

Recommendation 8
The Committee recommends that more emphasis be placed on educating parents, teachers and children on how to safely use social media. For children, this might incorporate peer-to-peer learning whereby children mentor their peers. It is the Committee's view that advice and technical support should come from the industry. The SPHE curriculum may also be revised to incorporate this.

Source: [42]

4.4 Workplace mental health promotion

The workplace is an important setting for promoting mental health. Mental Health Promotion (MHP) in the workplace encompasses both a settings approach to health promotion, where the workplace is a location to promote good mental health and wellbeing, and occupational health and safety, where the focus is on eliminating or managing workplace risks to mental health and wellbeing.

The Health and Safety Authority (HSA) estimated that 55,000 workers in Ireland suffered from a work-related illness in 2013 and over 790,000 days of work were lost [43]. Both here and internationally, there is evidence that musculoskeletal disorders (MSD) and stress, anxiety and depression (SAD) are the two largest categories of work-related illness reported by workers themselves. Research by the ESRI found these two types of illnesses accounted for 68 per cent of work-related illness in Ireland over the period 2002 to 2013, with MSD accounting for 50 per cent and SAD for 18 per cent [43]. Other Irish data sources providing evidence of the need for mental health promotion (MHP) in the workplace are the National Disability Survey of 2006 [44] and the census of 2011 which provides information on people with an emotional or psychological condition broken down by occupational type.

At policy level, a challenge is to integrate public health concerns with approaches to health and safety. Health and safety typically has a legislative basis whereas Workplace Health Promotion (WHP) is usually a voluntary activity. Health and safety legislation generally mandates action on occupational mental health risks (typically stress-related risks). This may cover occupational stress only or also include more general mental health provisions. In New Zealand, for instance, the Health and Safety at Work Act 2015 explicitly includes mental health in the workplace. Employers and organisations need to consider the mental health of their workers when planning a safe workplace, and employers who ignore this could find themselves facing penalties including imprisonment and fines.

Actions in the workplace beyond health and safety depend heavily on the willingness of public and private sector organisations to invest in mental health promotion. Larger businesses in many high-income countries are likely to have WHP programmes or employee assistance programmes (EAPs), which often cover stress and other mental health problems.

Box 4.6: Voluntary national standard for psychologically healthy and safe workplaces in Canada.
With government support, the Mental Health Commission of Canada launched a voluntary national set of guidelines to sustain psychologically healthy and safe workplaces in 2013 [45]. The guidance has been designed for workplaces of all sizes and sectors. It provides information on identification and assessment of risks to psychological health and on practices to reduce and mitigate this risk, and promote a mentally healthy workplace culture. Some workplaces may use the guidance to focus on creating policies and processes to promote good mental health, while others may use it to inform training programmes. In addition to the detailed guidelines a range of online resources are available for both employers and employees, together with case studies on how the guidance is being adopted in different Canadian workplaces. Evaluation of the impact of the guidance, including the economic costs and benefits is also underway
Source: [29]

Support for workplace MH promotion and illness prevention through voluntary guidelines has been a major focus of the work of the Mental Health Commission of Canada (Box 4.6).

There are some policy initiatives dealing with mental health at the workplace and MHP in Ireland. In 2008, the Health and Safety Authority published a workplace wellbeing strategy [50] which sought to raise awareness of the importance of the wellbeing of the workforce and to recommend actions to improve this. More recently, as part of the national wellbeing strategy, Healthy Ireland plans to develop a workplace element. Although still under development, this may be statutorily based and may include MHP actions as a means of promoting the wellbeing of employees.

In England, the Government introduced a pledge on mental health and wellbeing as part of the Government's responsibility deal with businesses and organisations [46]. The pledge promotes workplace wellbeing for all staff, and aims to improve the provision of work related support for people with mental health issues. It asks employers to promote wellbeing and resilience; support managers to recognise and respond to stress or mental health conditions; and apply practical guidance on making reasonable workplace adjustments for employees with mental illness.

In Europe, DG Employment has also developed guidelines for managing mental health issues at the workplace [47]. These go beyond traditional concerns about occupational stress to include, *inter alia*, recommendations on broader mental health issues and on MHP. In addition, the Joint Action for Mental Health and Wellbeing has produced a number of reports on workplace mental health and wellbeing [48, 49].

Measures can also be taken to tackle bullying in the workplace, as seen in the Veneto region of Italy for example (Box 4.7).

Box 4.7: Preventing bullying in the workplace in Italy
In 2010 the Veneto region of Italy passed a law promoting and supporting actions aimed at preventing psycho-social distress at work, including tackling bullying [51]. There is €700,000 per annum available from the regional government to support implementation and the work of a regional observatory which produces annual reports. Training is provided to primary care doctors, mental health services and occupational health services. Local health services are expected to provide advice services on bullying and stress in the workplace and refer individuals to relevant support services; they also are to provide 'reference centres for wellbeing in the workplace' containing a multidisciplinary team of experts, including occupational health professionals, psychologists and psychiatrists.
Source: [29]

Guides on this issue are also published by health and safety regulatory authorities in some countries. This includes a Preventing and Responding to Workplace Bullying guide from Worksafe New Zealand.

There are also a number of EU Commission funded projects which document good practice in MHP in the workplace. Examples include the work of the European Network for Workplace Health Promotion which ran a Europe-wide campaign in the area [52] and the work of EU-OSHA to collect examples of good practice. Health Promotion Award Schemes

are also used to audit company practice in workplace health promotion, and generally include a mental health promotion element. There are good examples in Wales [53] and Scotland [54] as well as in mainland Europe.

4.5 Unemployed

Unemployment is a risk factor for poor mental health, although there appear to be relatively few initiatives specifically targeting this. In England, long-term unemployed persons were a priority group for access to the IAPT (Improving Access to Psychological Therapy) services established in the last decade. The Department for Work and Pensions is also evaluating the impact of psychological supports for health and wellbeing outcomes. In Manchester, the Working Well programme will support older workers with chronic health problems and unemployed people with mental health problems to obtain employment [55].

4.6 Older people

In high-income countries at least 12% of older people are affected by clinically significant levels of depression at any one time [56], with rates as high as 16% reported in some studies [57, 58]. One risk factor for depression is involuntary social isolation and loneliness [59, 60, 61]. A recent meta-analysis of 19 studies also suggests higher risk of developing dementia amongst people with high levels of loneliness [62]. In Ireland, there are befriending services for older persons and evidence that these can significantly reduce loneliness [63].

Some countries have national helplines, such as the Silver Line service in England. Online supports and services have also emerged. They may ofer chat type services, or may also offer online cognitive behavioural therapy wellbeing courses tailored to older people with clinical and sub-clinical levels of depression and anxiety disorders, as seen in Australia.

4.7 Suicide prevention and initiatives addressing self-harm

Most high-income countries have actions to prevent suicide, such as restrictions in access to lethal means, as well as safety measures (e.g. on bridges). Guidelines on media reporting and web based information are provided in most countries. Telephone and more recently online counselling services are available in many countries. There also may be training programmes to recognise risk factors for suicide, for example, for gatekeepers such as the police, teachers and primary health care staff. Multi-component suicide prevention initiatives are in place in many regions of Europe, including Ireland, for example as part of the European Alliance Against Depression (http://www.eaad.net/).

Internationally, Ireland is a leading country in research on actions to tackle suicide and deliberate self-harm. Along with Northern Ireland we are almost unique in having a national registry of deliberate self-harm. In England, efforts are in place to increase the use of psychosocial assessments for individuals who attend a hospital accident and emergency department for a self-harm event [64]. There is some evidence of an association between psychosocial assessment (and therefore a plan for follow up support) and lower rates of future self-harm events [65]. A recent Cochrane systematic review also reports that the risk of subsequent suicidal events can be reduced through the use of cognitive behavioural therapy following assessment [66].

5 Recovery, Social Inclusion and Living Well with Mental Illness

The concept of recovery is now emphasised in mental health policy and practice guidance in Ireland, and is a frequent theme in the wider dialogue around mental health issues.

> *For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the 'recovery model' to describe this way of thinking....Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms...There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is hope – the belief that it is possible for someone to regain a meaningful life, despite serious mental illness.* (Mental Health Ireland)

The Mental Health Commission published a framework for *A Recovery Approach within Irish Mental Health Services* [67], and other organisations such as Mental Health Reform have also published documents encouraging the development of the recovery approach [68]. The HSE has also embraced the recovery approach, including development of a National Recovery Framework. Practical initiatives include Advancing Recovery in Ireland (ARI) (Box 5.1), as well as the HSE funding of initiatives like Gateway and Aras Folláin.

Box 5.1: Advancing Recovery in Ireland (ARI)
• Recovery Principles Training'. Sharing their experience of mental health distress in training mental health professionals • Developing 'Recovery Colleges'. Places where service users and providers create and give courses together on recovery. • 'Peer-led involvement centres'. Developing centres that support people with mental distress and are run by people who have themselves have had similar experiences • 'Consumer Panels'. Meeting up together to share their views on the local mental health service and feeding this back to the service. • 'Recovery story-telling'. Supporting people in hospital by sharing stories of their own recovery. • 'Trialogues'. Having community talks about mental health where everyone's voice gets heard and we tackle together the stigma of mental distress.
Source: [68]

In this Chapter the focus is on three dimensions of the recovery approach: housing; employment; and social inclusion. Chapter 6 addresses the implementation of recovery approaches within mental healthcare practice.

5.1 Housing

Access to appropriate housing is a core practical aspect of recovery. This is an area where inter-sectoral roles and responsibilities are important, especially across the remits of the mental healthcare sector and the (public/social) housing sector. In Ireland, both sectors acknowledge the importance of providing suitable housing for people with mental health problems, and they currently address the issue in a variety of ways. Following the direction

advocated in AVFC, the HSE is working on facilitating the transition to independent living for people with mental health conditions who currently live in community-based residential facilities such as HSE hostels, and who desire and can benefit from such a move. The Department of Housing, Planning, Community and Local government also has policies in this field, and there has been some activity through the local authority housing sector.

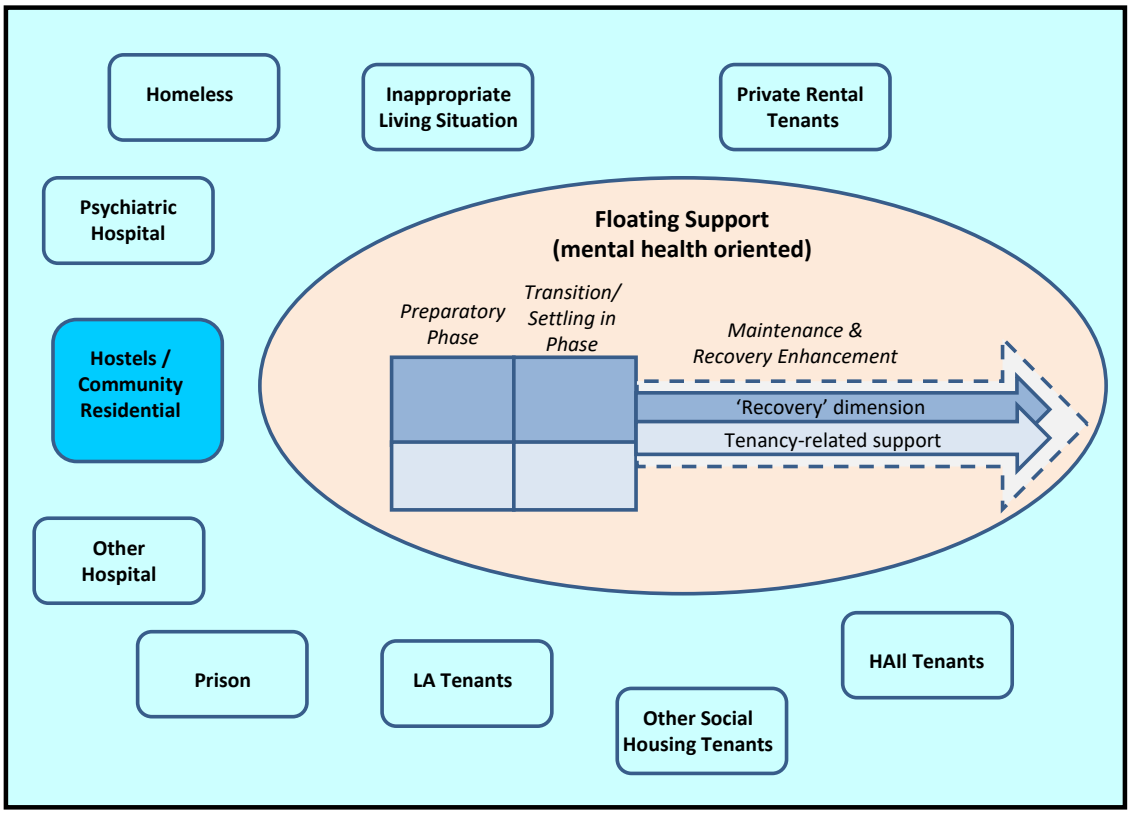
The Housing Agency prepared a review of housing and support options for people with mental health related housing needs [71]. This included some case studies of existing practice in Ireland. More recently, the Housing Agency and HSE launched housing design guidelines to assist those living with persistent mental health conditions [72]. The National Disability Authority has also published guidance on social housing and people with mental health difficulties [73]. More broadly, the *National Housing Strategy for People with a Disability 2011 – 2016* has a specific chapter on housing and people with mental health related disabilities [74]. This outlined inter-working arrangements between the local authority housing sector, HSE and other relevant players.

More generally, the social housing sector in Ireland has an important role in this field, through the direct provision of housing stock that may meet the needs of people with enduring mental health difficulties and, in some cases, through provision of specialist supports in this area. HAIL is one of the bodies to the fore in this area, providing both housing and tenancy sustainment services for people with mental health difficulties (Box 5.2). They are working with HSE to pilot support services to help the successful transition and sustainment of people with mental health difficulties moving from HSE hostels to independent living.

Box 5.2: HAIL - Mental Health Tenancy Sustainment Support Service
HAIL has a team of community based Mental Health Tenancy Sustainment Workers who work directly with those tenants who need additional support to manage their tenancy. Our Mental Health Tenancy Sustainment Workers provide a wide range of services in order to help our tenants settle in initially and then integrate into their community. The amount and type of support will vary depending on the needs of the tenant and will be very specific to the individual. We request that all tenants residing in our supported accommodation link in with our Mental Health Tenancy Sustainment Service. The tenant is central to identifying their needs and creating a support plan with their Mental Health Tenancy Sustainment Worker. The types of support offered include (but are not limited to): settlement planning and support; tenancy sustainment; mental health recovery; improving independent living skills; sourcing education, employment and training; accessing and signposting to statutory and community services; and integration into the new or existing community.
Source: [75]

Figure 5.1 locates this pilot within the broader sphere within which HAIL operates. It shows the range of living situations from which the service can help with transitioning to more suitable housing and living arrangements.

Figure 5.1 Housing-related supports for people with mental health difficulties



Source: [76]

There is a correlation between homelessness and poor mental health. Homelessness can be a risk factor for poor mental health and a consequence of poor mental health, which can hamper recovery. A lack of suitable housing as an alternative to institutional care can lead to an inefficient and expensive mental health system, with individuals receiving inappropriate care. Housing solutions will in part be dependent on the level of housing stock available.

As well a key component of a recovery strategy, appropriate housing services present substantial economic opportunities along the care pathway to improve outcomes and reduce costs for more expensive mental health services for mental health service providers. For example, in England a partnership between the not-for-profit 'One Housing Group' and an NHS Trust in London uses a Care Support Plus model to provide 15 high quality self-contained supported housing units, helping service users prepare for the transition to other forms of accommodation. The service has reduced hospital stays and costs to the health services by more than £400,000 per annum [69].

Housing First (HF) is another approach that can aid in recovery. Developed initially in the US and Canada and now used in some other countries, HF focuses on offering permanent, affordable independent housing as quickly as possible for individuals and families experiencing poor mental health. A review of economic studies of HF in Canada, the US and Australia suggests that they may be a very cost-effective intervention for chronically homeless populations [70]. However, the follow up time periods for most of these studies are quite short so less is known on long term impacts.

5.2 Employment

For many people with enduring mental health difficulties, or recovering from a once-off but significant mental health problem, the possibility to gain employment or return to work are key factors in recovery. However, the evidence shows that people with mental health problems are less likely to be in employment compared to people without mental health conditions, both internationally [11] and in Ireland [77, 78]. A survey of recipients of Disability Allowance by the Department of Social Protection found that fifty percent of the sample mentioned mental health difficulties, and mental health difficulties ranked highest along with basic physical activity difficulties in the list of incapacity, illness or disability mentioned by survey respondents. The survey also found that more than one-third of respondents mentioned mental health supports as important to helping achieve their employment ambitions and goals [79] (Box 5.3).

Employability and placement support services

In Ireland, some more generic supports are available to people with mental health difficulties seeking employment, for example, through the employment services provided by National Learning Network for SOLAS. The HSE Mental Health Division and the Department of Social Protection are working with Mental Health Reform on a Genio-funded project to pilot the Individual Placement and Support (IPS) model of supported employment for people with mental health difficulties in four sites across the country.

Box 5.3: Mental health issues and support needs amongst recipients of Disability Allowance (Ireland)

Figure 20: Supports mentioned by Disability Allowance recipients as important to helping achieve their employment ambitions and goals. A Respondent may mention multiple supports. (*Source: DSP*)

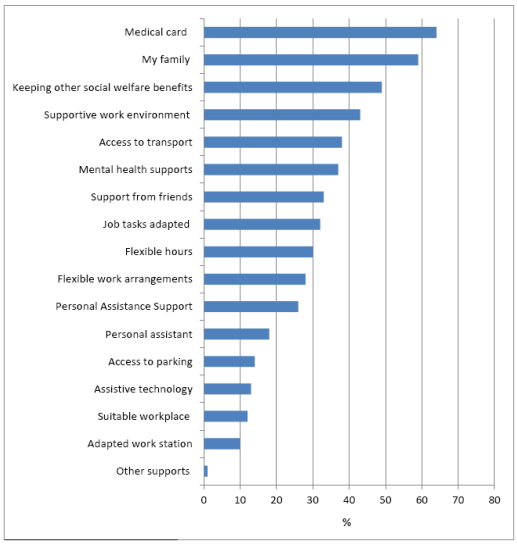
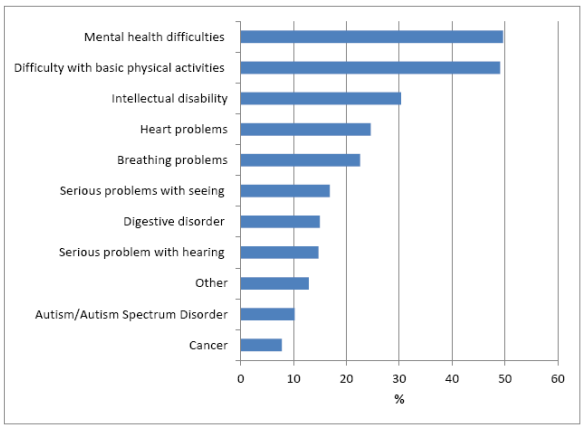


Figure 22: Incapacity, illnesses or disabilities indicated (*Source: DSP*)



Source [79]

In some countries approaches in this field are more developed and mainstreamed. For people with mental health problems not in employment and seeking work, the Individual Placement and Support (IPS) approach in the UK appears effective in helping individuals to

find and remain in employment. The Work in Progress campaign in the UK focused on improving the employment rates of people with depression. The Netherlands has a formalised programme of cooperation between the employee insurance agency and the sector agency of the mental health and addiction care providers (CGZ) (Box 5.4).

Box 5.4: Netherlands - Cooperation between employee insurance and mental healthcare provider sector
There is a Covenant between Employee Insurance Agency (UWV) and the sectoral organisation of mental health and addiction care providers (GGZ). This focuses on benefit recipients who are distant from the labour market, with severe psychiatric illness, and aims to promote retention or optimal reintegration. Areas for collaboration include: • sharing knowledge about the function of work as part of effective treatment; • increasing knowledge about (severe) psychiatric iillnesses for UWV professionals; • tailoring efficient treatments that facilitate job retention and effective reintegration
Source: [80]

Chapter 6 presents another element of the Dutch approach in this area, where employment specialists are included on multidisciplinary community mental health teams (FACT). More generally, flexible opportunities facilitating return fully or partially to the labour market for those with health problems, such as in Norway or Finland, can be helpful in this area.

As mentioned in Chapter 3, the Irish equality legislation covers many people with mental health problems under the disability grounds. This places responsibilities on employers to not discriminate against people with mental health difficulties, including the provision of reasonable accommodations where appropriate. The Equality Authority produced guidance material in this area *Equality and mental health: what the law means for your workplace* [20]. In addition, the Disability Act 2005 places an obligation on public service bodies to be pro-active in the employment of people with disabilities.

More generally, improving employer understanding of mental illness and putting in place policies and strategies to facilitate the integration and retention of people with mental health problems in the labour market has been one of the priorities in many anti-stigma activities. For instance, the Time to Change programme in the UK has a dedicated part of the programme specifically focusing on initiating conversations and reducing stigma about mental health problems in the workplace. The See Change programme in Ireland is another example of addressing mental health stigma in the workplace.

5.3 Social inclusion

Apart from more structural supports in the areas of housing and employment, there may also be barriers to more general social inclusion of people with mental health difficulties. Peer support groups and anti-stigma programmes are two areas of initiative in this field.

5.3.1 Peer support groups

Many peer support groups and initiatives are now active in the mental health field, both in Ireland and internationally. Some focus primarily on information provision or may also facilitate discussion-type support groups for people with mental health issues. As in other areas of health, online media provide an effective way for these groups to be accessible to and reach larger audiences. There are also peer support initiatives that provide a broader range of supports, including physical premises for social and other activities. Gateway and Aras Folláin are examples of this in Ireland. These are operated by the peer sector with financial support from HSE. A recent evaluation describes some of the key features of these initiatives (Box 5.5) and indicates the positive contribution they can make.

Box 5.5 Peer support - Gateway and Aras Folláin
Aras Folláin currently rents a detached house from which it hosts and operates a range of activities. Supports include peer support social activities, support groups, educational initiatives and one to one peer support. Gateway also rents premises from which it hosts and operates its activities. The initiative now has an expansive portfolio of activities and programmes offered five days a week and also out into the community. Gateway currently has more than two hundred members, with the majority participating on an active and frequent basis. Both initiatives employ a number of staff, with many volunteers providing peer support and other inputs.
Source: [81]

Peer support can take a variety of forms, including incorporating peer support into formal mental health services as well as peer-driven initiatives not directly connected to the formal mental health care sector. Chapter 6 addresses the former in more detail.

5.3.2 Tackling stigma

People with mental health problems frequently experience a variety of forms of social exclusion and discrimination. Stigma associated with poor mental health and negative attitudes towards people with mental health problems is a significant factor in this. Internationally and in Ireland, there have been a number of strategies and approaches to addressing this issue [82]. Anti-stigma legislation and other anti-discriminatory regulations has been one important area of activity in this field. Ireland is a member of the Global Anti-Stigma Alliance which facilitates and encourages knowledge exchange and sharing of best practices and experiences.

A study focusing on the nature and impact of depression-specific programmes in EU countries identified 26 depression anti-stigma initiatives across 18 member states [83]. Box 5.6 presents an overview of the campaigns run in a number of these countries and Box 5.7 presents some details on the See Change programme in Ireland.

