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An Comhchoiste um Chúram Meabhairshláinte sa Todhchaí

An Dara Tuarascáil Eatramhach: Gníomhartha a moltar de dhroim an dul chun cinn atá déanta go dtí seo

Aibreán 2018

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Joint Committee on the Future of Mental Health Care

Second Interim Report: Recommended actions arising from progress made to date

April 2018

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CHAIR'S FOREWORD

In July 2017, the Joint Committee on the Future of Mental Health Care was established with the aim to achieve cross-party agreement on the implementation of a single, long-term vision for mental health care and the direction of mental health policy in Ireland. This interim report outlines the recommended actions arising from progress made to date.

In the context of the implementation of 'A Vision for Change', the Joint Committee will examine current delivery of mental health services, including funding and recruitment challenges. The Committee will make recommendations on structuring mental health services, recruiting and retaining personnel, implementing 'A Vision for Change' and increasing access to services. 'A Vision for Change' was a ten year strategy by Government which recommended a wide range of reforms in mental health services, most of which were to be implemented by the HSE. The Committee has expressed a strong interest in implementation and ensuring that its report is 'not another report on a shelf'.

The Committee published its Interim Report in December 2017 in which it was stated that while the Committee is required to agree its final report by 31st October, the Committee intends to report regularly during the course of its deliberations. The Committee's agreed objectives as set out in its Interim Report are:

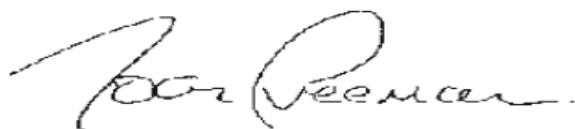
1. Primary Care;
2. Recruitment; and
3. Funding.

The Committee has endeavoured to analyse the current challenges and realities in each of these areas and has considered possible solutions and opportunities for improvement. As part of this, the Committee requested initial submissions from a number of relevant stakeholders to inform its meetings and to assist it in preparation of its first policy report.

The Committee also held a number of briefing sessions with relevant stakeholders. These stakeholders have included representatives from each of the Community Health Organisations, the Psychiatric Nurses Association, the Irish Medical Organisations, The Irish Association for Counselling and Psychotherapy and the Irish College of General Practitioners.

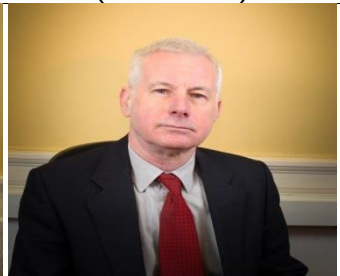
The Committee would like to thank all those organisations who took the time to prepare a submission and to all those who presented at public meetings of the Committee. These submissions and oral presentations have assisted the Committee greatly in its work. Copies of all presentations received are available on the Committee's webpage.

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



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

MEMBERS OF THE COMMITTEE

			
John Brassil T.D. (FF)	James Browne T.D. (FF) (Vice Chair)	Pat Buckley T.D. (SF)	Joe Carey T.D. (FG)
			
Marcella Corcoran Kennedy T.D. (FG)	Seán Crowe T.D. (SF)	Dr Michael Harty T.D. (RIG)	Alan Kelly T.D. (Lab)
			
Gino Kenny T.D. (S/PBP)	Catherine Martin T.D. (Green Party)	Tony McLoughlin T.D. (FG)	Tom Neville T.D. (FG)
			
Fiona O'Loughlin T.D. (FF)	Thomas Pringle T.D. (I4C)	Anne Rabbitte T.D. (FF)	

			
Senator Máire Devine	Senator Frank Feighan (FG)	Senator Joan Freeman [Chair]	Senator Colette Kelleher (Independent)
			
Senator Gabrielle McFadden (FG)	Senator Jennifer Murnane O'Connor (FF)		

INTRODUCTION

The Joint Committee on the Future of Mental Health Care was established by Order of the Dáil on 13th July 2017 and by Order of the Seanad on 18th July 2017 and held its first meeting on 28th September 2018. It reached consensus on the priority areas needed for investigation, which culminated in an interim report published on 12 December 2018, which identified Primary Care, Recruitment and Funding as three key areas of focus which would occupy the bulk of the Committee's time.

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

In considering these key areas, the Committee received 33 submissions from stakeholder organisations and held engagements with

- the national tier of HSE management,
- Community Healthcare Organisation management,
- the Minister of State for Mental Health,
- the Minister for Health, and
- advocacy organisations in the sector.

A full list of submissions received and stakeholder engagements are available in the Appendices.

This report represents the preliminary findings of the Committee in the three key areas identified