Box 5.6: Anti-stigma campaigns in selected European countries		
Country	**Campaign/Programme**	**Period**
Germany	Open the Doors	1999 - present
	Nuremberg Alliance Against Depression	2001 - 2003
Ireland	See Change	2010 - present
Italy	Open the Doors	1999 – present
The Netherlands	Samen Sterk Zonder Stigma	2013 – present
Scotland	See Me	2002 – present
Sweden	Hjärnkoll	2003 – present
United Kingdom	Defeat Depression	1992 - 1996
	Time To Change	2007 – present
Source: [83]		

Box 5.7: See Change - Ireland

See Change is Ireland's national programme working to change minds about mental health problems in Ireland. The programme is a partnership with over seventy organisations to create a disruptive, community driven social movement to reduce the stigma and discrimination associated with mental health problems. The target audiences are: young males 18-24; people in the workplace; farmers; and people living in rural communities. See Change works within a number of inter-related settings. See Change is about finding the conversation, joining in and working with people and communities to change minds about mental health problems in Ireland.

The aims are to achieve:

- an environment where people can be more open and positive in their attitudes and behaviour towards mental health;
- greater understanding and acceptance of people with mental health problems;
- greater understanding and knowledge of mental health problems and of health services that provide support for mental health problems; and
- a reduction in the stigma associated with mental health problems and challenge discrimination

Source: Adapted from [84]

Much of the focus of anti-stigma efforts has been on depression and anxiety. The refresh of AVFC may wish to also give attention to stigma associated with schizophrenia/psychosis, where stigma can be a significant and concrete barrier to recovery.

6 Mental Healthcare Provision

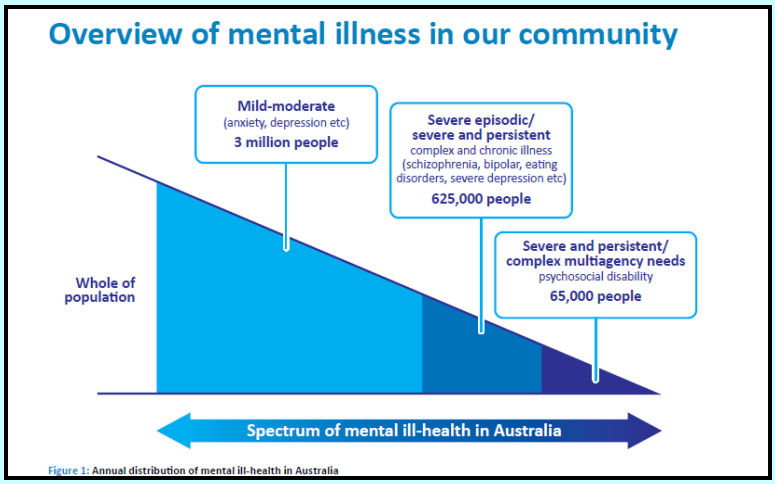
Like many other countries, Ireland has seen a significant shift from an institutional model to an outpatient and community-based approach to mental healthcare. Despite ongoing room for improvement and refinement in this aspect of the balance of care, it is possible to meet the bulk of mental health needs without resorting to hospitalisation in either dedicated psychiatric hospitals or psychiatric wards of general hospitals. A prominent policy issue today is how to organise and deliver effective mental health care in community and other ambulatory care settings. This Chapter looks at a number of issues and elements of the mental healthcare provision system. These include:

- the spectrum of mental health conditions and needs
- delivery systems and the balance of care
- recovery in mental healthcare practice
- e-Mental Health
- inpatient and other residential care settings
- other selected areas (addiction and substance misuse; prisoners, non-nationals and minorities; family carers).

6.1 The Spectrum of Mental Health Conditions and Needs

The spectrum of mental health conditions covers a very wide range of diagnostic categories which manifest themselves in a diversity of symptoms and associated impacts on functioning and well-being. As in a number of other countries, we do not have a comprehensive profile of incidence and prevalence rates for the various conditions in Ireland. This section presents some material from other countries that can help to put some indicative scaling on prevalence across a range of conditions. Data from Australia provides a useful yardstick for estimating the overall size and scale of different levels of mental health difficulties and the associated requirements they have for mental healthcare system services and supports (Box 6.1).

Box 6.1 The wellbeing burden of mental health disorders



Source: [8]

A crude extrapolation of the Australian data to the Irish situation would give rough estimates of about 600,000 people with mild-to-moderate conditions (anxiety, depression, etc.); about 125,000 people with severe episodic / severe and persistent complex and chronic conditions (schizophrenia, bipolar, eating disorders, severe depression etc.); and about 13,000 with severe and persistent complex multi-agency needs and psychosocial disability.

A recent European study compiled an extensive synthesis and analysis of data from countries with relevant available datasets [85] (Box 6.2). Extrapolation of these prevalence rates to Ireland would give rough estimates of about 41,000 for psychotic disorders, 281,000 for mood disorders, 518,000 for anxiety disorders, and 141,000 for somatoform disorders. The study also calculated DALY rates for each disorder covered. These show the very large DALY burden of depressive disorders, with this about twice the level of burden presented by dementia, the next highest condition.

Box 6.2 Prevalence of mental disorders – bset estimates for Europe

Diagnosis (DSM-IV)	Best estimate %	Applicable age range	Gender ratio f:m
Substance use disorders			
Alcohol dependence	3.4	15+	0.3
Opiod dependence	0.1-0.4	16-64	0.7
Cannabis dependence	0.3-1.8	15-64	0.4
Psychotic disorders	1.2	18+	0.8
Mood disorders	7.8		
Major depression	6.9	14+	2.3
Bipolar disorder	0.9	18-65	1.2
Anxiety disorders	14.0	14+	2.5
Panic disorder	1.8	14+	2.5
Agoraphobia	2.0	14+	3.1
Social phobia	2.3	14+	2.0
Generalized anxiety disorder	1.7-3.4	14+	2.1
Specific phobias	6.4	14-65	2.4
Obsessive-compulsive disorder	0.7	18+	1.6
Post-traumatic stress disorder	1.1-2.9	14+	3.4
Somatoform disorder	4.9	18-65	2.1
Eating disorder			
Anorexia nervosa	0.2-0.5	14-65	4.5
Bulimia nervosa	0.1-0.9	14-65	8.0

Source: [85]

6.2 Delivery Systems and Balance of Care

Ireland and other countries have recognised the challenge to put in place effective delivery systems and achieve an appropriate balance of care across this spectrum of mental health conditions and range of types and levels of support required. The WHO's pyramid model captures this well; the HSE has been developing similar frameworks to underpin its approach, for example in child and adolescent mental health services (Box 6.3).

Box 6.3 Balance of care pyramid

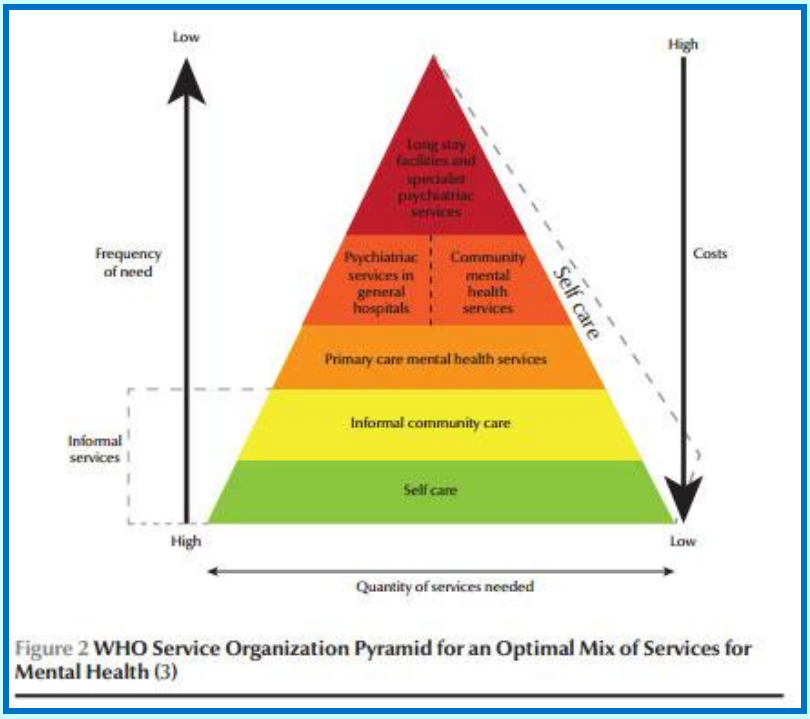
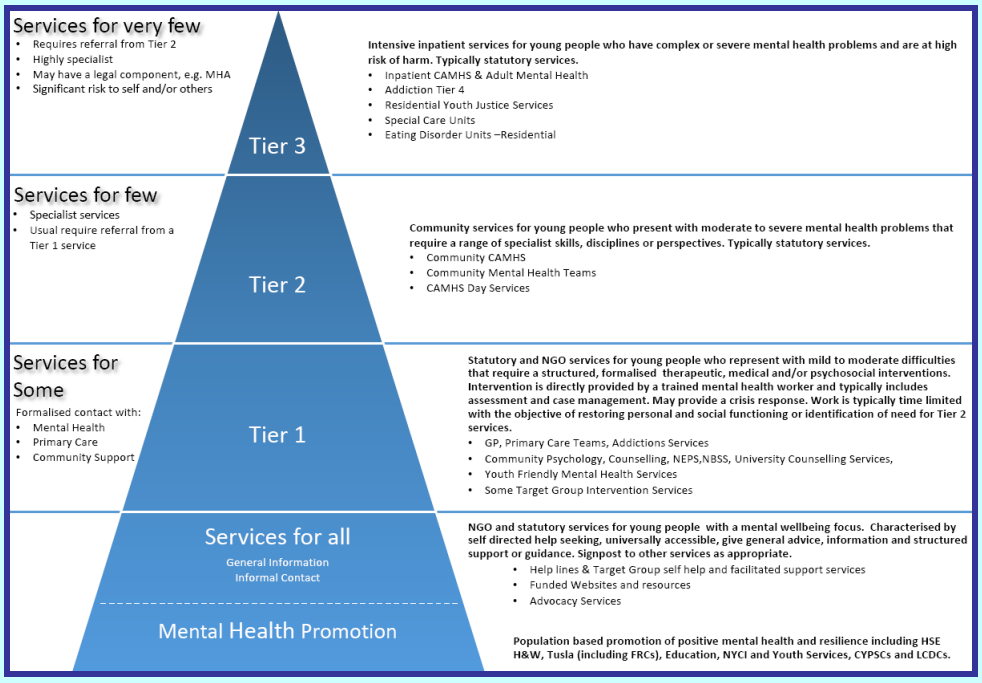


Figure 2 WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (3)



Source: [86] and HSE

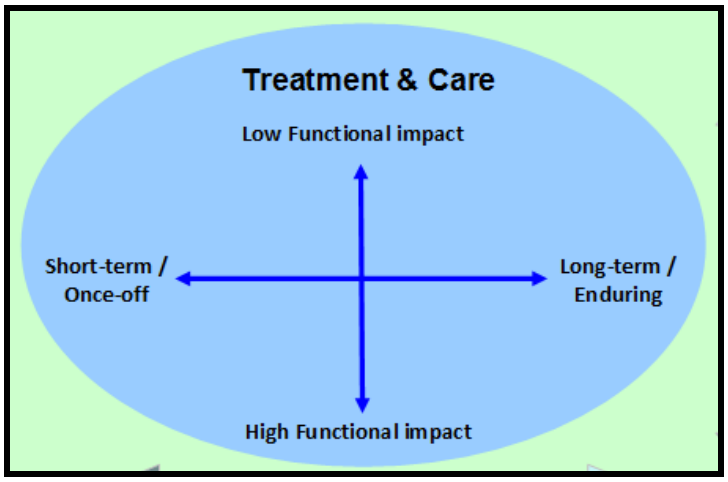
AVFC also addressed this theme and outlined a number of recommendations [1](Box 6.4).

Box 6.4 Balance of care recommendations in AVFC

Vision for Change Recommendations	
7.1	All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.
7.2	Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.
7.3	All mental health service users, including those in long-stay wards, should be registered with a GP.
7.4	Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing.
7.5	It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.
7.6	Mental health professionals should be available in the primary care setting, either within community care, the primary care team or the primary care network.
7.7	Local multidisciplinary CMHTs should provide a single point of access for primary care for advice, routine and crisis referral to all mental health services (community and hospital based).
7.8	Protocols and policies should be agreed locally by primary care teams and community mental health teams – particularly around discharge planning. There should be continuous communication and feedback between primary care and the CMHT.
7.9	A wide range of incentive schemes should be introduced to ensure mental health treatment and care can be provided in primary care.
7.10	Physical infrastructure that meets modern quality standards should provide sufficient space to enable primary care and CMHTs to provide high quality care.
7.11	The education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy (i.e. community-based mental health services). Service users should be involved in the provision of education on mental health.

The perspective introduced in Chapter 2 is also relevant here, identifying two important axes based on the nature of presenting conditions and their requirements for support (Figure 6.1).

Figure 6.1 Functional impact and temporal perspective



Source: the authors

To support resource allocation, the NHS in England has developed a clustering system and non-mandatory associated tariff structure that embodies this type of perspective and approach (Box 6.5) [87].

Box 6.5 NHS Mental Health Care Clusters

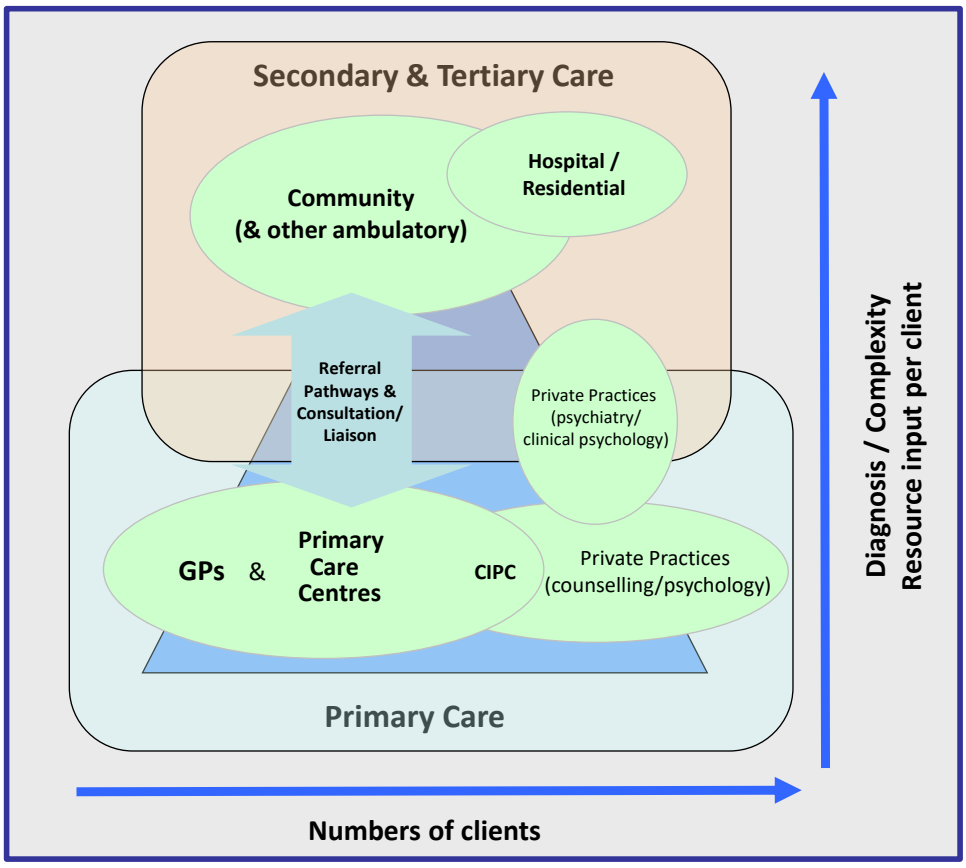
Cluster no.	Cluster label
0	Variance
1	Common mental health problems (low severity)
2	Common mental health problems
3	Non-psychotic (moderate severity)
4	Non-psychotic (severe)
5	Non-psychotic (very severe)
6	Non-psychotic disorders of overvalued Ideas
7	Enduring non-psychotic disorders (high disability)
8	Non-psychotic chaotic and challenging disorders
9	Blank cluster
10	First episode in psychosis
11	Ongoing recurrent psychosis (low symptoms)
12	Ongoing or recurrent psychosis (high disability)
13	Ongoing or recurrent psychosis (high symptom and disability)
14	Psychotic crisis
15	Severe psychotic depression
16	Dual diagnosis (substance abuse and mental illness)
17	Psychosis and affective disorder difficult to engage
18	Cognitive impairment (low need)
19	Cognitive impairment or dementia (moderate need)
20	Cognitive impairment or dementia (high need)
21	Cognitive impairment or dementia (high physical or engagement)

Source: [87]

Figure 6.2 presents an operational perspective identifying some relevant features of the Irish ecosystem today. This provides an orienting or reference frame for locating where and how elements of the international evidence and practice review in the following sections may apply in the Irish context. The ecosystem includes:

- primary care components
  - GPs
  - Primary care centres
  - Counselling in Primary Care
  - independent psychosocial services and professional practices
- secondary / specialist care components
  - community & other ambulatory
  - hospitals and other residential
  - independent psychiatric and other psychosocial services and professonal practices
- Linkages between primary and secondary/specialist services
  - referral pathways
  - other linkages - liaison, consultative etc.

Figure 6.2 Some relevant features of the Irish mental healthcare ecosystem today



Source: the authors

6.3 Management of mood disorders and other common conditions

Mood disorders including depression and anxiety are the most common mental health problems. In high income countries, management of these conditions tends to take place largely within primary care, with referrals made to specialist services for more severe cases. The European EseMed survey covered six European countries - Belgium, France, Germany, Italy, Netherlands and Spain - focusing on mood disorders or alcohol disorders but not psychoses. Overall lifetime rates of contact with any professional varied considerably between countries, but GPs were the most likely professional contact for people with these types of mental health problems, with an average of 64% across the countries reporting this [88]. Similarly, most mood disorder cases in Australia and New Zealand are managed by GPs with only those with severe disorders coming into contact with specialist services [89, 90].

Some countries have introduced initiatives to encourage or require primary care to provide an increased share of mental health consultations and treatment. In England, a GP may refer an individual to a specialist Access and Assessment team if the case is severe; the assessment team will then determine whether the individual should be managed by specialist services or by the GP. Developments in Northern Ireland may also be of interest, including the Emotional Wellbeing Hubs (Box 6.6).

Box 6.6 Emotional Wellbeing Hubs – Nothern Ireland

NHSCT Emotional Wellbeing Hub

October 22, 2015

The HSCB have commissioned Health and Social Care Trusts to coordinate multi-agency hubs working in partnership to screen referrals of people with common mental health problems and associated psychological distress referred from GP practices.

Each Hub will be made up of representatives from key stakeholder groups – Trust Mental Health Services, Primary Care, and the Community and Voluntary Sector providers. The Emotional Heath Hub Coordinator is employed by NHSCT to undertake this role on behalf of all the stakeholder parties.

It is envisaged that the Hub will consist of the Coordinator, a psychiatrist, a clinical psychologist, a general practitioner, a representative from the Community sector and a representative from the Voluntary sector. Its role will be to triage referrals and forward on referrals to the most appropriate Community and Voluntary sector organisations to deliver psychological talking therapies. It will also signpost clients to appropriate support services.

This is in line with NICE Guidelines 123 (Common Mental Health Disorders. Identification and pathways to care) promoting a Stepped-Care Model and the Bamford Review of Mental Health and Learning Disability (Northern Ireland) with its emphasis on resolving much psychological and emotional distress by the imaginative use of generic services, the voluntary sector and by community development approaches which provide support to people at times of need. It is also in keeping with Quality 2020 (A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland) for delivering the right care at the right time in the right place.

The Hub will focus on Step 1 and Step 2 levels of intervention delivering psychological talking therapies to treat low threshold common mental health problems. Such therapies will include:

- counselling;
- cognitive behavioural therapy;
- group therapy;
- facilitated self-help;
- life coaching;
- signposting to other support services; and support to get linked back into their communities and social activities

This approach is very much primary care facing with the emphasis on treatment for people where possible at a local level utilising the expertise and skills of the Community and Voluntary Sectors.

Source : [91]

In the Netherlands, new cost containment policies have recently urged GPs to adopt an even larger role in treating mental health conditions and to refrain from referring individuals to specialist mental health services [92]. Since 2014 it became obligatory to have a referral from primary care before use of specialist mental health services; referrals can only be made for individuals who meet criteria for DSM-IV (Diagnostic and Statistical Manual of Mental Disorders). Most Dutch GPs now employ mental health nurses (Box 6.7).

Box 6.7: Primary care mental health nurses in the Netherlands
Mental health nurses (MHN) were introduced into primary care in the Netherlands in 2008 and they assist GPs in the care for patients with mental health problems. Dutch MHNs receive higher vocational training in nursing or psychology, and their main tasks are to perform diagnostic research, to improve the quality of the referral to other mental health caregivers and to deliver short-term care (such as counselling) to patients with psychological symptoms or social problems. MHNs work under the supervision of the GP. In general, the GP decides after a first consultation if a patient should visit the MHN. GPs can also decide to treat patients themselves, or refer patients to specialised mental healthcare.
Source: (8)

National adult psychiatric morbidity survey data from England provides a more detailed view of consultation patterns and treatments [93]. A little over one-third of all individuals meeting the criteria for common mental disorders received treatment during the previous year, and just under 60% of adults who met criteria for depression. Treatment rates were lower for other common mental disorders such as General Anxiety Disorder (GAD) or Obsessive Compulsive Disorder (OCD). Most contacts with health services for adults with common mental health problems were with GPs. Small percentages came into contact with psychiatrists or with NHS funded psychology services other than the psychological therapy IAPT programme. More than half (51.4%) of people with depression reported treatment with medication, and medication combined with psychological therapy was reported by 17.1% of those with phobias and 14.9% of those with severe depression.

6.3.1 Primary care

In high income countries, innovation in the management of common mental disorders, such as depression, within primary care has focused on the promotion of a stepped and collaborative care model as well as increased access to psychological therapies. Some of these treatments can be provided online or by phone. Guidelines in Australia, England, the Netherlands and New Zealand recommend a stepped care approach based on the severity and duration of the depressive episode.

Box 6.8 summarises key components of the stepped care approach in England. People with mild depression are usually offered brief interventions such as self-help or counselling. More intensive treatment options are appropriate if there is no response to initial treatment or for more severe cases, with psychological therapies usually then initially offered without any drug therapy. Implementation of the stepped care approach can be challenging. In England, uptake of low level psychological therapies (Improving Access to Psychological Therapies) has been extremely varied across the country, reflecting differences in local practice despite the existence of national guidelines

Box 6.8 Stepped care in management of mild to moderate depression in primary care - English clinical guidelines
• Begin with general sleep hygiene advice, followed by active monitoring if necessary including psychoeducation. • If continued symptoms use low intensity psychosocial interventions such as group exercise programmes, peer support group, guided self-help based on principles of cognitive behavioural therapy (CBT) or computerised CBT • If symptoms still persist, high intensity psychosocial interventions comprising multiple sessions of CBT or Interpersonal Therapy (IPT) are recommended • Antidepressants are only recommended for people with persistent (more than two years) symptoms or for those whose symptoms persist after other interventions.
Source: [94]

In the Netherlands, a survey of GPs reported inconsistencies in the use of screening instruments and in the provision of low intensity self-management or e-health interventions, although all GPs surveyed provided psychotherapy and/or drug therapy to patients with severe depression [92].

One weakness has been the ability of general practitioners to recognise and diagnose mood disorders. Delays in diagnosis can lead to more severe disorders and poorer outcomes. In Italy, a survey of GPs in the Emilia Romagna region found only about 40% felt they had adequate knowledge to diagnose common mental disorders and 37% felt they knew how to treat these disorders (ref). A recent study in Australia suggested that GPs were providing sub-optimal care for people with mild/moderate depression [89]. It found prescription of antidepressants for many people with sub-threshold depressions, suggesting pharmacotherapy was commonly used instead of more appropriate interventions like sleep hygiene advice and psychoeducation.

The absence of such data in Ireland is an issue that the refresh of AVFC may wish to address. The data from the Eurobarometer survey in 2010 [6] places Ireland at around the EU average in antidepressant usage rates, but the more detailed data from other surveys in other countries suggest that 'average' therapeutic practice in primary care may be sub-optimal.

6.4 The balance of care for severe mental disorders

In this section the focus is on the balance of care in the provision of services for people with psychosis, as an example of how severe disorders are managed. Severe mental disorders are initially more likely to be managed by specialist mental health services. Primary care services can then be heavily involved in the long-term management of many severe disorders, including psychosis. Canada has a reimbursement system to encourage GPs to establish care plans and regularly monitor people with enduring mental health conditions.

One UK study estimated that between 25% and 30% of people with severe and enduring mental illness will lose contact with specialist mental health services and support will be

entirely by GPs [95]. This is despite a requirement in England (at least) for specialist planning to be in place at hospital discharge. In another analysis of 1,935 individuals who had been in receipt of secondary care for psychosis (hospital or specialist mental health teams), 38% were discharged to primary care in the past year [96]. This analysis also indicates that the percentage of patients with subsequent contact with primary care services was similar between the group no longer the responsibility of specialist mental health services and those still under their care over the subsequent 4-year period.

It is important to have effective referral pathways between primary and specialist care, as well as within primary care itself. Consultation and other liaison-type arrangements between specialists and GPs are also central to an effective balance of care and delivery system.

6.4.1 Early intervention for severe mental disorder

There has been significant innovation in earlier intervention for people with severe mental disorders. Early Intervention (EI) can result in better long term prospects of recovery, and there has been considerable attention on early intervention for psychosis. A recent study found early intervention programmes in a number of countries including Australia, England, Canada, the Netherlands and Denmark [97]. Ireland also has a small number of early intervention teams. These teams are multi-disciplinary usually involving a combination of psychiatrists, psychologists, psychiatric nurses, social workers and therapists, and providing a range of pharmacological and non-pharmacological treatments.

A growing body of evidence supports the cost effectiveness of EI, particularly when taking into account additional outcomes such as employment status, education, and housing related outcomes [99]. A recent study in England showed improvements in health and psychological outcomes, but also better housing status in mainstream accommodation arrangements [100]. In Denmark, evaluation of early intervention teams also showed long-term positive changes in more stable housing status over a 10-year time period [101]. Analysis in Ireland following the introduction of an early intervention service found an association with reduction in the number and duration of future hospital admissions for psychosis [102].

The Duration of Untreated Psychosis (DUP) is a marker combining duration of initial help-seeking delay after the onset of symptoms and treatment delay following a help-seeking contact. Evidence indicates that a long DUP may lead to poorer social and clinical outcomes, including negative symptoms and suicide as well as a higher risk of depression and anxiety disorders [97, 98]. There have been efforts to expand specialist early intervention teams as a way of reducing DUP and providing a cost-effective approach to improving outcomes for people experiencing psychosis for the first time.

An analysis of 14 new and established EI services in England reported a much lower median DUP of less than three months for each of the two elements of DUP [98]. The authors hypothesised that the reduction in DUP was probably due to the catalytic effect on mental health organisations of introducing EI services, leading to a more prompt response to first episode psychosis across the whole secondary system of care.

Early intervention services networks tend to focus on people aged between 15 and 35, although access criteria vary between programmes in different countries [98]. However, about 25% of all new cases of schizophrenia emerge after the age of 40 and EI services in a number of countries have now expanded to older age groups.

There may also be structural barriers to contact with EI services for young people in some countries, especially where child and adolescent mental health services are organised and funded separately from adult mental health services. In Australia, efforts to overcome the stigma associated with mental illness have focused on providing youth oriented centres for mental health and wellbeing rather than 'psychosis centres'. This means collaborating with young people to ensure that support is youth friendly, delivered in low-stigma community settings and focused on outcomes relevant to them.

Although the evidence is promising on the economic and clinical case for investment, early intervention services are expensive compared to mental health teams that focus on all severe mental health issues rather than psychosis alone. It may not be practical in all settings to set up dedicated stand-alone teams and an alternative approach has been piloted in northern Italy. The GET UP PIANO trial assessed the case for re-training existing mental health staff to provide EI services as well as general mental health services. Psychiatrists and psychologists received training sessions on CBT for psychosis, family interventions and case management [103].

Whatever the model of early intervention, primary care services also have an important role to play to ensure continuity of care after individuals are discharged from EI services. The most developed EI services in Europe are mainly in countries with strong primary care systems such as in the UK. In countries such as Germany and Austria, many mental health professionals are in stand-alone private practice and are often a first point of contact on the pathway to services [104]. This may act as a disincentive to more collaborative care models involving primary care practitioners. In France, poor links with primary care and poor knowledge within primary care of mental health services are also highlighted as one challenge to development of early intervention services [105].

Policy issues to consider in a refresh of AVFC might include how best to provide better training, support and incentives for primary care practitioners to support early intervention services, as well whether embedding the principles of early intervention for psychosis within existing community mental health services is more practical than setting up specialist teams, and what implications there might be for relative levels of effectiveness and cost effectiveness.

6.4.2 Crisis care and interworking with police and judicial system

There are currently efforts to improve access to crisis mental healthcare in Ireland. Some initiatives have recently been announced, as well as inter-working with the police and other elements of the judicial system. Approaches in other countries may provide ideas and guidance for this. Examples include the covenant between the police and mental healthcare service providers and a number of other programmes in the Netherlands (Box 6.9) and the Crisis Care Concordat in England (Box 6.10).

Box 6.9 Interworking with police and judicial system, and other elements of crisis care - Netherlands

Covenant between police and GGZ (2003, updated 2011)

Aims to create more uniformity in the approach to sheltering and assisting people with psychiatric illness or substance abuse who come into contact with the police. Clear guidelines and protocols:

- The accessibility and availability of mental health care services to the police;
- Temporary deprivation of freedom and temporary deprivation of residence of mentally disturbed persons (containment, where and for how long);
- Transportation of people with mental health problems;
- Help for persons in a non-acute situation;
- The accessibility and availability of public mental health care networks for police and mental health care providers;
- Information exchange;
- What to do with missing persons or unauthorised absence from a mental health care institute;
- Reporting of criminal offences conducted within mental health care providers;
- Education and knowledge-sharing;
- Consultation structure;
- Evaluation of the covenant.

Safety Houses

- Nationwide collaboration between (mental) health care and social care providers, local governments and police departments; funded by Ministry of Security and Justice.
- Multi-agency approach for complex cases in order to reduce severe nuisance and criminality - where case is so problematic or complex that regular care trajectories are not sufficient.

Forensic MH care

- Non-judicial: before or after a judicial verdict
- Judicial; 22 verdicts that can lead to this; 3 main types of judicial forensic care: placement at disposal of government (TBS), care as part of conditional sentence, care in detainment.

Source: [80]

Box 6.10 Crisis Care Concordat - England

This is an agreement between a number of national organisations from health and policing. It aims to improve the responses that people in mental health crisis situations receive from services, and in particular, to keep people in mental distress, who have committed no crime, out of police cells. Since February 2014 there have been a number of achievements. Health, policing and local authority services across England have been developing joint Local Crisis Declarations. Use of police cells as places of safety for people detained under the Mental Health Act has reduced. Ambulance Trusts apply a new protocol for rapid response to people in mental health crisis. Department of Health funded street triage schemes involve nurses advising police officers on people in mental health crisis. This can reduce detentions and keep these people out of police cells.

Source: [22]

6.5 Services across the stages of the lifecycle

Given the broad scope of the review, the previous sections mainly address general adult mental health services. Older people will also avail of these general services unless they require more specialist psychiatry of old age services and these are available. Children and adolescents will also come into contact with the more general services to a certain degree, but most countries also have specific child and adolescent mental health services (CAMHS).

6.5.1 Child and Adolescent Mental Health Services (CAMHS)

In Ireland, the HSE has established CAMHS services covering many parts of the country and also funds Jigsaw to provide services in some areas. Waiting times for access have been a focus of attention in recent years. The Mental Health Commission and others have raised concerns that some young people are still admitted to adult inpatient facilities.

There are ongoing initiatives to improve CAMHS services, including HSE clinical programmes and the Task Force on youth mental health. The international review identified some comparative profiling of European approaches in this field that may provide useful insights in this context [106].

6.5.2 Older people

In Ireland, specialist mental healthcare services for older people appear to vary across the country. Psychiatry of old age services may address both dementia-related needs and other aspects of specialist mental health for older people. There is ongoing work by HSE in this field. The review identified a variety of European sources that may provide useful insights in this context (e.g. [107]).

6.6 Recovery in Mental Healthcare practice

Recovery perspectives and approaches have become increasingly influential in mental healthcare practice. In Ireland, AVFC espoused this approach. The HSE Mental Health Division has embraced the perspective and there are various activities underway in this field.

6.6.1 Guidelines

The Guidelines for Recovery-Oriented Practice in Canada provide an example of the development of this approach elsewhere (Box 6.11).

6.6.2 Intersectoral approaches

As discussed in Chapter 5, recovery is an intersectoral issue. As well as clinical care, it requires inputs in areas such as housing, employment, and more general social inclusion. There are various ways to organise this integrated perspective, such as inclusion of skills in these wider areas of support within mental health teams and/or or coordinated inter-sectoral working arrangements between the mental healthcare sector, housing, employment and other relevant sectors.

Box 6.11 Guidelines for Recovery-Oriented Practice in Canada

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90 Guideline 6D: Workforce Development and Planning
92 Getting Started and Measuring Progress
97 Conclusion

Source: [108]

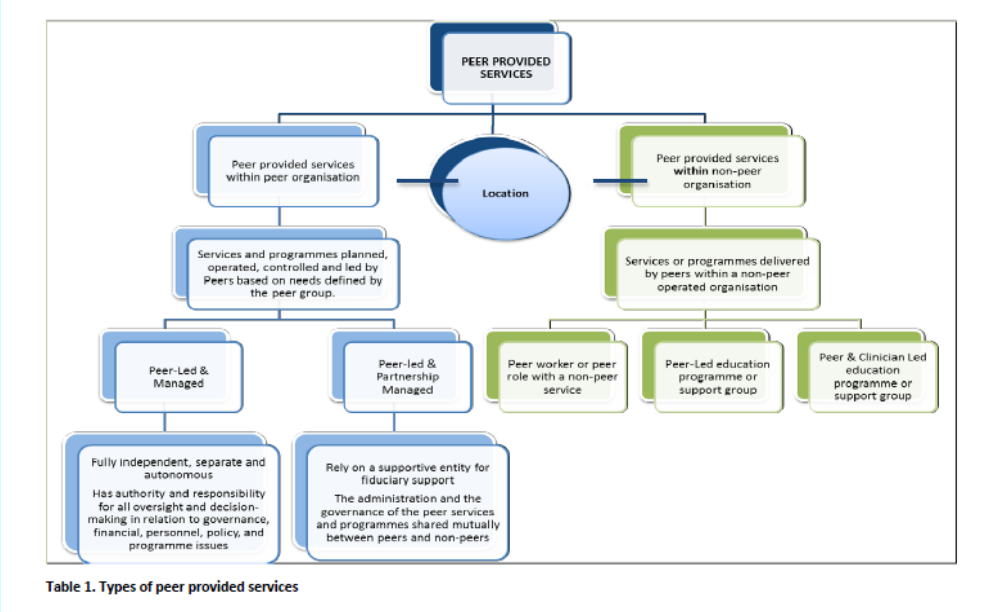
The FACT (Flexible Assertive Community Treatment) team approach in the Netherlands provides an example of the incorporation of a broad range of skillsets in mental healthcare teams. FACT teams are multi-disciplinary, including professionals such as psychologists, psychiatrists, addiction specialists, nurses, peer counsellors, and employment placement service specialists. A core feature of the FACT approach is flexibility, so that care plans can be easily adapted depending on individuals' mental health care needs. The FACT model also includes a crisis plan allowing a patient in crisis to get more intensive care in the community to avoid hospital admissions where appropriate.

6.6.3 Peer support

In Ireland and internationally there has been increasing interest in the role that peer support can play in recovery for people with mental health difficulties. The HSE has published *Peer Support Workers – A Guidance Paper* to support formal services wishing to incorporate peer support [109]. A recent analysis of peer support initiatives in Ireland may also provide useful

insight and guidance for the AVFC refresh [81]. Box 6.12 presents the conceptual framework developed to map the types of peer support.

Box 6.12 Types of peer support



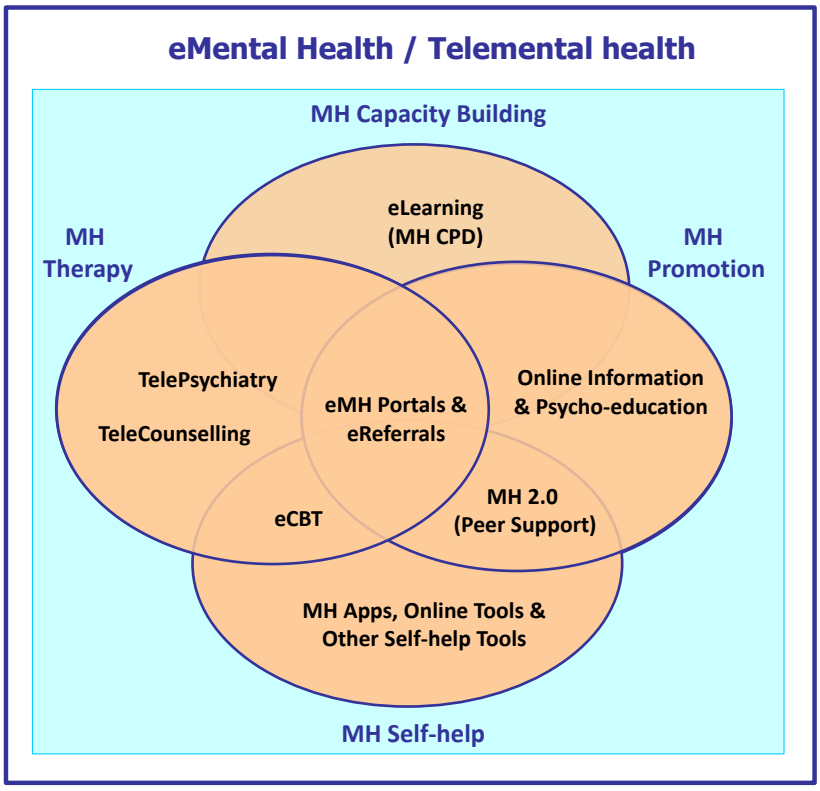
Source: [81]

A review of evidence conducted for the Substance Abuse and Mental Health Services Administration (SAMSHA) in the US focused on three forms of peer support within formal mental health services: peers added to traditional services; peers in existing clinical roles; and peer delivery of structured curricula [110]. The review found a moderate level of evidence for the effectiveness of each type. Many studies of services with peers added or peers delivering curricula showed some evidence of the positive added value provided by peers, including enhancing reduction of inpatient use and improving a range of recovery outcomes. Evidence of effectiveness of peers in existing clinical roles was more mixed.

6.7 eMental Health - a potential Game Changer?

One of the challenges facing the mental healthcare sector in Ireland and other countries concerns effective (and cost-effective) ways to reach the large numbers of people with common mental disorders. Some commentators suggest that eMental Health has the potential to be a game changer in this field. Figure 6.3 presents an overview of the spectrum of applications of eMental Health (or Telemental Health).

Figure 6.3. The spectrum of applications of eMental Health



Source: the authors

eMental health covers a broad spectrum, from formal delivery of therapy to self-help apps and online information. The scope includes:

- telephone-based delivery of therapy sessions, including telepsychiatry and telecounselling
- delivery of structured therapeutic protocols such as CBT, including eCBT (online) and cCBT (computer-based); approaches may vary in the involvement or not of human service professionals (i.e. whether 'blended' or not)
- mental health self-help applications, including mental health apps, online tools and other self-help tools; these may include formal services, such as medication reminders, ongoing supports in addition treatments, and other applications
- online peer support through social media and other platforms (mental health '2.0'), either moderated (by professionals or peers) or unmoderated
- online information and psycho-education.

There is a broad body of emerging evidence on aspects of efficacy and cost-effectiveness across this spectrum. Systematic reviews have found some evidence of efficacy although also point to limitations in the methodologies of many of the reviewed studies [111, 112]. Overall the indications are that well-developed applications can have comparable efficacy to traditional approaches when appropriately provided and in approriate delivery environments [113-116].

eMental health might merit focused attention in the refresh of AVFC policy in Ireland. It may be worth examining the extent to which eMental Health could be something of a 'game-changer' through provision of cost-effective ways of providing access to treatment and other supports and reaching more people who can benefit. In this context it may be useful to look at approaches in other countries where eMental health in various forms is now actively incorporated as a component of the mainstream system and spectrum of available services. These include almost all the countries covered in some detail in our review.

In doing this, it is important to adopt a measured perspective and avoid blanket generalisations. This is a dynamically evolving domain, with inevitable hype. There may be risks of technology-push as well as unwarranted professional resistance, with neither in clients' interest. A considered and balanced perspective is required, through informed and organised mapping of the terrain and evidence base, and of opportunities and risks presented in the Irish mental healthcare ecosystem. A recent report on telecare and telehealth in Ireland addresses more general aspects of this domain from an independent living perspective [117].

In the Netherlands, there has been utilisation of eMental health for a number of years. Between 2007 and 2011 the numbers receiving online treatment for depression or eating disorders tripled to 181,000, and in 2010 almost 1.8 million individuals had accessed an online site for help [80]. Other countries with extensive and routine provision and utilisation of online and other applications of eMental health include the UK (in different ways in England, Scotland and Northern Ireland, for example), Sweden and Australia. Approaches include provision of telephone-based, computer-based and online therapeutic applications as part of the formal care systems and broader development of the overall eMental health ecosystem (e.g. in Australia), both of which may be of interest in the Irish context.

In England, policy encourages access to computer/online CBT across all mental health trusts. A survey in 2012 found 77% of trusts provided computers for direct patient use, with almost all having capacity to access cCBT [118]. The research identified various IT-related and other technical challenges for effective access across all parts of the country, and these may be instructive for efforts to provide similar access to such services in Ireland.

In Northern Ireland, following the Bamford policy framework, GPs and some other organisations may provide access to the online ‘Beating the Blues’ CBT programme. Usage has grown over the past few years. A small-scale user evaluation by the Patient and Client Council found that many respondents (61%) assessed it as ‘very’ or ‘quite’helpful. However, a considerable number would have preferred one-to-one therapy instead and there was varying levels of support by GPs for programme [119].

The other side of mental health online?

Although eMental health services offer considerable potential, the internet and social media also bring new mental health issues and new challenges for mental healthcare services. These include cyberbullying, as well as a range of conditions and impact areas such as online grooming, excessive utilisation of online sexual material, online gambling, more general concerns about overuse of online media at the expense of face-to-face social interaction, and many other issues.

The research evidence on positive and negative aspects of social media is limited and sometimes contradictory [120]. Reported benefits include increased self-esteem, perceived social support, increased social capital, safe identity experimentation and increased opportunity for self-disclosure; reported negative impacts include increased exposure to harm, social isolation, depression and cyber-bullying.

As mentioned already in section 4.3, there is an Oireachtas report on *Addressing the Growth of Social Media and tackling Cyberbullying* [42]. The refresh of AVFC may wish to revisit this important theme.

6.8 Inpatient care & other residential settings

Given the timeframe available, the current study focused especially on community and other elements of ambulatory care, and adopted a lighter touch approach to inpatient care and other residential settings. The refresh of AVFC may wish to address these areas in a more detailed manner.

6.8.1 Inpatients

One issue is the adequacy or otherwise of the current stock of psychiatric inpatient beds now that the de-institutionalisation agenda has been extensively progressed. OECD data positions Ireland at a little below the OECD average in number of beds provided per capita. This is not necessarily a good or a bad thing, but there is need for a review of the current supply as regards the amount and mix of types of beds relative to need in the Irish context.

In Ireland, the Mental Health Commission monitors and reports on various aspects of inpatient mental healthcare including use of restraint and seclusion. Box 6.13 presents a summary of the issues raised in the Commission's Annual Report 2015. The review of other countries for this study found some examples of well-developed approaches to improving practice on restraint and seclusion (England and the Netherlands), as well as extensive investment to upgrade inpatient infrastructures and patient facilities (England) and provision of advocacy for inpatients (Netherlands).

6.8.2 Community residential facilities

The Mental Health Commission has pointed to a number of issues of concern in the current provision of community residential facilities for people with mental health conditions in Ireland. The HRB conducted a survey of facilities in 2006 and their report also outlines a range of issues [121].

The AVFC report envisaged a major reduction in usage of community residential facilities and a re-focusing towards supporting independent living in the community. Progress appears to have been slow in this area, although there are now initiatives aiming to address this. The HSE and HAIL programmes mentioned in Chapter 5 are important in this context, and the refresh of AVFC may wish to give further attention to the possibilities offered by this approach.

Box 6.13 Issues for Inpatient and Residential Care sector: Mental Health Commission Annual Report 2015

Standards
• Residential settings:
  ○ Needs for improvements in areas such as individual care planning and privacy
  ○ 43% of applicable approved settings were found to breach the rules on seclusion
Involuntary admissions
• 9% increase from 2014 to 2015
• Reasons unclear, but modern mental health policy and practice suggests that admission to inpatient care and, in particular, involuntary admission, should be a last resort intervention
• Preponderance of involuntary admissions where the family and Gardai are the primary applicants (23% and 47% respectively); this is a matter for concern....
Community residences
• Commission continued to be concerned about a number of issues:
  ○ Fundamental issues around identifying precisely the number of residences and people living in such residences
  ○ Some residences are too large, have poor physical infrastructure, are institutional in nature and lack individualised care plans
Admissions, Transfers and Discharge
• Children still being admitted to adult units (95 in 2015)
• Instances where residents are transferred or discharged early to make room for new admissions
  ○ Need for a more coherent, responsive bed policy and, perhaps a review of the required number of beds to serve the present population
  ○ Pressures to admit is also reflective of the ability or otherwise of services to maintain people in their own community

More generally, it might also be useful to look more broadly at the role that (upgraded and refurbished) community facilities might continue to play in the Irish situation. This could include a potential role in provision of short term crisis care facilities, as well as in step-down and other interim or transitional arrangements for people discharged from psychiatric inpatient beds or other situations. In England, some inpatient care is in residential units or supported housing, and for some patients living in such a unit is an obligation under a Community Treatment Order [22].

6.9 Selected topics

The review selected some additional topics for lighter touch attention – addiction and substance misuse; mental healthcare for prisoners; non-nationals and minorities; and family carers. These are all important issues in Ireland today. There may well be other specific topics that the refresh of AVFC might also wish to address in more detail.

6.9.1 Addiction and substance misuse

Many commentators have suggested the need for better integration of addiction and substance misuse services within the mental healthcare system in Ireland. The HSE clinical programme on Dual Diagnosis should help improve the situation. The Netherlands is an example of a country that gives a high importance to addiction and substance misuse within mental healthcare (Box 6.14), encompassing addictions to nicotine, alcohol, drugs, and sedatives and tranquilisers.

Box 6.14 Addiction services – the Netherlands
The system and practice is well-informed about prevalence and effective treatments, with 9 categorical and 8 integrated providers for addiction care; categorical providers have nearly 5,000 professional staff. Usage data for 2012 indicate that 66,000 sought help (78% male). This equates to a rate of 395 per 100,000, with an average number of 30 contacts per client totalling to about 2 million contacts overall. These comprised: Alcohol (46.5%); Opiates (16%); Cannabis (15.4%); Cocaine (11.4%); Gambling (3.4%); and Amphetamines (2.2%). Opiates treatment may include prescription of heroin (as well as methadone), for selected patients; research has found it cost-effective (reduction of societal costs of €13,000 per person per year). For alcohol treatment there were approximately 30,800 thousand registered clients and there has been an increase in children and adolescents treated for intoxification
Source: [80]

6.9.2 Mental health services for prisoners

A current focus in Ireland is on improving the mental healthcare provision for prisoners. Some elements of the approaches from other countries may provide useful insights in this context. Studies consistently show that the prevalence of mental disorders in prisons is far greater than in the general population. Suicide rates for male prisoners are much higher than the general population. The research found variation across countries in whether funding and responsibility for prison mental health care is the responsibility of a Ministry of Justice (or similar ministry) or the Ministry of Health, with a shift towards mainstream health system responsibility in some countries in the last decade.

Box 6.15 Reforming prison mental health care in New Zealand
Before 2011, New Zealand prison mental health services were provided without an explicit model of care but were generally expected to provide specialist mental health care to prisoners with severe mental health problems, including pre-release care planning. Practice varied considerably across the country and caseloads fell short of expected levels calculated from epidemiological prevalence rates, and there were concerns about lapses in the continuity of care between prison and community. Consequently, as part of the development of evidence-based approaches to care, the Auckland and Midland Regional Forensic Psychiatric Services developed a new prison model of care (PMOC) for mental health in-reach services for prisoners with severe mental health problems. The model was designed to provide secondary and tertiary services and to bridge the gap with primary health care provision already established in prisons. Evaluation results have been promising, with a tendency towards decreasing post-release reoffending at 6 months following release, whether measured by new charges or new convictions. [122].
Source: [9; 10]

Recent innovations in New Zealand may be of interest, including ways to better identify mental health problems in the prison population and also to improve planning for mental health as part of the discharge planning process (Box 6.15).

In England there has been a shift from a Home Office commissioned prison health service to NHS commissioning of all health services for prisoners today [22] (Box 6.16). Specialist 'assertive community treatment teams' are also developing to operate in prisons and better recognise risk and provide support.

Box 6.16 Mental healthcare for prisoners – England
The Bradley Report from 2009 has informed policy in recent years and has been followed up with the 2014 Bradley Report. Following challenges under the Human Rights Act, prisoners are entitled to "equivalence of care" and receive the same NHS healthcare treatments as non-prisoners. The Health and Justice Partnership Board is a cross-government activity to improve outcomes for offenders. NHS England is rolling out a national liaison and diversion programme to identify, in police custody and at courts, people with mental health problems, learning disabilities, personality disorder and drug or alcohol problems. The 10 pilot liaison and diversion services went live on 1 April 2014, with coverage in 50 police custody suites. If the pilots are successful, the aim is to have 100% coverage by 2017. NHS England commissions almost all prison and secure facility healthcare. The Office of National Statistics (ONS) 1998 survey Psychiatric Morbidity among Prisoners in England and Wales is the most reliable data currently available. Based on self report data, this found that around 90% of adult prisoners had one or more of five mental health related disorders - personality disorder, psychosis, neurosis, alcohol misuse and drug dependence. Prison regulations now require reception screening before a prisoner's first night, to detect immediate physical health and mental health problems and significant drug or alcohol abuse. Reception screening should assess a prisoner's risk of self-harm and suicide, risk of harm to others, or risk harm from others. People with a severe mental health problem, or vulnerable to suicide, may be referred for a further mental health assessment. Prisons have on-site primary health care teams who can treat most health problems. If a particular prison cannot provide the required treatment, a prisoner may be transferred to another prison or escorted to hospital on an inpatient or outpatient basis. NHS prison mental health services are provided through 102 in-reach teams, accessible to all prisons. Procedures are in place for prisoners requiring inpatient treatment for severe mental disorder and transfer to secure mental health services. Department of Health good practice guidance indicates transfers between prison and hospital should be completed within 14 days, where there is clinical need for this.
Source: [22]

6.9.3 Non-nationals and minorities (including Irish Traveller community)

Appropriate mental healthcare services for non-nationals and minorities (including the Irish Traveller community) is an important issue in Ireland.

The Irish population now includes a substantial number of non-nationals, including people from other EU countries and from further afield. As shown in Chapter 2, the 2015 QNHS special module on health indicates that these may be an underserved group in regard to mental healthcare services [5].

The Irish Traveller Community and the Roma are also important groups for attention [123]. The All Ireland Traveller Health Study (AITHS) identified a disproportionate burden of mental health issues experienced by travellers, including excess suicide rates in comparison to the population overall [124]. HSE has supported various initiatives in this field, including the independent Traveller Counselling Service. More generally, HSE has a number of small primary health teams, staffed part-time by Travellers, to help address the challenges faced by members of the Travelling community. There are HSE's plans to build on this resource, as well as continue to help Travellers access mainstream mental health services.

The refresh of AVFC may wish to address in more detail the provision of mental healthcare for non-nationals, Irish Travellers and other minority groups.

6.9.4 Family carers

In Ireland, the National Carers Strategy recognises the challenges faced by family carers and emphasises the importance of supporting their physical, mental and emotional wellbeing needs [125]. From the mental healthcare perspective, carers have a dual importance. They are key parties in the care and support for a family member with mental health problems, as well as at risk of mental and emotional wellbeing issues themselves because of the strains of the caring role. There may also be impacts on employment and on education for young carers.

Irish surveys [126] and surveys of carers in other countries [127] find a substantial proportion of carers are caring for someone with mental health or behavioural problems. They are caring for people of all ages with mental health issues, including children with ADHD and other behavioural conditions, young adults developing psychosis, and adults and older people with a broad range of conditions.

Recent Irish research has addressed some aspects of caring for persons with mental health difficulties [128]. Some research has also focused on information sharing with carers by mental health professionals [129], identifying a number of problematic issues for carers in this area. More generally, there are many anecdotal reports by carers in Ireland expressing concerns about professional reluctance to provide information about the needs of the person they are caring for and the risks that this may pose. There appears to be a lack of consistency across the country and across individual practitioners in this regard. Amongst others, the support group Shine has produced guidelines on this issue [130].

The refresh of AVFC may wish to address these important aspects of family caring for persons with mental health problems.

7 System Governance and Financing

A refresh of mental health policy in Ireland to follow-up AVFC requires consideration of the overarching issues of mental healthcare system governance and financing. This Chapter addresses a number of relevant aspects:

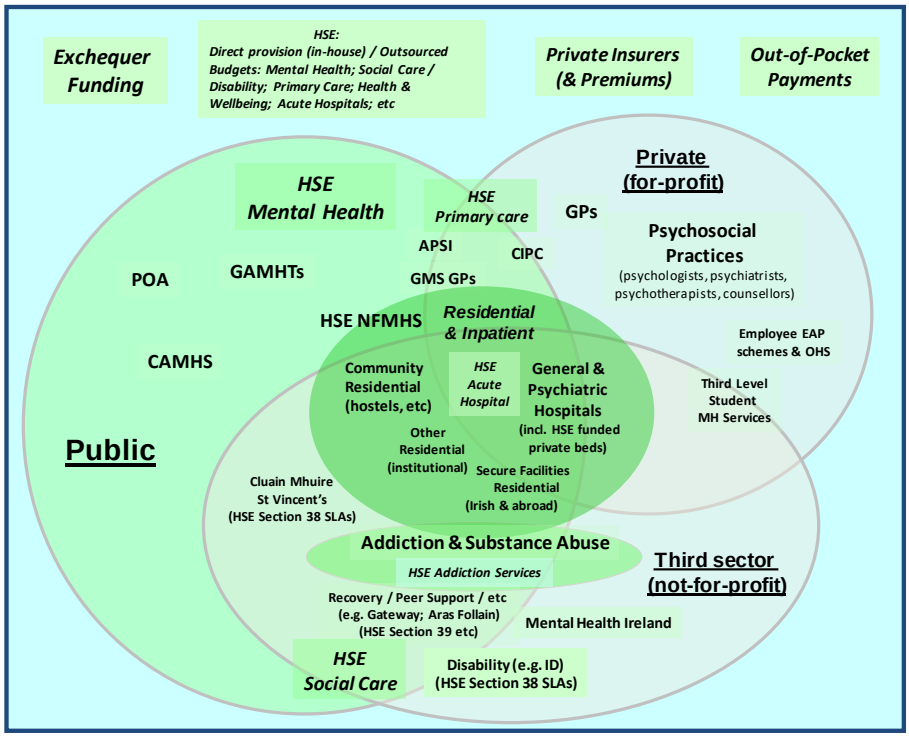
- governance, universality and the public-private mix
- the public mental healthcare provision system
- quality assurance
- innovation and change
- research, statistics and evaluation.

7.1 Governance, Universality and Public-Private Mix

7.1.1 Universality, public-private mix and equality/equity issues

There is ongoing policy consideration of how best to achieve universality in Irish healthcare against the background of the public-private mix that currently prevails. One feature of the mix is the differential access to healthcare services for those with medical cards and those with private health insurance. Another feature is the range of public, private (for-profit) and non-profit organisations involved in the provision of services. Figure 7.1 presents a mapping of some of the many elements of this complex ecosystem as it applies in the mental healthcare field in Ireland today.

Figure 7.1 Mapping of some of the elements of the public-private mix in mental healthcare



Source: the authors

This schema is for illustrative purposes and is not intended to be comprehensive or definitive. It helps to show the sectoral composition of the mental healthcare ecosystem and their areas of activity. The ecosystem comprises a mix of public services (or publicly-funded services), private (for-profit) services and third sector (not-for-profit services).

The public system provides much of the public services directly but also outsources (and/or funds in various ways) a considerable volume of service provision in the mental health domain. The HSE Mental Health division accounts for the largest share of public spending; other divisions also make important contributions. HSE Primary Care involvement is through the GMS scheme in a general way as well as through programmes such as Counselling in Primary Care (CIPC); HSE Social Care has a role through general homecare services as well as through funding of disability services which include elements of mental healthcare provision. HSE also provides or funds a substantial part of inpatient care as well as a range of community-based residential settings.

Third sector service providers play a formal role in some parts of the public services. For example, a number of area-based services receive funding under Section 38 arrangements and a range of mental health activities are funded through Section 39 arrangements. HSE also outsources to the private sector in various ways, for example through the CIPC scheme (funding counselling services for medical card holders), and funds some high cost services for small numbers of clients in secure units in Ireland or abroad.

The private mental healthcare sector provides both institutional and community/ ambulatory services, including the private psychosocial practitioner sector (psychiatrists, psychologists, psychotherapists, counsellors, etc). Clients of these services may be covered by private health insurance and/or have to pay out-of-pocket (in addition to any private health insurance premiums they may already be paying).

The schema also identifies at least two other provision systems in specific settings. Employee Assistance Programmes or other occupational health services may provide access to free or subsidised mental healthcare services. These would tend to be in larger organisations, in both the public and private sectors. Student mental health services are another relevant feature of the ecosystem, with coverage of a substantial share of the 18-25 age group (as well as the growing number of mature students) through a range of types and levels of services and supports across the universities and other third level institutions.

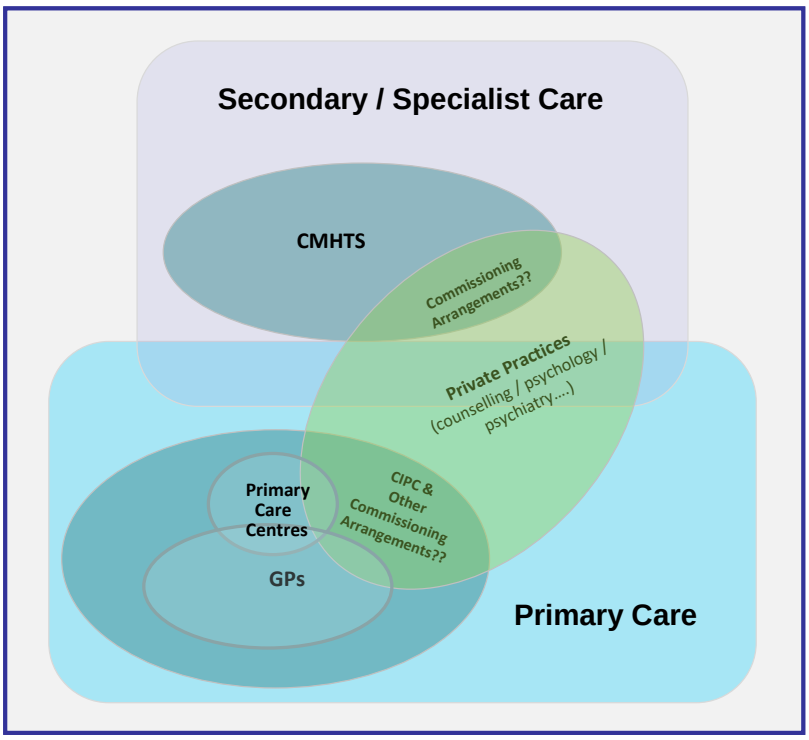
The refresh of AVFC may wish to consider how best to encompass this broad canvas in the articulation of an overarching policy framework and, where relevant, in practical governance arrangements. This perspective may also be helpful in seeking ways to effectively cover the full population and to optimally leverage the available capacity and activity across the different elements and sectors.

7.1.2 Commissioning community/ambulatory mental healthcare services

There has been discussion of the potential offered by commissioning arrangements to address some of the challenges in the Irish healthcare system overall as well as in the mental healthcare system, although there have also been differences of perspective and opinion voiced in the political and broader stakeholder discourse. Figures 7.1 and 7.2 show that 'commissioning' in various forms is an established and long-standing element in some parts

of public health and social care provision already in Ireland, with new applications emerging to support greater access and service improvements in various areas.

Figure 7.2 Key delivery systems in community-based mental healthcare in Ireland



Source: the authors

These types of arrangements may have relevance for the recruitment challenges that appear to be a significant barrier to service improvement in the public mental healthcare domain. They may also have relevance in the broader context of seeking ways to achieve more universality in the overall mental healthcare system in Ireland.

Previous Chapters have presented examples of approaches in other countries that relate to a variety of elements this 'commissioning' space. These may provide useful insights for the refresh of AVFC and the more general elaboration of the mental health vision and policy in Ireland. One example is in efforts to incentivise GPs (and primary care practitioners more generally) to play a larger and improved role in relevant parts of the overall balance of care in mental health services. This includes financial incentives through quality frameworks for GPs in the UK; detailed specification of services and associated billing arrangements for GPs in Canada (covering both counselling-type work for common mental disorders and longer-term care planning and monitoring for people with more severe and enduring mental health problems); and the variety of ways that the regulated universal insurance arrangements in the Netherlands have addressed the reimbursement of GPs and psychosocial practitioners in this area.

7.1.3 Differential access for public system users and private system users

The current de facto arrangements result in differential access for public system users and private system users of mental healthcare services. Both groups - crudely dichotomised into medical card holders and those without medical cards (with or without private health

insurance at different pricing and coverage levels) - generally begin their care pathway through the GP gate keeping system. Some form of GP-based gate keeping arrangement applies in many but not all countries. In Ireland, those eligible (and who wish to or have no option) may be referred to mental healthcare services in the public (or publicly-funded) primary or secondary mental healthcare systems. Others will decide to, or have to, follow the private route.

Chapter 2 presented data from the 2015 QNHS that underscores the need to improve access to mental healthcare services for users following the public route. Initiatives such as CIPC are relevant in this context. Public oversight of the private route is also important. This applies mainly in the public regulatory role of the private health insurance sector under the Minimum Benefit legislation. Historically, the focus in this area has been on inpatient care, with minimum provisions of 100 days in a calendar year for general psychiatric cover and 91 days for alcohol and substance abuse cover in a (rolling) five-year period. Specific insurers and insurance policies may increase this aspect of cover, as well as provide varying degrees of out-patient/psychosocial practitioner cover and excesses on same. In general, the current coverage of mental healthcare by health insurers in Ireland may encourage utilisation of in-patient rather than community/ambulatory care. The refresh of AVFC may wish to give attention to this aspect of the public policy remit in the mental healthcare domain.

The Health Insurance Authority has consulted the healthcare sector on the minimum benefit regulations. St Patrick's University Hospital responded to the consultation in 2010 and provides an example of the mental healthcare services perspective in this area [131]. Suggestions included: minimum benefit for psychiatric illness be increased to 180 days and that this limit would encompass both inpatient and day care services; the use of claims excesses be abolished completely for mental health care provision; the provision of child and adolescent mental health care in an approved centre be included as a minimum benefit; the transition period be extended from thirteen weeks to six months in the case of young adults moving from their parent or guardian's policy with no waiting period applying; the 91 day benefit in relation to alcohol coverage be abolished and extended to standard psychiatric cover in an approved centre.

More general data on inpatient admissions and length of stay for psychiatric care are also instructive in this context (e.g. [132]). The patient profiles for general hospital psychiatric units, psychiatric hospitals/continuing care units and independent/private and private charitable centres differ significantly. This includes patterns in median length of stay and profiles of diagnoses. It is possible that some of this may reflect incentive structures applying in the Irish public-private mix.

This issue of public-private mix and differentials also has relevance in the wider review of the Irish healthcare system as part of the ongoing efforts to design a more universal system. Studies conducted in this context have included mental health in their modelling of costings for various benefit 'Baskets' [133, 134]. The KPMG modelling, for example, included mental healthcare in three settings: care provided by community mental health teams; care in day hospitals and day centres; and care in acute hospital inpatient and outpatient settings. For all three settings, the modelling was for care for a period not exceeding 12 months. The refresh of AVFC may also wish to give attention to this wider aspect of universality in mental

healthcare in Ireland, including parity issues in the coverage of mental health care and physical health care.

7.1.4 Stakeholder roles in governance

Given the mix of players in the current mental healthcare ecosystem in Ireland as outlined in Figure 7.1, the issue of stakeholder roles and involvement in the overall governance of the domain is important. This is a theme that the refresh of AVFC may wish to address.

As an illustration, the arrangements in the Netherlands may provide insights useful for Ireland. Box 7.1 shows the latest mental health policy framework, the administrative agreement / mental health strategy (2013-2014, extended to 2017) [80].

Box 7.1 Administrative agreement / mental health strategy (2013-2014, extended to 2017) - Netherlands

This agreement is between: mental health provider organisations (GGZ); mental health professionals' associations (various Psychologist and Psychotherapist Associations; Psychiatrists Association; Primary Care Organisations); Health Insurers; umbrella organisation for user and family groups in mental health care (LPGGZ); and Ministry of Health (MoH). It includes:

- joint anti-stigma campaign (client organisations, insurers, care providers); MoH will co-finance projects to improve labour participation, outpatient provision, reducing/ preventing work absenteeism
- insurers and providers will organise a system based on GP care - where patients with both mental and physical conditions are properly identified and given the treatment and support they need (multi-stage approach, primary and secondary care linked to needs)
- insurers and providers to reduce the number of inpatient beds and give more importance to mental health outpatient care; recovery oriented programmes to enable people currently institutionalised to move towards social independence
- patient organisations to develop a personally-controlled electronic health record system to give patients access to information from medical records
- mental health care professional bodies and patient bodies, in close collaboration with all stakeholders, to establish ambitious programme of quality-driven development of treatment guidelines and related instruments such as care pathways, care standards, questionnaires and quality indicators (psychiatrist and psychologists' associations, with direct involvement of patient bodies)
- mental health providers to increase provision of information on the appropriateness, effectiveness and safety of care provided, as well as feedback on patients' experiences (primary and secondary care).

Source: [80]

The transition in 2006 to compulsory universal health insurance in the Netherlands through a (regulated) competitive private insurance provider market required the development of appropriate governance and regulatory arrangements to reflect the various stakeholders in the system. The result is a system regarded as very transparent and underpinned by strong information systems that facilitate negotiation and agreement amongst the competing interests. Those with formalised structural roles include the government, insurers,

healthcare providers (including mental healthcare providers), professional organisations (including mental health professionals) and user/family organisations.

7.1.5 Service user involvement

In the Irish context, national policy and the HSE strongly espouse the user role. This encompasses various levels of involvement, including a mandated involvement in the composition of the Mental Health Commission and the significant efforts and investments by the HSE in this area. Forms of support for user organisation involvement include HSE funding for Mental Health Ireland and funding for Mental Health Reform through Department of the Environment and Local Government's Statutory Scheme for National Organisations. Structural arrangements support local involvement of users in HSE mental healthcare services, as well as a variety of peer support and other initiatives.

The structural arrangements to involve user organisations in the governance processes in the Netherlands are of interest and may provide useful insights for a review of this area in the refresh of AVFC in the Irish context. There, the National Mental Healthcare Platform (LPGG) has a structural role in the multi-stakeholder oversight and governance processes. LPGG comprises user/consumer associations, carer associations and other NGOs. It addresses a number of areas of the mental health field, including: improving the overall mental healthcare system (quality, safety, transparency, legal issues, care integration); improving support systems for consumers and carers (financing self-help, peer-support groups, family involvement and consumer/carer organisations); and promoting appropriate work, payment and education for people with mental health conditions.

LPGG also has a quality label to reward care institutions for achievements important from the patient perspective, and they engage in many activities around recovery, eMental health and self-management, involvement of family in care, and other areas. The Dutch governance arrangements now include mandatory patient councils within healthcare institutions and may also include family councils although these are not yet mandatory.

User/consumer and carer organisations also have a role in the preparation of multidisciplinary guidelines, which ultimately require formal endorsement by boards of the professional organisations [80]. The user/consumer input may through a range of formal approaches, with results either incorporated as separate chapter in guidelines or integrated in the guideline text. Examples include: schizophrenia - user group led the patient perspective chapter in the guidelines; depression and anxiety - qualitative research on patient experiences with care; personality disorders - survey of consumers and carers. There is also a Network for Development of Quality in Mental Health Care involving collaboration between the associations of Psychologists and of Psychiatrists and the user/family umbrella organisation.

One feature of the Dutch situation is the strong visibility and involvement of the family/carer (as well as the direct client/user) sector and perspective, at both collective and individual case level. In Ireland, the main focus appears to be at the collective level and there has been less attention to the role of family/carer at the case level. Anecdotal evidence suggests that this can be a problematic issue and that the absence of national practice guidelines results in variability across clinicians in the extent to which they involve families and the criteria they

use to decide on this. The refresh of AVFC may wish to consider this case-level aspect, as well as the broader collective levels of user/family engagement.

7.2 Public System - resource allocation, and professional and skills mix

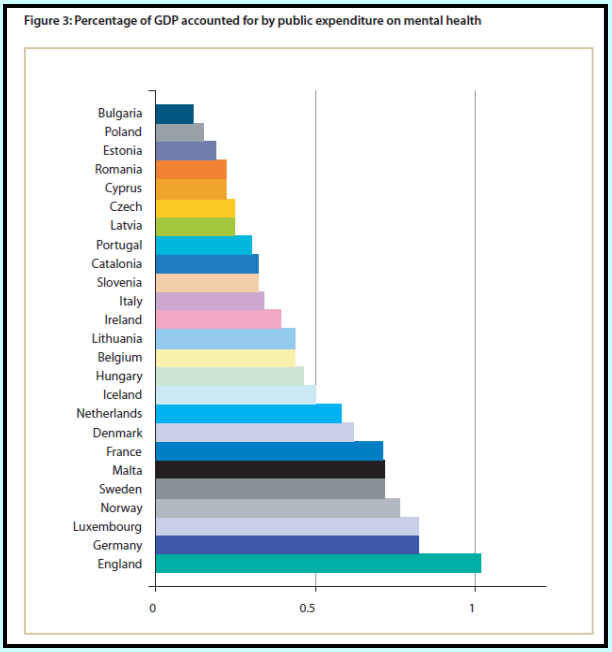
This section looks at some aspects of the public system (publicly provided or publicly-funded mental healthcare), with a focus on resource allocation and professional and skills mix.

7.2.1 Resource allocation

Other Chapters, especially Chapters 2 and 3, have already addressed issues of resource allocation within the overall healthcare budget and the following is a brief reprise of this. Based on official data, the current percentage allocation to mental health seems to be around 6%, although the percentage varies depending on which elements of overall health expenditure are taken into account as well as what elements of healthcare are included within the mental health allocation (e.g. relevant parts of the social care allocation, and of dementia care services).

A comparative positioning of Ireland internationally suggests that the percentage resource allocation today is around the median level across EU countries, and lower than in some of the countries with better developed and better performing mental healthcare systems (e.g. [135, 136]). These data indicate levels of allocation of 10-13% in countries such as Sweden, Netherlands, Germany, France and UK. The public element of overall health expenditure in Ireland in 2013 (not counting the insurance contribution and out-of-pocket payments) was about 7.1% of GDP. The data in Box 7.2 suggests that the public spend on mental health, in percentage GDP terms, is well below the levels recommended in AVFC and other sources. AVFC also presented data showing that the relative spend on mental health had declined considerably in the twenty-year period leading up to the report in 2006.

Box 7.2 Public mental health expenditure as a percentage of GDP



Source: [12]

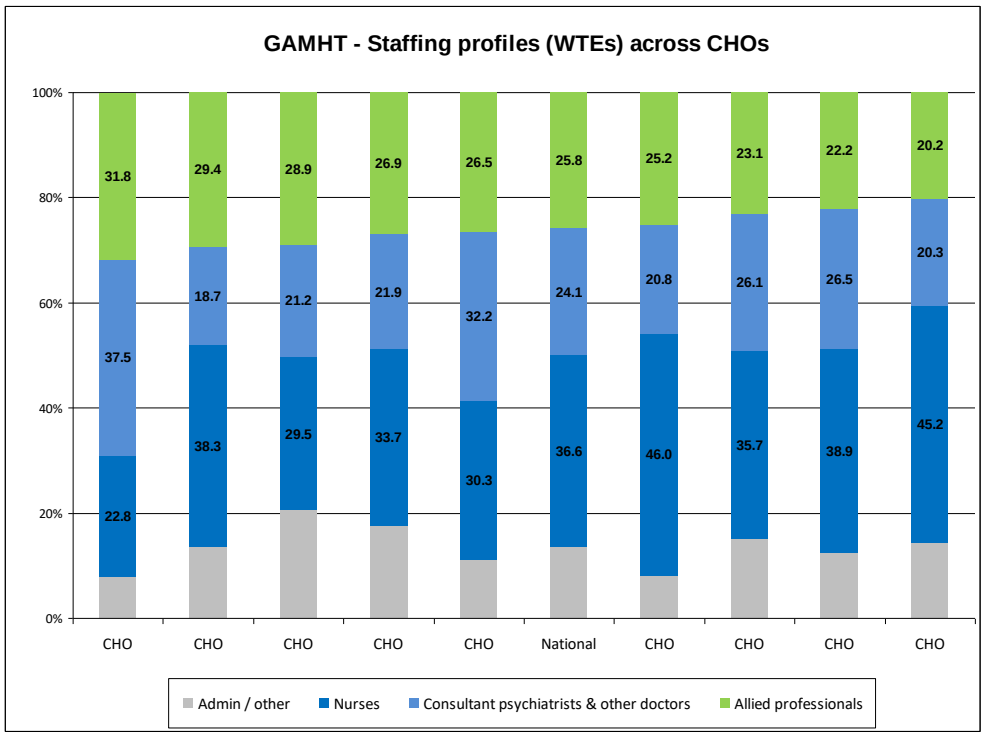
Although such comparative data must be treated with caution because often they do not compare like with like, they do provide some indicative positioning of the (relative) importance given to mental health as reflected in the level of financial resources allocated. AVFC proposed a target of 8% for mental health spending from the overall health allocation. Other commentators have suggested higher figures (e.g. [10]).

Equally important is the allocation of resources (and costs) within the mental healthcare sector itself. Given the timeframe, this research could not focus on such data in Ireland. However, data from other countries suggest that large proportions of expenditure are consumed by a relatively small number of high cost clients and that, despite the de-institutionalisation agenda, there has not been commensurate shifting of resources to the community/ambulatory sector

7.2.2 Manpower and skills - mix and sufficiency

The issue of professional manpower/skills mix and sufficiency is another theme in mental healthcare in Ireland today. Much of the focus has been on the yardsticks proposed in AVFC. On the aggregate, the available data suggests that the manpower levels in the HSE's community/ambulatory services have been increasing but are currently at about seventy five per cent of the AVFC targets. The refresh of AVFC might wish to re-examine the basis for the original targets in today's environment, as well as whether it is possible to develop needs-based or other approaches to complement the population-based perspective.

Figure 7.3 Staffing mix in General Adult Mental health Teams (GAMHT)



Source: HSE (data for September, 2016)

As regards the manpower/skill mix, the latest available HSE data on staffing profiles in general adult mental health teams (GAMHT) show considerable variation across CHOs in the manpower mix in key professional categories - psychiatric/medical (consultant psychiatrists, senior registrars, registrars, SHOs); nurses; and allied professionals (psychologists, occupational therapists, social workers, addiction counsellors) (Figure 7.3).

Box 7.3 presents a comparative profiling of Ireland against other OECD countries. Although this data is instructive it is also important to consider the underlying skills mix that the staffing profiles encompass, as well as the extent to which particular skills are actually applied. For example, there have been many developments in the skills profile of nursing staff in the mental health field in Ireland and many nurses may be operating, or at least skilled to operate in areas (such as psychosocial intervention) that might traditionally have been the preserve of other disciplines [137]. Likewise, there has been discussion about the skillsets that some disciplines (such as social work) might best contribute to the multidisciplinary approach.

Box 7.3 Professional manpower and mix in mental health care

Table IV. 42. Human resources working in mental health (public and/or private) services in 2011, per 100,000 inhabitants in EU

COUNTRY	PSYCHIATRISTS	GENERAL QUALIFIED NURSES	PSYCHOLOGISTS WORKING IN MENTAL HEALTH SERVICES	SOCIAL WORKERS	OCCUPATIONAL THERAPISTS
Austria	19.7	–	–	–	–
Belgium	–	0.0	1.3	0.9	0.0
Bulgaria	6.7	431	0.9	0.5	–
Croatia	10.2	35.6	2.9	1.0	0.6
Cyprus	6.8	42.2	28.9	–	8.4
Czech Republic	11.8	28.2	2.0	.9	.3
Denmark	14.1	–	–	–	–
Estonia	13.5	–	–	–	–
Finland	28.1	–	–	–	–
France	22.3	86.2	47.9	3.8	–
Germany	15.2	56.1	–	–	–
Greece	12.9	–	26.8	–	–
Hungary	6.52	21.9	2.5	3	–
Ireland	6.1	112.8	3.5	3.8	3.2
Italy	7.8	19.3	2.6	1.9	2.2
Latvia	10.8	–	–	–	.4
Lithuania	17.8	–	–	–	–
Luxembourg	21.1	–	–	–	–
Malta	3.2	66.8	4.4	5.1	4.6
Netherlands	18.8	132.3	15.1	–	–
Poland	5.1	17.6	3.6	.6	5.3
Portugal	6.1	12.1	2.1	1	.5
Romania	6.4	14.1	–	–	–
Slovakia	11.5	19.3	–	–	–
Slovenia	7.1	69.7	4.5	3.7	1.3
Spain	8.6	9.8	5.8	2.6	1.3
Sweden	3.5	28.9	.9	18.4	.5
UK	–	–	–	–	–

Source: Mental Health Atlas 2011, WHO

Source: [138]

7.2.3 Service configuration

A focus on quantitative profiling of staffing numbers and on numbers of teams has tended to dominate the presentation of developments in community mental healthcare services in Ireland. It is less clear how the relatively large number of teams actually operate. This makes it difficult to gain a picture of the levels of service available across the country, where they operate from and the scope of the services they provide.

A perusal of the websites of the HSE LHOs indicates wide variation in the nature and detail of the mental health service descriptions across the country. Some LHO service descriptions are quite elaborate whereas others are somewhat minimalistic in content. Catchment area reports from Mental Health Commission also suggest quite wide variation across the country, and other sources [139] also underline this.

The refresh of AVFC may wish to give attention to this aspect, including qualitative mapping of existing community based services / teams in their structural and operating characteristics and in the service portfolios that they offer. In regard to service portfolios on offer, the issue of choice may also be a topic for attention. A recurrent theme in the wider discourse has been differences across the country in the therapeutic options available, dependent on the orientations of the clinical leadership and/or the available staffing/skills profile. Aspects include orientations towards medication or talking therapies, as well as preferred approaches in the talking therapy domain. This is an important element for consideration in quality assurance of mental healthcare in Ireland.

7.3 Quality Assurance

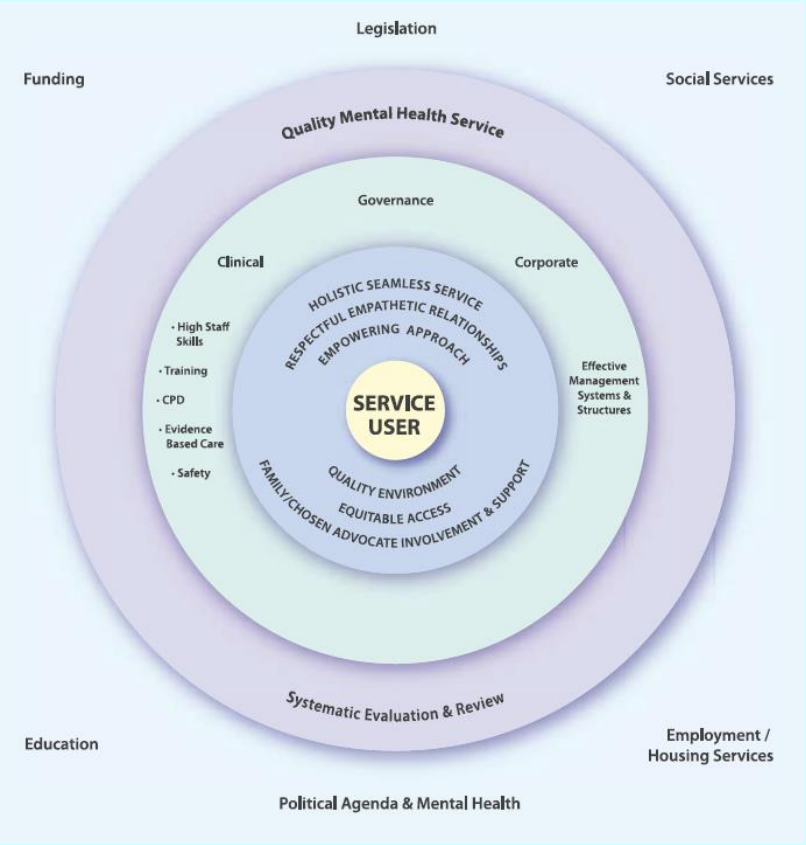
There are many important elements to quality assurance. Some are already mentioned in section 7.2, including timely access to appropriate services and choice between therapeutic approaches where relevant and desired. Consistent provision of services across the country is another aspect requiring consideration.

There are a number of HSE initiatives addressing quality assurance, including clinical programmes and standard operating procedures. The Mental Health Commission also developed a series of quality tools as well as an overall quality framework (Box 7.4) which maps to the contents of AVFC [140]. This might be relevant to re-visit in the refresh of AVFC.

More generally, some of the other countries covered in the review have developed service and clinical guidelines for mental healthcare practice. In England, NICE has established a specific centre for mental health (National Collaborating Centre for Mental Health - NCCMH). This centre develops guidelines on appropriate care and treatment within the NHS. Guidelines have been published on Anxiety; Bipolar disorder; Depression in Adults; Schizophrenia; and other mental health disorders.

In the Netherlands, there are a number of multidisciplinary guidelines on mental healthcare (Box 7.5). The Trimbos Institute is a key player in the mental health quality field as well as the Network for Development of Quality in Mental health Care [80]. The network is a collaborative programme involving the associations of psychologists and of psychiatrists and user/family umbrella organisations. A collaboration between Trimbos in the Netherlands and NICE in UK is working on guideline projects for autism for adults and bipolar disorders.

Box 7.4 Mental Health Commission's Quality Framework



Source: [140]

Box 7.5 Multidisciplinary guidelines on mental health (2003-2011) - Netherlands

- Anxiety disorders
- Depressive disorders
- Schizophrenia
- ADHD in children
- Eating disorders
- Personality disorders
- Interventions following disasters
- Alcohol disorders
- Domestic violence
- Anxiety disorders in the elderly
- Depressive disorders in the elderly
- Depressive disorders in children
- Somatically unexplained complaints and somatoform disorders
- Suicidal behaviour
- Heroin addiction
- Autism in adults (with NICE)
- ADHD in adults
- Bipolar disorders (with NICE)

Source: [80]

7.4 Innovation and Change

There are a number of current HSE and other programmes to promote and accelerate innovation and necessary change in mental healthcare in Ireland. The HSE has established a transformation programme and there is also the Service Innovation Fund initiative with Genio. The refresh of AVFC will likely seek to align with these areas of activity where relevant.

Approaches in other countries may also be of interest in this context, such as the Breakthrough Quality Collaboratives (QICS) in the Netherlands (Box 7.6). This approach to promote rapid change and progress in priority areas might be helpful in the Irish context, to enable relatively quick-fixes in relevant areas alongside the slower and more transformational change processes.

Box 7.6 Breakthrough Quality Collaboratives (QICS) - Netherlands
Breakthrough Quality Collaboratives (QICS) are quality improvement projects that use multi-faceted strategies in order to rapidly improve performance and outcomes. In the mental health field, QICs have been used to implement the guidelines on depression, anxiety disorders, schizophrenia and ADHD. Essential features include: • a focus on a specific topic, where there are gaps between best and current practice • clinical experts who provide ideas and support for improvement • participation of multidisciplinary teams from multiple sites • a model for improvement (setting targets, collecting data and testing changes) • a collaborative process with a series of structured activities within a given timeframe.
Source: [80]

7.5 Research, Statistics and Evaluation

The issue of parity of esteem for mental health within the wider healthcare domain applies also to health research funding. In Ireland, apart from suicide research and mental health promotion, there has been a limited volume of research on mental healthcare issues, with many gaps in knowledge on the prevalence of mental health conditions and their impacts, and on how the mental healthcare system is performing in addressing needs. Service development and resource allocation requires good underpinning evidence. The refresh of AVFC may wish to consider the development and commensurate funding of a research strategy on mental health, including basic research as well as research that can directly support policy, system and service developments.

Linked to this is the development of an adequate statistical profile of the mental health situation in Ireland today. The current focus tends to be towards key performance indicators addressing operational features of the system and services. Other countries have developed more elaborate statistical and monitoring systems, including efforts to produce more meaningful operational performance data as well as detailed data on prevalence and need and on outcomes. The Netherlands provides an example of what is possible in this area, including prevalence/needs data and outcomes data (Box 7.7). Also of interest is the NHS

Dashboard initiative with performance indicators covering employment and housing (https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/).

Box 7.7 Prevalence / need / service utilisation / outcomes data - Netherlands

NEMESIS-2 national survey (Netherlands Mental Health Survey and Incidence Study-2)

- prevalence of common mental health problems: mood disorder; anxiety disorder; substance abuse disorder; ADHD or behaviour disorder, any Axis 1 disorder; antisocial personality disorder
- 11.4% of population aged 18-64 used any form of mental healthcare in past 12 months; 5.7% had taken medication; mood disorder most frequent users, and most frequently prescribed medication; followed by anxiety disorder or ADHD
- severe mental illness: consensus group agreed definition and numbers (2013)
    - In 2013: estimated 160,00 aged 18-65 were receiving care for this; total number (including younger and older) was 216,000 (estimated pop prevalence was 281,000 - one third higher):
        - psychotic disorder (60%); addiction (10%; 30% (other)
        - outpatient ambulatory (60%), inpatient (13%), combination (25%)
        - FACT teams the main provider groups treating these patients

Mental Health Care Benchmark Foundation collects outcomes data on seven categories of mental healthcare clients:

- adults: common mental disorders; severe mental disorders; substance abuse in short-term treatment; substance abuse in long-term treatment
- children and adolescents
- elderly (psychogeriatric and gerontopsychiatric care)
- forensic care

Records outcomes data in a number of domains:

- reductions of symptoms
- functioning in daily life
- quality of life
- parental stress (children and adolescents)
- use of substances
- etc.

Commenced data collection in 2012 - in 2013 had about 100 thousand cases covered (of 1 million registered Diagnostic Treatment Conditions). Primary and secondary mental healthcare care providers are required to collect patient satisfaction and experience data; results can be disclosed to health care providers, health care insurers, patients, patient organisations, etc in order to help patients make informed choices.

Source: [80]

8 Synthesis and conclusions

This Chapter presents a synthesis of the material collated and reviewed in previous Chapters and suggests how it may be helpful in guiding a refresh of AVFC policy in Ireland. The report provides a broad overview and mapping of evidence and developments in the mental health area that may be helpful in guiding policy development and practice in Ireland. It presents an information resource and does not make recommendations as such. Nevertheless, it may be useful and appropriate to comment briefly on the relevance and possible approaches for taking forward the various issues raised in the report.

Box 8.1 lists some of the key points arising from the evidence and practice review, and the following sections elaborate briefly on these. This might be helpful in the context of any operational follow-up, such as an Action Plan, to progress the policy agenda and improve services and other aspects of the mental health field in Ireland. It may be that sufficient consensus will emerge around key areas for action, and that an action plan underpinned by a light touch 'refresh' of AVFC might be an effective approach.

Key points from the evidence and practice review
Prioritisation of mental health as a major societal issue • Recognition and strategic action to address its economic and social importance • Establishment of concrete cross-sectoral actions • Within healthcare system: parity of esteem; physical health co-morbidities **Primary prevention and positive mental health** • Perinatal and early years • Educational settings • Workplace • Other target groups **Social inclusion/recovery** • Living well with mental illness • Housing • Employment • Social inclusion & peer support **Mental healthcare services** • Addressing the spectrum of conditions and needs • Balance of care and delivery systems: primary and secondary • Recovery approaches in mental healthcare practice • eMental health • Inpatients and community residential settings • Other areas: addiction/substance misuse; prisoners; non-nationals/minorities; carers. **Governance and financing** • Universality, public-private mix and equality/equity • Quality assurance • Innovation and change • Research, statistics and evaluation.

8.1 Prioritisation of mental health as a major societal issue

The review found extensive evidence indicating the economic and social importance of mental health issues, as well as efforts in various countries to give more priority to mental health both within the healthcare system and by other relevant sectors. Attention focused on three aspects of this theme:

- Recognition and strategic action on addressing the economic and social importance
- Establishment of concrete cross-sectoral actions
- Within the healthcare system: parity of esteem and addressing co-morbidity issues.

8.1.1 Recognition and strategic action on the economic and social importance

There is strong evidence showing the economic and social importance of mental health disorders in Ireland and internationally. This includes the enormous human costs but also the very large economic costs. A large portion of these costs accrue to the social protection system, employers and the wider economy.

Studies have shown the substantial returns on investment that a broad range of prevention and treatment mental healthcare interventions can yield. This may include better outcomes for the mental health care sector and for the physical healthcare sector, cost-savings arising from prevention, and substantial cost-savings and other contributions across other areas of the public sector, economy and society.

Public spend on mental health - especially strategic 'upstream' investment in preventative, early intervention and community-based services - is therefore best viewed as an investment rather than a cost. Australia has clearly articulated this perspective to underpin government policy. Such investment can yield substantial 'downstream' savings from less utilisation of more expensive services / facilities and gains in other areas of public expenditure and the wider economy and society. For optimal economic and societal gains, this requires a visionary cross-sectoral perspective by government. Investments in one area of the public sector (such as mental healthcare treatment and prevention) may yield cost-saving and economic benefits in other areas of the public sector, sometimes in the short-term but also in the medium and longer term.

8.1.2 Establishment of concrete cross-sectoral actions

The review indicated the cross-sectoral nature of many of the issues in the mental health domain. The mental healthcare sector has important shared and overlapping responsibilities with other sectors, including the legal and judicial systems; the employment, education and housing sectors; and the social protection system.

There is recognition of this cross-sectoral dimension in Ireland, with some structures and activity emerging between mental health and sectors such as housing, employment and the judicial system. Other countries provide potentially useful examples of concrete inter-sectoral actions at governmental/ministerial levels and amongst key players at sectoral levels. Just some examples are the covenants and concordats with the police in England and the Netherlands, and the arrangements between mental healthcare services and employment services in the Netherlands.

8.1.3 Within the healthcare system: parity of esteem; physical health comorbidities

Along with many other countries, Ireland appears to allocate a smaller proportion of the overall health budget to mental healthcare than its relative importance warrants because of disability burden, economic impact and potential for efficient use of scarce resources. Countries with better developed mental healthcare systems allocate proportionally greater amounts to this sector.

Some countries, such as England, frame the issue as one of 'parity of esteem', albeit sometimes experiencing challenges to realising this vision. Parity of esteem refers both to resourcing mental healthcare commensurate with its importance in the wider healthcare system and to broader issues around professional recognition for mental health care. There may be merit in developing this perspective in Ireland as well.

Another development since AVFC has been the increasing recognition and evidence base indicating the interplay between mental health conditions and physical health conditions. Apart from relatively independent co-morbidities, there are important interactions between mental health and physical health. These include causal associations (in either or both directions) as well as other interactions such as impacts of mental health conditions on management and outcomes of long-term physical health conditions. International studies consistently find mental disorders are associated with much higher risks of all-cause mortality compared to the general population, as well as increased risk of many health conditions and poorer outcomes with these.

8.2 Primary Prevention and Positive Mental Health

There is now a wide recognition of the importance of primary prevention and promotion of positive mental health. The review addressed a number of settings and target groups for prevention and mental health promotion:

- Perinatal and early years
- Educational settings
- Workforce
- Other target groups.

8.2.1 Perinatal and early years

The perinatal period (pregnancy to 1 year) brings risks of mental health problems for some women and is also an important period for early intervention and mental health promotion more generally. Screening is important but integration of services is also a key issue. The refresh of AVFC may wish to give attention to these aspects, in particular the integration of services (mental health, maternity, GP, public health nurses) and specialist perinatal mental health services. The approach in New Zealand provides an example of focused efforts in this area, addressing the challenge of developing effective provision of specialist perinatal mental healthcare inputs within the more general continuum of care over the perinatal and early parenting/childhood years.

8.2.2 Educational settings and young people

The government recently announced plans to roll out mental health promotion programmes as part of a school wellbeing curriculum in Ireland. The review identified potentially useful examples of approaches in other countries that may be helpful in this context, for example, NICE guidelines and programmes by the Department for Children, Schools and Families in England. Given that the youth focus now tends to extend to include the 18-25 year age group, the Irish approach might also consider the possibilities for engaging with the third level sector as well as primary and secondary level schools.

Initiatives tackling bullying and cyberbullying are also important. In 2013, the Oireachtas published a report on 'Addressing the Growth of Social Media and tackling Cyberbullying'. This might be re-visited in the refresh of AVFC.

8.2.3 Workplace

Extensive evidence is available showing the importance of mental health (and mental health promotion) in the workplace to address morbidity, absenteeism, reduced productivity and early retirement of skilled workers. Stress and other psychosocial factors at work can lead to mental health problems and mental health conditions can affect work performance. Some of the reviewed countries have a strong focus on workplace mental health, including legislative provisions and a range of sectoral programmes and initiatives. This is an area requiring more attention in Ireland.

8.2.4 Other groups

The review identified a range of programmes across other countries targeting particular at-risk groups, for example, unemployed people and older people. The refresh of AVFC may wish to give more detailed attention to mental healthcare issues and supports for these groupings. Given the timeframe, the review gave just brief attention to suicide prevention and initiatives addressing self-harm. These are clearly important areas for the refresh of AVFC.

8.3 Recovery, social inclusion and living well with mental illness

AVFC had a strong focus on recovery and on the social inclusion of people with mental health difficulties more generally. There has been progress in this area in Ireland, but many stakeholders feel there is a lot more to be done. The international review found examples of well-developed recovery oriented supports in some of the other countries. The review addressed a number of aspects of this, including:

- Living well with mental illness
- Housing
- Employment
- Social inclusion & peer support.

8.3.1 Living well with mental illness

It is increasingly recognised that mental illness and positive sense of wellbeing are not necessarily mutually exclusive. Some people with enduring mental illness may have good

mental health in the sense of positive wellbeing, especially if they have the opportunity for fulfilment in their personal, social and working lives. The report introduces the notion of 'living well with mental illness' to encompass this perspective, borrowing from the perspective commonly applied in the dementia field. This is a central aspect of the recovery perspective.

8.3.2 Housing

Appropriate housing is essential for recovery and for living well with mental illness. This is a recognised area of responsibility for the public housing sector in Ireland, including provision of mainstream housing options for people currently residing in community hostels and other residential situations. However, progress appears slow in implementing practical supports and achieving stated policy goals.

The review identified some promising initiatives in Ireland based on floating support services that help people with mental health difficulties find suitable housing. This includes transition to independent living and support in managing tenancy-related and other aspects thereafter. Expansion of such services in Ireland could make an important contribution to delivering on this aspect of mental health policy. The international review found examples of well-developed approaches to this in a number of other countries.

8.3.3 Employment

Opportunities for employment can be very important for recovery and for living well with mental illness. Again, the review found examples of well-developed approaches to this in a number of other countries, such as the Netherlands, including structural linkages and operating procedures between mainstream employment-finding and support services and mental healthcare services. The Individual Placement and Support (IPS) model is an important approach in this field. Although there have been some recent initiatives in Ireland, the more mainstream linkages between the employment services and mental healthcare services remain under-developed. Again, expansion of this area of support in Ireland would be important for delivering on the recovery aspect of mental health policy.

8.3.4 Social inclusion and peer support

In addition to housing and employment opportunities, broader social inclusion supports may also be helpful for many people with mental health difficulties. Peer support initiatives have an important role in this, building or enhancing various forms of social capital. In Ireland, there has been public funding for some initiatives of this type and there may be value in considering further expansion of this approach.

8.4 Mental healthcare services

The review gave particular attention to good practice and innovation in mental healthcare services. This covered a number of aspects, including:

- Addressing the spectrum of conditions and needs
- Balance of care and delivery systems: primary and secondary
- Recovery approaches in mental healthcare practice

- eMental health
- Inpatient and community residential settings
- Other themes - addiction/substance misuse; prisoners; non-nationals/minorities; carers.

8.4.1 Addressing the spectrum of conditions and needs

The spectrum of mental health conditions covers a very wide range of diagnostic categories which manifest themselves in a diversity of symptoms and associated impacts on functioning and well-being. Although we do not have a comprehensive profile of incidence and prevalence rates for the various conditions in Ireland, data from other countries can help to put some indicative scaling on prevalence across a range of conditions.

A crude extrapolation of Australian data to the Irish situation would give rough estimates of about 600,000 people with mild-to-moderate conditions (anxiety, depression, etc.); about 125,000 people with severe episodic/severe and persistent complex and chronic conditions (schizophrenia, bipolar, eating disorders, severe depression etc.); and about 13,000 with severe and persistent complex multi-agency needs and psychosocial disability. European prevalence data extrapolated to Ireland would indicate about 41,000 for psychotic disorders, 281,000 for mood disorders, 518,000 for anxiety disorders, and 141,000 for somatoform disorders. Other conditions worthy of note include Post-Traumatic Stress Disorder (PTSD), important in the context of historical sexual abuse and in the increased exposure to terrorist violence.

Depression and anxiety are particularly important due the scale of their impact in years lost to disability across the population. Across all health conditions, they rank high on the list in this regard and especially high in impacts on subjective wellbeing. The allocation of resources within the Irish mental healthcare sector must endeavour to cover the full spectrum of needs in an appropriate manner, including both the more common conditions and those less common but costlier to treat.

8.4.2 Balance of care and delivery systems: primary and secondary care

Ireland and other countries have recognised the challenge to put in place effective delivery systems and achieve an appropriate balance of care across this spectrum of mental health conditions and range of types and levels of support required. To support resource allocation in England, for example, the NHS has developed a clustering system and a non-mandatory tariff structure linked to this. The approach identifies a number of care clusters based on a combination of diagnostic category and level of associated disability.

The report develops an operational framework identifying relevant features of the Irish care ecosystem today. This includes primary care components (GPs, primary care centres, Counselling in Primary Care, independent psychosocial services and professional practices); secondary/specialist care components (community & other ambulatory; hospitals and other residential; independent psychiatric and other psychosocial services and professional practices); and linkages between primary and secondary/specialist services (referral pathways and other linkages - liaison, consultative etc.).

The report presents examples of approaches to optimal utilisation of primary and secondary care services from a number of other countries. These include efforts to increase capacity

and incentivise GPs to address common conditions and also to provide continuing care and care management for people with more severe and enduring conditions. Also important is early intervention in severe mental disorder, and the report presents evidence and examples of approaches in other countries that may provide useful insights for Ireland.

Crisis care and interworking with the police and judicial system is another important theme. The report presents examples of well developed approaches in this area, including the covenants and concordats with the police in England and the Netherlands.

Coverage across the stages of the lifecycle is also important. Due time constraints the review mainly focused on general adult mental healthcare services, with more limited attention to child and adolescent mental health and to specialist areas of mental healthcare for older people. It is likely that the refresh of AVFC will wish to give more detailed attention to these areas.

8.4.3 Recovery in mental healthcare practice

Recovery perspectives and approaches have become increasingly influential in mental healthcare practice. In Ireland, AVFC espoused this approach and the HSE Mental Health Division has embraced the perspective, with various activities underway in this field. The report presents guidelines from Canada as an example of the development of this approach elsewhere.

As well as embracing recovery within mental healthcare service provision and practice, recovery is recognised as an intersectoral issue. Alongside clinical care, it requires inputs in areas such as housing, employment and more general social inclusion. This may involve the inclusion of skills in these wider areas of support within mental health teams, or coordinated inter-sectoral working arrangements between the mental healthcare sector, housing, employment and other relevant sectors. The FACT (Flexible Assertive Community Treatment) team approach in the Netherlands provides an example of the incorporation of a broad range of skillsets in mental healthcare teams.

In Ireland and internationally there has been increasing interest in the role that peer support can play in recovery for people with mental health difficulties. The HSE has published guidance to support formal services wishing to incorporate peer support. The report also presents a recent evaluation and analysis of peer support initiatives in Ireland that may provide useful insight and guidance for a refresh of AVFC.

8.5 eMental Health

One of the challenges facing the mental healthcare sector in Ireland and other countries concerns effective (and cost-effective) ways to reach the large numbers of people with common mental disorders. Some commentators suggest that eMental Health has the potential to be a game-changer in this field.

eMental health covers a broad spectrum, from formal delivery of therapy to self-help apps and online information. The scope includes:

- telephone-based delivery of therapy sessions, including telepsychiatry and telecounselling

- delivery of structured therapeutic protocols such as CBT, including eCBT (online) and cCBT (computer-based); approaches may vary in the involvement or not of human service professionals (i.e. whether 'blended' or not)
- mental health self-help applications, including mental health apps, online tools and other self-help tools; these may include formal services, such as medication reminders, ongoing supports in addiction treatments, and other applications
- online peer support through social media and other platforms (mental health '2.0'), either moderated (by professionals or peers) or unmoderated
- online information and psycho-education.

There is a broad body of emerging evidence on aspects of efficacy and cost-effectiveness across this spectrum. Systematic reviews have found some evidence of efficacy although also point to limitations in the methodologies of many of the reviewed studies. Overall, the indications are that well-developed applications can have comparable efficacy to traditional approaches when appropriately provided and in approriate delivery environments.

eMental health might merit focused attention in the refresh of AVFC policy in Ireland. It may be worth examining the extent to which eMental Health could be something of a 'game-changer' through provision of cost-effective ways of providing access to treatment and other supports and reaching more people who can benefit. In this context, it may be useful to look at approaches in other countries where eMental health in various forms is now actively incorporated as a component of the mainstream system and spectrum of available services. These include almost all the countries covered in some detail in our review.

In doing this, it is important to adopt a measured perspective and avoid blanket generalisations. This is a dynamically evolving domain, with inevitable hype. There may be risks of technology-push as well as unwarranted professional resistance, with neither in clients' interest. A considered and balanced perspective is required, through informed and organised mapping of the terrain and evidence base, as well as the opportunities and risks presented in the Irish mental healthcare ecosystem.

Although eMental health services offer considerable potential, the internet and social media also bring new mental health issues and new challenges for mental healthcare services. These include cyberbullying, as well as a range of conditions and impact areas such as online grooming, excessive utilisation of online sexual material, online gambling, more general concerns about overuse of online media instead of face-to-face social interaction, and many other issues. As mentioned already above, the Oireachtas published a report on 'Addressing the Growth of Social Media and tackling Cyberbullying' and the refresh of AVFC may wish to revisit this important theme.

8.6 Inpatient care and other residential settings

Given the timeframe available, the current study focused especially on community and other elements of ambulatory care, and adopted a lighter touch approach to inpatient care and other residential settings. The refresh of AVFC may wish to address these areas in a more detailed manner.

One issue is the adequacy or otherwise of the current stock of psychiatric inpatient beds now that the de-institutionalisation agenda has been extensively progressed. OECD data positions Ireland at a little below the OECD average in number of beds provided per capita. This is not necessarily a good or a bad thing, but there is need for a review of the current supply as regards the amount and mix of types of beds relative to need in the Irish context.

In Ireland, the Mental Health Commission monitors and reports on various aspects of inpatient mental healthcare, including use of restraint and seclusion. The Commission's Annual Report 2015 raises a number of issues. The review of other countries for this study found some examples of well-developed approaches to improving practice in the use of restraint and seclusion (England and the Netherlands), as well as extensive investment to upgrade inpatient infrastructures and patient facilities (England) and provision of advocacy for inpatients (Netherlands).

The Mental Health Commission has also pointed to a number of issues of concern in the current provision of community residential facilities for people with mental health conditions in Ireland. The AVFC report envisaged a major reduction in usage of community residential facilities and a re-focusing towards supporting independent living in the community. Progress appears to have been slow in this area, but there have been recent initiatives aiming to address this. The HSE and HAIL programmes mentioned earlier are important in this context, and the refresh of AVFC may wish to give further attention to the possibilities offered by this approach.

It may also be useful to look more broadly at the role that (upgraded and refurbished) community facilities might continue to play in the Irish situation. This could include a potential role in provision of short-term crisis care facilities, as well as in step-down and other interim or transitional arrangements for people discharged from psychiatric inpatient beds or other situations.

8.6.1 Other themes

The report also addressed some other specific mental healthcare themes:

- addiction/substance misuse
- prisoners
- non-nationals/minorities
- family carers.

Addiction and substance misue
Many commentators have suggested the need for better integration of addiction and substance misuse services within the mental healthcare system in Ireland. The HSE clinical programme on Dual Diagnosis should help improve the situation. The Netherlands provides an example of a country that has given a high importance to addiction and substance misuse within mental healthcare, with the scope encompassing addictions to nicotine, alcohol, drugs, and sedatives and tranquilisers.

Prisoners
A current focus in Ireland is on improving the mental healthcare provision for prisoners. Some elements of the approaches from other countries may provide useful insights in this

context. Studies consistently show that the prevalence of mental disorders in prisons is far greater than in the general population. Suicide rates for male prisoners are much higher than the general population.

The research found variation across countries in whether funding and responsibility for prison mental health care is the responsibility of a Ministry of Justice (or similar ministry) or the Ministry of Health, with a shift towards mainstream health system responsibility in some countries in the last decade. In England there has been a shift from a Home Office commissioned prison health service to NHS commissioning of all health services for prisoners today. Specialist 'assertive community treatment teams' are also developing to operate in prisons and better recognise risk and provide support.

Non-nationals and minorities (including the Irish Traveller community)
The Irish population now includes a substantial number of non-nationals, including people from other EU countries and from further afield. The 2015 QNHS special module on health indicates that these may be an underserved group as regards access to mental healthcare services.

The Irish Traveller Community and the Roma are also important groups for attention. The All Ireland Traveller Health Study (AITHS) identified a disproportionate burden of mental health issues experienced by travellers, including excess suicide rates in comparison to the population overall. HSE has some services and has supported various initiatives in this field.

The refresh of AVFC may wish to address in more detail these issues of mental healthcare for non-nationals, Irish Travellers and other minority groups.

Family carers
In Ireland, the National Carers Strategy recognises the challenges faced by carers and emphasises the importance of supporting their physical, mental and emotional wellbeing needs. From the mental healthcare perspective, carers have a dual importance. They are key parties in the care and support for a family member with mental health problems, as well as having risk of mental and emotional wellbeing issues themselves because the strains of the caring role. There may also be impacts on employment and on education for young carers.

Surveys of carers in Ireland and other countries show that a substantial proportion of carers are caring for someone with mental health or behavioural problems. They are caring for people of all ages with mental health issues, including children with ADHD and other behavioural conditions, young adults developing psychosis, and adults and older people with a broad range of conditions. Recent Irish research and many anecdotal reports by carers express concerns about professional reluctance to provide information to carers about the needs of the person they are caring for and the risks that this may pose. There appears to be a lack of consistency across the country and across individual practitioners in this regard. The refresh of AVFC may wish to address these important aspects of family caring for persons with mental health problems.

8.7 Governance and financing

The review also addressed issues of governance and financing of mental healthcare services. This covered a number of aspects, including:

- Universality, public-private mix and equality/equity
- Quality assurance
- Innovation and change
- Research, statistics and evaluation.

8.7.1 Universality, public-private mix and equality/equity issues

There is ongoing policy consideration of how best to achieve universality in Irish healthcare against the background of the public-private mix that currently prevails. One feature of the mix is the differential access to healthcare services for those with medical cards and those with private health insurance. Another feature is the range of public, private (for-profit) and non-profit organisations involved in the provision of services. The report develops a mapping of some of the many elements of this complex ecosystem as it applies in the mental healthcare field in Ireland today.

The public system provides much of the public mental healthcare services directly but also outsources (and/or funds in various ways) a considerable volume of service provision in the mental health domain. The HSE Mental Health division accounts for the largest share of public spending; other divisions also make important contributions, including Primary Care, Social Care, and Health and Wellbeing. HSE also provides or funds a substantial part of inpatient care, as well as a range of community-based residential settings.

Third sector service providers play a formal role in some parts of the public mental healthcare services. For example, a number of area-based services receive funding under Section 38 arrangements and a range of mental health activities are funded through Section 39 arrangements. HSE also outsources to the private sector in various ways, for example through the Counselling in Primary Care (CIPC) scheme (funding counselling services for medical card holders), and funds some high cost services for small numbers of clients in secure units in Ireland or abroad.

The private mental healthcare sector provides both institutional and community/ ambulatory services, and includes the private psychosocial practitioner sector (psychiatrists, psychologists, psychotherapists, counsellors, etc). Clients of these services may be covered by private health insurance and/or have to pay out-of-pocket (in addition to private health insurance premiums they may already be paying).

The refresh of AVFC may wish to consider how best to encompass this broad canvas in the articulation of an overarching policy framework and, where relevant, in practical governance arrangements. This perspective may also be helpful in seeking ways to effectively and equitably cover the full population and to optimally leverage the available capacity and activity across the different elements and sectors.

Commissioning

There has been discussion of the potential offered by commissioning arrangements to address some of the challenges in the Irish healthcare system overall as well as in the mental healthcare system, although there have also been differences of perspective and opinion voiced in the political and broader stakeholder discourse. The ecosystem mapping in this report shows that 'commissioning' in various forms is already an established and long-standing element in some parts of public health and social care provision already in Ireland,

with new applications emerging to support greater access and service improvements in various areas.

These types of arrangements may have relevance for the recruitment challenges that appear to be a significant barrier to service improvement in the public mental healthcare domain. They may also have relevance in the broader context of seeking ways to achieve more universality in the overall mental healthcare system in Ireland. The report presents examples of approaches in other countries that relate to a variety of elements this 'commissioning' space, including approaches to incentivise GPs to provide primary mental healthcare as well as ongoing care management for people with enduring mental health conditions. These may provide useful insights for the refresh of AVFC and the more general elaboration of the mental health vision and policy in Ireland.

Differential access for public system users and private system users
The current de facto arrangements result in differential access for public system users and private system users of mental healthcare services. The data from the 2015 QNHS shows an inverse socio-economic gradient in need and in utilisation of mental healthcare services in Ireland. This underscores the importance of improving access to mental healthcare services for users following the public route. Initiatives such as CIPC are relevant in this context. Public oversight of the private route is also important. This applies currently in the public regulatory role of the private health insurance sector under the Minimum Benefit legislation. The issues of public-private mix and differentials also have relevance in the wider review of the Irish healthcare system as part of the ongoing efforts to design a more universal system. Studies conducted in this context have included mental health in their modelling of costings for various benefit 'Baskets'. The refresh of AVFC may also wish to give attention to this wider aspect of universality in mental healthcare in Ireland, including parity issues in the coverage of mental health care and physical health care.

Stakeholder roles and user organisation involvement
Given the mix of players in the current mental healthcare ecosystem in Ireland, the issue of stakeholder roles and involvement in the overall governance of the domain is important. This is a theme that the refresh of AVFC may wish to address.

As an illustration, the arrangements in the Netherlands may provide insights useful for Ireland. The transition in 2006 to compulsory universal health insurance through a (regulated) competitive private insurance provider market required the development of appropriate governance and regulatory arrangements to reflect the various stakeholders in the system. The result is a system regarded as very transparent and underpinned by strong information systems that facilitate negotiation and agreement amongst the competing interests. Those with formalised structural roles include the government, insurers, healthcare providers (including mental healthcare providers), professional organisations (including mental health professionals) and user/family organisations.

In the Irish context, national policy and the HSE strongly espouse the user role. This encompasses various levels of involvement, including a mandated involvement in the composition of the Mental Health Commission and the significant efforts and investments by the HSE in this area. However, the strong involvement of user (and family) organisations at a structural level in the Netherlands is noteworthy and may provide useful insights for a refresh of AVFC.

8.7.2 Public System

Resource allocation

Based on official data, the current percentage allocation to mental health in Ireland seems to be around 6% of overall health spend, although the percentage varies depending on which elements of overall health expenditure are taken into account as well as what elements of healthcare are included within the mental health allocation (e.g. relevant parts of the social care allocation, and of dementia care services). AVFC proposed a target of 8% for mental health spending from the overall health allocation and other commentators have suggested higher figures. AVFC also presented data showing that the relative spend on mental health had declined considerably in the twenty-year period leading up to the report in 2006. A comparative positioning of Ireland internationally suggests that the percentage resource allocation today is around the median level across EU countries, and lower than in some of the countries with better developed and better performing mental healthcare systems.

Equally important is the allocation of resources (and costs) within the mental healthcare sector itself. Data from other countries suggest that large proportions of expenditure are consumed by a relatively small number of high cost clients and that, despite the de-institutionalisation agenda, there has not been commensurate shifting of resources to the community/ambulatory sector.

Manpower and skills mix and sufficiency

The issue of professional manpower and skills mix and sufficiency is another theme in mental healthcare in Ireland today. Much of the focus has been on the quantitative yardsticks proposed in AVFC. On the aggregate, the available data suggests that the manpower levels in the HSE's community/ambulatory services have been increasing, with levels now about seventy-five per cent of the AVFC targets. The refresh of AVFC might wish to re-examine the basis for the original targets in today's environment, as well as whether it is possible to develop needs-based or other approaches to complement the population-based perspective.

Available HSE data on staffing profiles in adult mental health teams show variation across CHOs in the manpower mix in key professional categories - psychiatric/medical (consultant psychiatrists, senior registrars, registrars, SHOs); nurses; and allied professionals (psychologists, occupational therapists, social workers, addiction counsellors). Although this data is instructive it is also important to consider the underlying skills mix that the staffing profiles encompass, as well as the extent to which particular skills are actually applied. For example, there have been many developments in the skills profile of nursing staff in the mental health field in Ireland and many nurses may be operating, or at least skilled to operate, in areas (such as psychosocial intervention) that might traditionally have been the preserve of other disciplines.

A focus on quantitative profiling of staffing numbers and on numbers of teams has tended to dominate the presentation of developments in community mental healthcare services in Ireland. It is less clear how the relatively large number of teams actually operate. This makes it difficult to gain a picture of the levels of service available across the country, where they operate from, and the scope of the services they provide.

The refresh of AVFC may wish to give attention to this aspect, including the need for a qualitative mapping of existing community based services / teams in their structural and operating characteristics and in the service portfolios that they offer. In regard to service portfolios on offer, the issue of choice may also be a topic for attention. A recurrent theme in the wider discourse has been variation across the country in the therapeutic options available, such as in orientations towards medication or talking therapies. This is an issue for consideration in quality assurance of mental healthcare in Ireland.

8.7.3 Quality assurance

There are many important elements to quality assurance. These include timely access to appropriate services, and choice between therapeutic approaches where relevant and desired. Consistent provision of services across the country is another aspect requiring consideration.

There are a number of HSE initiatives addressing quality assurance, including the clinical programmes and standard operating procedures introduced. The Mental Health Commission also developed a series of quality tools as well as an overall quality framework which maps to the contents of AVFC. Other countries covered in the review have developed service and clinical guidelines for practice in mental healthcare. These include NICE guidelines in England and a range of multidisciplinary guidelines on mental health in the Netherlands. The refresh of AVFC may wish to giver further attention to this area.

8.7.4 Innovation and Change

There are a number of current HSE and other programmes to promote and accelerate innovation and necessary change in mental healthcare in Ireland. The HSE has established a transformation programme and the Service Reform Fund programme with Genio is underway. The refresh of AVFC will likely seek to align with these areas of activity where relevant.

Approaches in other countries may also be of interest in this context, such as the Breakthrough Quality Collaboratives (QICS) in the Netherlands. Such initiatives to promote rapid change and progress in priority areas might be helpful in the Irish context, to support achievement of relatively quick-fixes in relevant areas alongside the slower and more transformational change processes.

8.7.5 Research, Statistics and Evaluation

The issue of parity of esteem for mental health within the wider healthcare domain applies also to health research funding. In Ireland, apart from suicide research and mental health promotion, there has been a limited volume of research on mental healthcare issues. There are many gaps in knowledge on the prevalence of mental health conditions and their impacts, and on how the mental healthcare system is performing in addressing these needs. Service development and resource allocation requires good underpinning evidence. The refresh of AVFC may wish to consider the development and commensurate funding of a research strategy on mental health, including basic research as well as research that can directly support policy, system and service developments.

Linked to this is the development of an adequate statistical profile of the mental health situation in Ireland today. The current focus tends to be towards key performance indicators addressing operational features of the system and services. Other countries, such as the Netherlands and England, have developed more elaborate statistical and monitoring systems, including efforts to produce more meaningful operational performance data, as well as detailed data on prevalence and need, and on outcomes.

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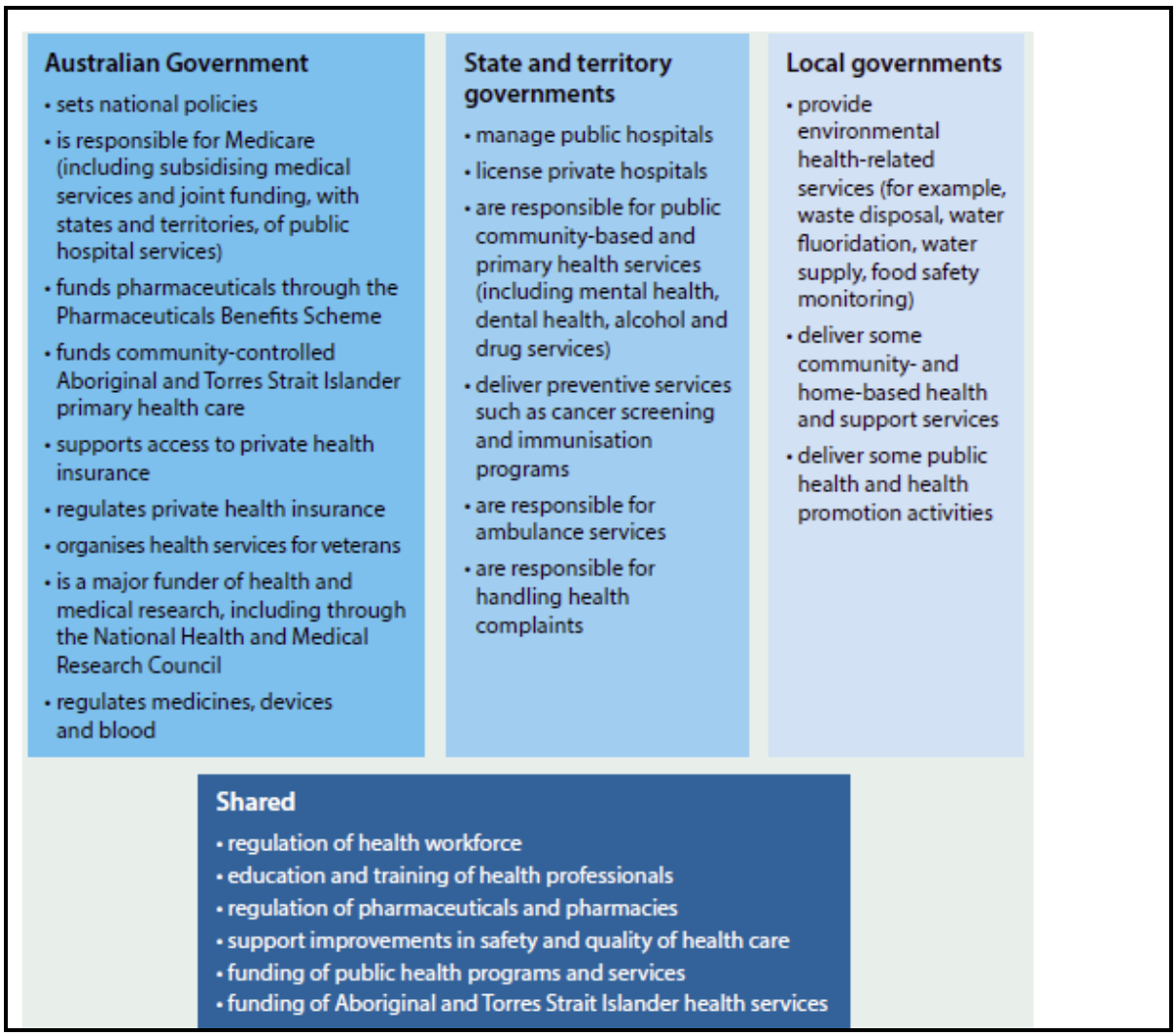
Annex: Country Profiles

Australia

Organisation, funding and provision of health and mental health care

The governance, coordination and regulation of Australia's health services are the joint responsibilities of the Australian, state and territory and local governments. Planning and delivery of services are shared between the government (public) and non-government (private) sectors.

Figure 1: The role of the government in Australian health system



http://www.aihw.gov.au/australias-health/2016/health-system/

Almost 68% of total health expenditure during 2013–14 was funded by governments, with the Australian Government contributing 41% and state and territory governments nearly 27%. The remaining 32% ($50 billion) was paid for by individuals through out-of-pocket expenses (18%), by private health insurers (8.3%) and through accident compensation schemes (6.1%). There is a universal public health insurance scheme called Medicare which provides free or heavily subsidised access to hospitals and medical professionals. Medicare offers fee-free treatment as a public patient in a public hospital, by a doctor appointed by the hospital. It also covers 75% of the Medicare Benefits Schedule (MBS) fee for services and procedures for private patients in a public or private hospital). Practitioners can charge higher fees than those set by Medicare, in which case the patient has to pay the difference. About 47% of the population has supplementary private health insurance.

Primary health care is usually the first point of contact for service use, delivered in general practices, community health centres, allied health practices, and via communication technology such as telehealth and video consultations.

Mental health reform

In 2014, the Australian Government requested the National Mental Health Commission to undertake a review of existing mental health programmes and services across government, non-government and private sectors. The Fourth National Mental Health Plan expired in June 2014.

The Mental Health Commission came up with 25 recommendations and three overarching goals to achieve long term sustainability:

1. Person-centred design principles
2. A new system architecture
3. Shifting funding to more efficient and effective 'upstream' services and supports.

And in particular, to

rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training

repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care

reform the approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth.

In response to the National Mental Health Commission's Review was undertaken, the Fifth National Mental Health Plan, released on Oct 2016 for consultation, aims to encourage collaborative government efforts at the national level from 2017 to 2022, focusing on key priorities such as integrated planning and service delivery at regional levels, coordinated supports for people with severe and complex mental, suicide prevention strategies, Aboriginal and Torres Strait Islander mental health, co-morbid physical health issues of people with mental health problems, tackling stigma and discrimination associated with mental illnesses, and monitoring safety and quality in mental health care services.

https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan

The costs for mental health services indicating recurrent expenditures by federal, state and territory governments do not include expenditures on services for dementia care programs, learning difficulties, alcohol and substance abuse problems. General government health expenditures refer to recurrent expenditures only (WHO, 2011).

http://www.who.int/mental_health/evidence/atlas/profiles/aus_mh_profile.pdf?ua=1

Other mental health reforms

A series of mental health reform activities have been initiated. For example, responsibility for a range of Australian Government mental health and suicide prevention activities was shifted to the newly created Australian government's **Primary Health Networks** from 1 July 2016. These Primary Health

Networks were then renamed as Primary and Mental Health Networks; their role has also been expanded to be the major regional infrastructure for planning and purchasing mental health services to promote equity, especially in rural communities.

Integration of funding between health and social care has been achieved through pooled budget, based on CareWorks. Each partner makes contributions to a common fund to spend on agreed projects or services (Mason et al, 2015). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4469543/

In response to the Mental Health Commission report there will be a major funding shift from hospitals to primary and community-based services. Some Commonwealth acute hospital funding will be reallocated to community-based mental health services over the five years from 2017.

Importance of mental health in health care system and other sectors - comorbid physical health issues

Shift in services and funding from mental health hospitals to community-based services, integrated approaches to providing mental health services into more primary care services.

A staged implementation of the National Disability Insurance Scheme (NDIS) began in July 2013. People with **a psychiatric disability who have significant and permanent functional impairment** will be eligible to access **funding through the National Disability Insurance Scheme (NDIS).** In addition, for people with a disability other than a psychiatric disability, funding may also be provided for mental health-related services and support if required.

It is recommended to introduce incentives to included pharmacists as one of the key community facilitators in the mental health care team. It is recommended to introduce incentives to included pharmacists as one of the key community facilitators in the mental health care team.

Modernisation /Reforms /Current developments

The Australian government (mental health commission) has also recommended a new model of stepped care across Australia focusing on self-care and empowerment. More personalised mental health services will also be implemented through 'stepped care model', allowing service users to step up from self-help type intervention demanding less resources to services requiring more clinical input or step-down when those in less need, depending on the complexity of individual needs (Australian government, Department of health and ageing, 2012)

Good practice and innovation

There has been much innovation with digital technologies and e-health services, including biometric monitoring in addition to access to telephone helpline and internet-based support in the case of an emergency.

http://www.health.gov.au/internet/main/publishing.nsf/Content/7C7B0BFEB985D0EBCA257BF0001BB0A6/$File/emstrat.pdf

More e-mental health services were promoted via the Virtual Clinic. Between 2011 and 2014, the Australian government invested $20 million in setting up a Virtual Clinic, which can provide real-time online counselling or phone-based counselling services by a trained CBT counsellor, as one of the alternative cost-effective therapy options to traditional face- to- face offline services. The national online counselling service (Virtual Clinic) can help people with mild to moderate levels of mental health problems. As shown in the diagram below, it was planned to establish more efficient data linkage system via the Virtual Clinic by connecting e-health records with the national e-mental health portal. It is expected to respond to a maximum number of 50,000 service users over five years.

.http://www.health.gov.au/internet/main/publishing.nsf/Content/7C7B0BFEB985D0EBCA257BF0001BB0A6/$File/emstrat.pdf

There are also major initiatives around the development of Headspace, a national foundation targeted at young people that in addition to general mental health and wellbeing issues also provides early intervention for psychosis. Other innovation has included actions re vocational rehabilitation and physical health improvement for people with mental health needs.

https://www.headspace.org.au/

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http://www.mentalhealthcommission.gov.au/media/119896/Summary%20%20-%20Review%20of%20Mental%20Health%20Programmes%20and%20Services.PDF

Canada

Organisation, funding and provision of health and mental health care

The Canadian health system is largely publicly funded through general taxation from the federal, provincial and territorial governments[1]. The funds are mainly used to finance the universal Medicare system that covers hospital costs and physician services that are free at the point of service delivery for all residents. Services such as long-term care and medication prescriptions are also partly financed from the tax-raised revenues. Prescription medication is determined at a provincial level; although there are some exemptions for those on low incomes and older people, as well as a ceiling for catastrophic costs most costs are not covered. This means that Canadians pay more for prescription drugs than in many OECD countries because of this lack of a national scheme. Private health insurance, usually via employers, covers many services not included in the medicare such as prescriptions for medications, dental and vision care[2]. Health care providers are regulated by the means of licensing, certifications, and the controlled acts system[3]

The Canada's 10 provinces and 3 territories are in charge of service planning and provision. Primary care physicians are the first point of contact, and depending on the diagnosis, they can either provide treatments or make referrals to medical specialists. In recent years, though, primary care system has been moving towards more professionally diverse primary care teams providing wider range of services. Most of the primary mental health care is provided by physicians. Hospital mental health services are provided in specialised psychiatric hospitals and in general hospitals. Mental health services provided in the community include, for instance, crisis response care, case management, and supported housing,[4] including support for the innovative Housing First/Chez Soi programme that provides stable housing for homeless people with mental health problems.

Importance of mental health in the health care system and other sectors

There have been substantive discussions and commissions on the future of mental health in the last decade, culminating in 2012, the first mental health strategy – *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*[5]. This set out 26 priorities and 109 recommendations clustered around 6 strategic directions including mental health promotion; fostering recovery; improving access to services; reducing disparities in services; working closely with indigenous First Nation, Inuit and Métis populations to develop tailored services according to their needs; and improving leadership. The strategy places recovery at the centre of improving the quality of life of people with mental illness.

Modernisation /Reforms /Current developments

The provinces and territories are responsible for planning and provision of health care services which makes the Canadian health system highly decentralised. While delivery and planning of health

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[1] Marchildon, G.P. (2013) Canada: Health system review. Health Systems in Transition; 15(1): 1 – 179. http://www.euro.who.int/__data/assets/pdf_file/0011/181955/e96759.pdf?ua=1

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[3] Ibid.

[4] Allin, S. and Rudoler, D. (2016) The Canadian Health Care System in E. Mossialos, M. Wenzl, R. Osborn, and D. Sarnak (eds.) (2016) International Profiles of Health Care Systems, 2015, The Commonwealth Fund. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf

[5] Mental Health Commission for Canada (2012) Changing Directions, Changing Lives: The Mental Health Strategy for Canada. http://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf

services are quite decentralised, the administration of the health system has, over the years, become more centralised[6].

Good practice and innovation

The Canadian Recovery Inventory is an example of knowledge sharing about recovery-based practices. Developed by the Mental Health Commission of Canada (MHCC), the inventory is a collection of practices, policies, and research focusing on recovery[7]. To support the adoption of the recovery approach, the MHCC has developed the *Guidelines for Recovery-Based Practice*[8].

[6] Marchildon, G.P. (2013) Canada: Health system review. Health Systems in Transition; 15(1): 1 – 179. http://www.euro.who.int/__data/assets/pdf_file/0011/181955/e96759.pdf?ua=1

[7] Recovery Inventory http://www.mentalhealthcommission.ca/English/inventory

[8] Mental Health Commission of Canada (2015) Guidelines for Recovery-Based Practice; http://www.mentalhealthcommission.ca/sites/default/files/2016-07/MHCC_Recovery_Guidelines_2016_ENG.PDF

England

Organisation, funding and provision of health and mental health care

The health care system in England - the National Health System (NHS) - is funded from general taxation and national insurance contributions. With the exceptions of dental, optical and fixed fee prescription charges, most NHS services are free at the point of use for all UK residents. The Department of Health is responsible for setting the overall policy and allocation of funding. The Health and Social Care Act 2012 introduced major changes in the organisation, governance and accountability of the health and mental health care system[9]. Commissioning of health care service, including mental health, is mainly the responsibility of local clinical commissioning groups (CCGs) that have budgets to purchase health care services, including mental health, The Care Quality Commission (CQC) is responsible for regulating the mental health care providers.

While primary mental health care is mainly provided by GPs who received funding from the NHS linked to the size of their patient list, some specialist services such as eating disorder, forensic and secure services, perinatal mental health care, services for autism and Asperger disorder, and several other conditions are commissioned nationally through the NHS England. NHS mental health trusts are commissioned by local CCGs to provide of specialist community and hospital based mental health services[10]. Some mental health trusts also provide services for other patient populations. CCGs also commission services from the private sector, particularly for residential care for individuals with more severe mental disorders, as well as in situations when inpatient services are not available locally.

Importance of mental health in the health care system and other sectors

Mental health has received a considerable attention in recent years and continues to do so. The evidence of the individual and societal costs of mental ill health has contributed to realising the importance of good mental health through prevention and adequate treatments. To address the burden of mild-to-moderate mental conditions, efforts had been made to improve access to psychological therapies. In 2009, supported by the evidence of economic benefits of investing in psychological therapies, the Improving Access to Psychological Therapies (IAPT) programme was rolled out across the country[11] . This is a free at the point of use service and does not require referral from a GP. It consists of a stepped care approach to psychological therapy beginning with use of self-help materials and culminating in the provision of specialist one to one cognitive behavioural therapy.

In 2011, the Conservative-Liberal Democrat government published *No Health Without Mental Health* strategy focusing on achieving a parity of esteem between mental and physical health services[12]. A strategy document - *Closing the Gap* – published in 2014, identified 25 priority areas in mental health

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[9] Hewlett, E. and Horner, K. (2015) Mental Health Analysis Profiles (MhAPs): England; OECD Working Paper No. 81; http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2015)4&docLanguage=En

[10] Ibid.

[11] OECD (2014), Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care, OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/9789264208445-en

[12] HMG/DH (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

care[13]. A recently published report - The Five Year Forward View for Mental Health - made 58 recommendations for improving mental health with references to commissioning, quality of care, innovation and research, workforce, transparency, incentives, regulations and inspections, and leadership[14]. New waiting time targets for access to some specialist mental health services, including early intervention for psychosis, were introduced in 2016.

Modernisation /Reforms /Current developments

England was one of the pioneers of deinstitutionalisation in mental health care. Most of the mental health services are nowadays provided in the community. Around 90 per cent of adults with more severe mental health conditions receive community-based care and support[15]. The services however vary between local areas in terms of accessibility (e.g. 7 days/24 hours crisis care), waiting times, availability, and coordination of care including integration of mental and health care provision. The policy priorities are currently focused on developing clearer mental health care pathways to effective, accessible, and good quality mental health services.

In 2012, a new payment system – *Care Clusters* - was introduced based on individuals' needs where services are tailored depending on their specific needs. It is expected that these payment changes will primarily act as incentives towards improving quality and efficiency of mental health services. The new system has been criticised for not fully capturing the diagnostic complexities of some populations and missing to incentivise care outcomes[16]. While there are published national tariffs for mental health care, their use is not currently mandatory.

Good practice and innovation

England has been at the forefront of developing mental health outcome measures which are regularly used in making decisions about the purchasing mental health services. A number of outcome-based frameworks had been developed including the NHS Outcomes Framework, Clinical Commissioning Group (CCQ) Outcomes Indicator Set, and Quality and Outcomes Framework (QOF)[17]. There has also been a very strong focus in the last decade on mental health promotion and wellbeing services, and intersectoral work, for instance with schools, employers and the police.

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Hewlett, E. and Horner, K. (2015) Mental Health Analysis Profiles (MhAPs): England; OECD Working Paper No. 81; http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2015)4&docLanguage=En

HMG/DH (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

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[13] National Audit Office (2016) Mental health services: preparations for improving access; https://www.nao.org.uk/wp-content/uploads/2016/04/Mental-health-services-preparations-for-improving-access.pdf

[14] Mental Health Taskforce (2016) The Five Year Forward View for Mental Health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[15] Ibid.

[16] Ibid.

[17] OECD (2014) Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care, OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/9789264208445-en

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http://dx.doi.org/10.1787/9789264208445-en

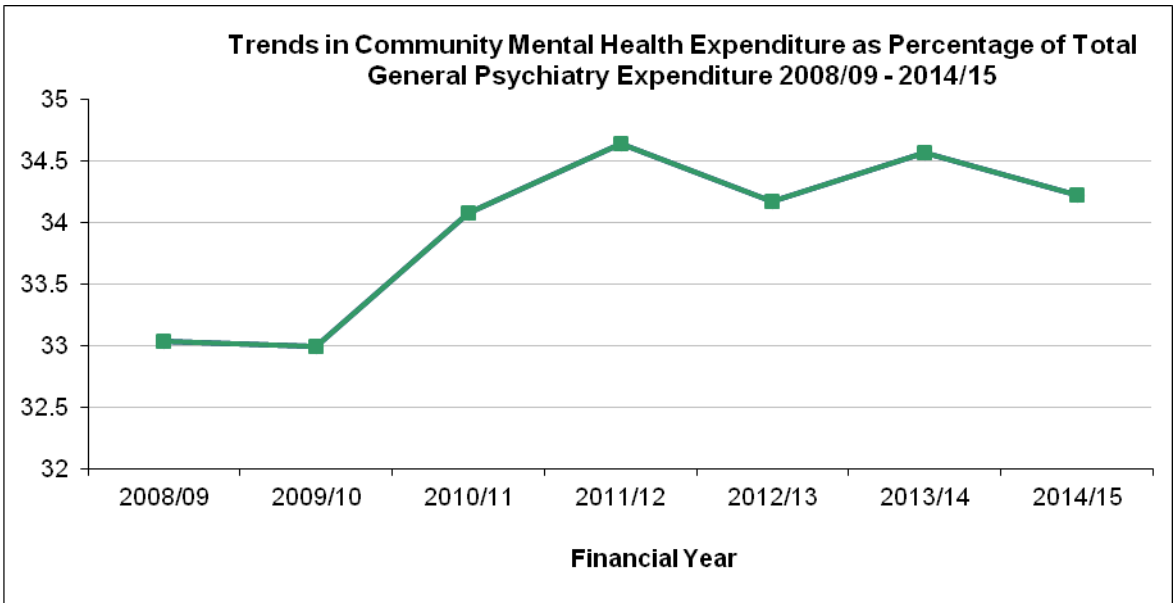
Scotland

Organisation, funding and provision of health and mental health care

The health care system in Scotland - the Scottish National Health System (NHS) - is funded through an allocation of central UK government general funds. In 2016 NHS Scotland received £9.7 billion with a further £1.4 billion going to community health services. The responsibility for most health issues, with some exceptions (e.g. salary scales and pharmaceutical pricing) has been devolved to the Scottish government. Most services are free at the point of use.

It is difficult to be precise on spending on mental health as services are provided in general as well as specialist settings. However, in 2014/15 £905 million was spent on general psychiatry services, of which inpatient spend accounted for 58% and community spend 34%. This was 8.7% of total health expenditure in Scotland, but will be an underestimate of total mental health spend. This figure also does not include the budget for forensic hospitals. The share of spending on community services has generally been increasing as Figure 1 shows.

Figure 1. Trends in community mental health expenditure in Scotland



GP led primary care services act as the principal gateway to all health services, including the use of specialist mental health services. There is a current focus on a greater integration of health and social care services, with primary care being crucial to these efforts. Measures are currently being implemented to extend primary care out of hours services. Between 2015 and 2017 an additional £50 million has been invested to address immediate workload and recruitment issues, as well as putting in place long-term, sustainable change within primary care. In addition, £10 million has been invested in primary care mental health services to encourage innovative ways of encouraging better identification and management of people with mental health needs in the community.

The majority of NHS services for those with mental health problems are delivered in the community through GPs and NHS Boards community mental health services (e.g. specialist and non-specialist teams containing mental health officers (social workers with mental

health training), community psychiatric nurses, psychiatrists, occupational therapists, psychologists etc.).

NHS Boards also provide in-patient units in general hospitals and psychiatric hospitals for those patients requiring more intensive care. Bed numbers have been falling – in 2014 there were 83.5 beds per 100,000 population compared with 109.2 beds per 100,000 population in 2009. Specialist mental health services are delivered primarily through the NHS and local authorities, in partnership with not-for-profit organisations. NHS Boards are responsible for the treatment of those with mental health problems either in community or acute settings, whilst local authorities are responsible for securing social care and support services (e.g. housing, day care services etc.) in the community, as well as providing a range of mainstream services to support recovery. Not for profit organisations may be commissioned to provide some services, support and information. There is a regulatory and monitoring framework designed to safeguard the rights of those with mental health problems and ensure they receive good quality services. The third sector, which includes charities, voluntary and other not-for-profit organisations, plays an important role in the provision of services, support and information for people with mental health conditions.

Importance of mental health in the health care system and other sectors

Scotland has put mental health promotion and mental wellbeing at the heart of policy developments over the past decade. Towards a Mentally Flourishing Scotland: Policy and Action Plan (2009-2011) set out 22 commitments to promote good mental wellbeing across the lifespan, reduce the prevalence of common mental health conditions, suicide and self-harm and improve the quality of life of those experiencing mental health conditions. This was followed by the Mental Health Strategy for Scotland (2012-2015) which included commitments across mental health improvement, services and recovery to support the delivery of effective, quality care and treatment for people with a mental health condition, their carers and families. Specific targets were set during the decade on mental health change including a withdrawn target to reduce the use of antidepressants, as well as to reduce readmissions and deliver 18 weeks referral to treatment for psychological therapies. A waiting time target for referral to treatment for Child and Adolescent Mental Health Services of 26 weeks was achieved for 96% of all service users by 2014. There is also a national programme, See Me, to tackle mental health stigma and discrimination. This is funded by Scottish Government and Comic Relief.

Reforms and innovation

Planned reforms in a new planned 10-year mental health strategy from 2017 include an emphasis on transformation in the way primary care works to include new approaches to responding to mental health problems. This will include helping people manage their own health. Link workers will direct people to non-clinical services and support them to stay in employment, contribute to the economy, and access employment opportunities. There will also be more focus on the premature mortality of people with mental health problems, tackling preventable physical health problems within an overall approach to population health. More generally there is a strong focus on early intervention for young people, whether this is through the creation of early intervention for psychosis services, or a national roll out of parenting programmes by 2020. A whole of government approach to parity between physical and mental health is also planned.

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Northern Ireland

Organisation, funding and provision of health and mental health care

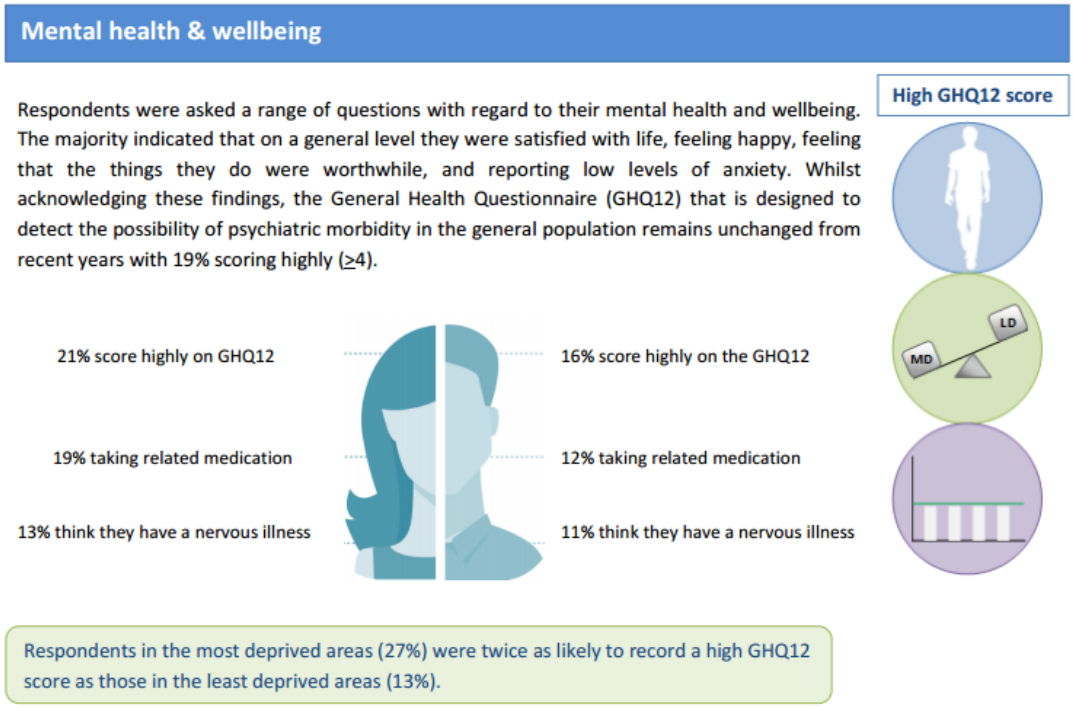
The health care system in Northern Ireland is funded through central UK government general funds. In 2016 the Northern Ireland Executive allocated £4.9 billion of received funds to health related actions: £2.7 billion to hospital services, £1.0 billion to social care services and £0.8 billion to family services. The responsibility for most health issues, with some exceptions has been devolved to the Northern Ireland Executive. Most services are free at the point of use.

The Health and Social Care Board is responsible for commissioning health and social care services (including mental health) in Northern Ireland. Five Health and Social Care Trusts (HSCT) provide integrated health and social care services. They manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities and they provide a wide range of health and social care services to the community. GPs act as gatekeepers to specialist health care services, including mental health services.

Importance of mental health in the health care system and other sectors

In 2011 only 7% of the health budget was spent on mental health services (Appleby 2011); in England by contrast in 2016 spending on mental health (including dementia) was over 12% of local Clinical Commissioning Group spend. The latest Health Survey indicates that 19% of individuals were showing signs of mental health problems; 21% of women and 16% of men, although lower percentages believed they had had a nervous illness (See Figure 1) (Information Analysis Directorate, 2016).

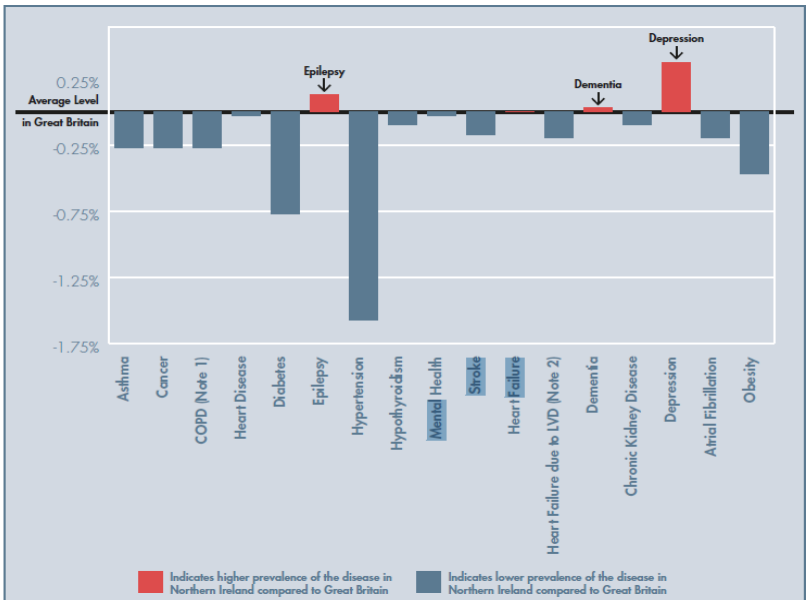
Figure 1: Mental health and wellbeing in Northern



Ireland

Northern Ireland appears to have a higher prevalence of depressive disorders than in Great Britain. (Figure 2). It also historically has had higher levels of antidepressant prescribing.

Figure 2: Prevalence of selected health problems in Northern Ireland and Great Britain



Northern Ireland has the lowest rate of generic prescribing in the UK which has meant that the cost of antidepressant prescribing has been consistently higher than in Great Britain. A recent Assembly inquiry heard evidence indicating that long waiting times for access to counsellors for psychological therapies was one key reason for the high costs of antidepressant prescribing. One witness to the Inquiry noted that

"*We have to invest in counselling and psychological therapies absolutely but we do not have a limitless supply of funding, so we have to reduce on the antidepressant side and reinvest whatever efficiencies we have into those sorts of services.*"

Referrals to counselling services must come from GPs or community mental health teams. Unlike in England it is not possible for individuals to self-refer to these services. The mix of services is similar to that seen in England but will vary between Trusts. (Northern Ireland: Northern Ireland Assembly Public Accounts Committee, 2015)

Figure: The cost of antidepressant prescribing per head of population in the UK 2010-2013

Source: Donnelly 2014

Reforms and innovation

Reform in the last decade has been dominated by the Executive's response to the 2007 Bamford Review of Mental Health and Learning Disability. This called for continued emphasis on promotion of positive mental health ; reform of mental health legislation; a continued shift from hospital to community based services (with 60% of spending in the community) and the closure of all long stay residential places by 2015; development of a number of specialist services, to include children and young people, older people, those with addiction problems and those in the criminal justice system; and an adequate trained workforce to deliver these services. The Review envisaged a 10-15 year timescale for full implementation of its recommendations.

A 2011 review, Transforming Your Care (TYC) recognised that while the pace of change had been slow a stepped care approach had been adopted where the model of mental health care had evolved to promote greater care at home and in the community rather than in hospital. Similar to England Crisis and Home Treatment Mental Health Teams had been developed in all five Trust areas (albeit working in different ways) to provide intensive support where needed to help people with mental health needs stay at home. TYC also recommended creation of programme for early intervention for mental and wellbeing, more efforts to tackle suicide, the reinvestment of savings from a reduction in hospital care in community services and the greater involvement of the voluntary sector in the provision of services. (TYC 2011).

The 2012-2105 Bamford Action plan included a commitment to undertake a programme of work that will facilitate an enhanced culture of recovery across all mental health service (Department of Health, Social Services and Public Safety 2012). It also included actions to develop early intervention services, including psychological therapy services, and to build up some highly specialist services including eating disorders and perinatal mental health. Goals for more promotion, including school based promotion, were also included. In terms of having a focus on recovery the 2012-2015 plan stated the goal was to have an improved and consistent understanding of recovery throughout mental health services, ensuring that a recovery based approach becomes embedded in the value base of practitioners and services

and enabling service users to maximise their abilities, independence and their general health.

Monitoring reports have been published. In 2014 this indicated that Pilot Primary Care Talking Therapy Hubs had been established in each Trust and that over 5000 people had signed up for the Computerised CBT Beating the Blues programme.

See http://www.belfasttrust.hscni.net/BelfastRecoveryCollege.htm for example Recovery College

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Netherlands

Organisation, funding and provision of health and mental health care

The Dutch healthcare system is based on compulsory health insurance where individuals are free to choose their health insurers and care providers. Prices and standards are set by the government, however - under the managed competition model - the insurance companies compete for patients on price, quality and supplemental healthcare packages[18]. The Dutch Healthcare Authority (NZa) is responsible for monitoring healthcare markets including the supervision of healthcare providers and insurers.

Healthcare is financed by a mix of a compulsory health insurance (72%), general taxation (13%)[19], and out-of-pocket payments. Mandatory insurance consists of a community-rated premium paid to the insurer and an income-dependent premium paid into a central fund. Children under 18 are insured by the government's contribution into the health insurance fund. Services such as mental health care (outpatients and inpatient), GP services, hospital care, home nursing care, maternity care, and pharmaceutical care are included in the basic health care package.

Mental healthcare is reimbursed via a DBC (Diagnostic Treatment Combination)-system based on the type of care, diagnosis, and treatment. In the case of comorbidities patients can be assigned to more than one DBC group[20]. The financing of the mental healthcare is organised as follows: the first 365 days of mental health treatment are part of the basic health insurance and covered by the Health Insurance Act (Zvw); the first three years of mental health care including inpatient services are also financed through the Zvw; prevention and mental health promotion measures are separately funded under the Social Support Act (Wmo).

The responsibility for the provision of healthcare services rests with private healthcare providers and health insurers. The Dutch health system is organised following the gatekeeping principle where patients need to be referred by their GPs for hospital and specialist care services. GPs are also the first point of contact for mental health services. As the GPs are qualified to provide a broad range of services, a large majority (93%) of all GP contacts are dealt within in primary care[21]. In case of diagnosed mental disorders a referral may be made to specialist mental health services. There are four types of mental health care, defined as short, medium, severe, and chronic with a maximum payment for each of the care products.

Importance of mental health in the health care system and other sectors

A development of *Health-in-all* policies focusing on intersectorality has resulted in some examples of collaboration between different ministries. There are however, no national-level policies on intersectorial cooperation based on Health-in-all policies. These policies, in particularly related to the mental health, seemed to be well-developed in other countries such as the UK, Sweden, and Finland. There are also local initiatives. At a local level, many schools have been actively involved with local government in developing mental health promotion programmes.

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[18] Forti, A. et al. (2014), "Mental Health Analysis Profiles (MhAPs): Netherlands", OECD Health Working Papers, No. 73, OECD Publishing, Paris

[19] Kroneman M. et al. (2016) The Netherlands: health system review. *Health Systems in Transition*, 18(2):1–239.

[20] Forti, A. et al. (2014), "Mental Health Analysis Profiles (MhAPs): Netherlands", OECD Health Working Papers, No. 73, OECD Publishing, Paris

[21] Kroneman M. et al. (2016) The Netherlands: health system review. *Health Systems in Transition*, 18(2):1–239.

The number of psychiatric hospital beds in the Netherlands is the double the EU average. This has been addressed through moves to facilitate desinstitutionalisation and more community-based care services. There is a wide network of early intervention in psychosis teams around the country. Labour market policies, where employers are responsible for paying the sickness benefits of workers for up to two years means that there has been a strong focus by employers on promoting mental health in the workplace.

Modernisation /Reforms /Current developments

A major reform in 2006 aimed to improve access, promote efficiency, and develop a more decentralised system of governance[22]. In 2014, a reform of the mental healthcare system focused on changing the balance between the secondary and primary care mental healthcare provision with a greater emphasis on provision of services in the primary care and community. Since 1 January 2014 mental health services are provided by GP-based mental health services; generalist basic mental health services, and specialist mental health care. The evidence so far suggests that moving away from the specialist to generalist – mainly GPs and mental health nurse led services – has been positive but not necessarily cost saving[23].

A further decentralisation of the health care system was carried out in 2015 with the transfer of responsibilities for long-term care and parts of youth care to the municipalities under the Long-term Care Act (Wlz).

Good practice and innovation

A Dutch model of Flexible Assertive Community Treatment (FACT) is a good example of integrated care[24]. The FACT teams are multi-disciplinary, including a whole range of professionals such as psychologists, psychiatrists, addiction specialists, nurses, peer counsellors, employment placement service specialists. The FACT approach provides a flexibility in care services that is otherwise not available in other types of mental health services. A care plan can be easily adapted depending on individuals' mental health care needs. The FACT model also includes a crisis plan where a patient in crisis is provided more intensive care in the community leading to fewer hospital admissions.

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[22] Kroneman M. et al. (2016) The Netherlands: health system review. Health Systems in Transition, 18(2):1–239.

[23] Ibid.

[24] The Economist Intelligence Unit (2014) Mental Health and Integration: Provision for supporting people with mental illness: A comparison of 30 European countries. http://mentalhealthintegration.com/media/whitepaper/eiu-janssen_mental_health.pdf

Sweden

Organisation, funding and provision of health and mental health care

The Swedish health system is largely (around 80%) funded through general taxation providing universal coverage and equal access to health care services as stated in the 1982 Health and Medical Services Act. Around 17% of health expenditure is raised through privately paid user charges[25].

While the central government is responsible for overall health policy, the provision and organisation of mental health services comes under the remit of 17 counties and 4 regions[26]. The responsibility for the care of older and disabled people lies with 290 municipalities. Since the 1995 Psychiatric Care Reforms, the municipalities have responsible for mental health services. The National Board of Health and Welfare is the main regulatory agency responsible for monitoring the quality of care services.

The mental health services are part of the healthcare system and are governed by the same regulatory laws. In addition, two supplementary laws - the *Compulsory Mental Care Act* and the *Forensic Mental Care Act* – regulate the treatment of people with serious mental illness and those who commit crimes and have been diagnosed with a serious mental health condition[27]. For people with mental health conditions, primary care is the first point of contact. As there is no formal gatekeeping to specialist services individuals are entitled to access specialist care without a referral from their GP.

Importance of mental health in the health care system and other sectors

The current mental health action plan was implemented between 2012 and 2016. As part of this plan, additional funding was allocated towards the prevention of mental illness and improvement of mental healthcare for the existing service users. The action plan offers financial incentives to local authorities committed to improving the mental health services for their population[28].

Modernisation /Reforms /Current developments

The Swedish health system is quite decentralised with county councils, regions and municipalities being in charge of funding and provision of health care services including mental health.

Ever since the 1960s, deinstitutionalisation has been an integral part of the Swedish mental health policy developments. Compared to other OECD countries, the number of psychiatric beds is quite low, which is mainly attributed to the ongoing process of deinstitutionalisation focusing on creating more community-based services. An emphasis on providing housing and employment for people with mental health problems had long been recognised as important aspects of developing the mental health services in the community.

Similarly, the prevention of suicide has been one of the major priority areas over the past 20 years. The National Programme for Suicide Prevention, established in 2008, focuses among other issues, on suicide reduction among disadvantaged groups, support for a range of psychological and medical suicide support interventions, and dissemination of knowledge about the evidence-based practices

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[25] Anell A, Glenngård AH, and Merkur S. (2012) Sweden: Health system review. Health Systems in Transition, 14(5):1–159 http://www.euro.who.int/__data/assets/pdf_file/0008/164096/e96455.pdf

[26] Ibid.

[27] Ibid.

[28] Patana, P. (2015) Mental Health Analysis Profiles (MhAPs): Sweden, OECD Health Working Papers, No. 82, OECD Publishing, Paris. http://dx.doi.org/10.1787/5jrxr7qx6ctb-en

for suicide reduction[29]. The evidence shows a 13% reduction in suicide rates between 2005 and 2011[30].

A further initiative includes an anti-stigma campaign launched in 2009 with the two main objectives: to raise awareness of the prevalence of mental illness and to reduce discrimination of people with mental health conditions. The anti-stigma initiative was found to be effective in changing attitudes towards people with mental illness.

Good practice and innovation

A multidimensional quality framework – *Good Care* – has been developed to monitor the performance of the mental health care system. The system performance is assessed on several dimensions including safety, effectiveness, patient centeredness, equity, efficiency, and timeliness allowing for comparisons between regions and patient groups[31].

Other relevant innovations include the internet-based cognitive behavioural therapy (CBT), suicide reporting initiative (Lex Maria), and the national strategy for developed parental support targeting early mental health wellbeing[32].

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Italy

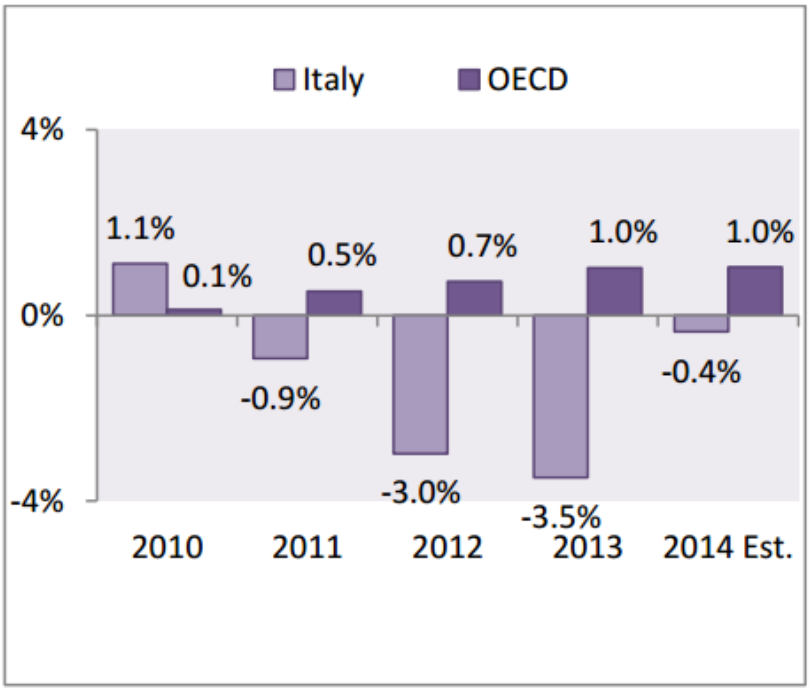
Organisation, funding and provision of health and mental health care

The Ministry of Health is responsible for overall functioning of the National Health Service Servizio Sanitario Nazionale (SSN). The SSN is largely under the control of regional governments and is administered by local health authorities (Azienda di Sanità Locale/ASL – often referred to by their former name Unità Sanitaria Locale/USL). The SSN provides universal coverage and it is free of charge at the point of service, but the quality and breadth of services varies between regions. Regions can also have their own specific health priorities and plans.

Primary care services, public health, community-based health services are delivered by the ASLs. Secondary specialist care is delivered via public hospitals or accredited private providers. Primary care represents the first point of contact with the SSN. The primary care network provides health education, diagnosis and treatment of diseases in different settings. Self-employed and independent GPs and paediatricians play roles as gatekeepers in referring patients to specialist or more complex levels of care if needed.

Italy spends about 9% of its GDP on public and private health expenditure. The public system has been under severe pressure with cuts in funding since 2010 due to the economic crisis. This has also impacted on mental health services

Figure 1: Annual health spending growth in Italy and OECD 2010-2014. (OECD 2015)



** Per capita spending in real terms*
Source: OECD Health Statistics 2015

Financing systems for primary care are mostly based on a mix of capitation (70%) and fee for services 30%. There are also some additional limited target payments related to performance. Hospitals are funded by 'case-based payment' and global budgets subject to regional variations (Donatini, 2016).

There has been a movement towards to integration of the health and social care sectors. It is reflected in the most recent Pact for Health in July 2014. All regions in Italy are required to form “primary care complex units” (Unità Complesse di Cure Primarie), which consist of GPs, specialists, nurses, and social workers.

In contrast to the traditional solo practice GP models, the new change in organisational structure is promoting the better environments for interdisciplinary team work. For instance, 62 medical homes in Emilia-Romagna are offering multispecialty team services to 1 million people (Donatini, 2016).

Importance of mental health in the health care system and other sectors: health and social care integration

Italy considers itself to be a pioneer of community focused mental health services. The system has undergone reform (Law 180) to move away from a traditional model of restrictive mental health asylums (*manicomi*) in 1970s to a modern community oriented system. In theory, there are no psychiatric beds in specialist mental health facilities in Italy (although some remain in general hospitals and in the private sector). There was an effort from an early stage in reform to integrate mental health services within community-based facilities, being mindful of the needs of service users and moving towards a social integration and recovery based approach (Forti, 2014).

Modernisation /Reforms /Current developments

Today mental health care services are provided by the National Health Service in various settings such as community- based mental health centres, community psychiatric diagnostic centres, inpatient wards in general hospitals, and residential facilities. There are departments dedicated to provide mental health-related services in local health units and they offer mental health promotion and mental disorder prevention strategies, treatments, and care to help recovery process. Multidisciplinary teams consist of psychiatrists, psychologists, nurses, social workers, educators, occupational therapists and those trained in psychosocial rehabilitation. Importantly, primary care does not play a significant role in offering mental health services. However, there have been some experiments that some GPs can deal with less intense cases such as people with mild depressive symptoms in primary care settings. (Lo Scalzo et al., 2009).

Good practice and innovation

In northern Italy, the GET UP (Genetics, Endophenotypes, Treatment: Understanding early Psychosis) PIANO (Psychosis: early Intervention and Assessment of Needs and Outcome) Trial was implemented in routine mental health services. Multi-component psycho-social interventions for people with First-Episode Psychosis (FEB) included CBT, family intervention and case management. Usually, it is costly to set up a new separate model, given the organisation changes and financial costs associated with the design and implementation. Rather than continue to expand specialist team for EI provision (which have not had much traction in Italy), it was financially more attractive to re-train existing mental health staff to provide early intervention in psychosis services in addition to general mental health services.

Psychiatrists and psychologists in the Community Mental Health Centres were given training sessions to deliver CBT for psychosis to patients, family interventions to family members, and case management to patients, families, and nurse/educators. The study found to be

effective in alleviating the severity of symptoms, and improving global functioning and emotional well-being, although there was no difference in self-reported hallucinations and the number of hospitalisations. The evaluation did not look at the cost-effectiveness of this model, and this needs to be determined.

Another new development is on reducing the number of forensic psychiatric hospitals. In a new law (Law 9/2012), new residential facilities such as small-scale facilities, which can accommodate a maximum number of 20 people, up to 4 people per each bedroom, have been planned. More recent developments, in line with a new law of 30 May 2014 after the first decree in 2012, envisaged the gradual downsizing and closure of the 6 forensic mental health hospitals in Italy. These in total have around 1,000 patients. This implies the transition of resources from a forensic psychiatric hospital to the newly established small-scale residential facilities or the community-based care arrangements with less restrictive security environments (Babui, 2015).

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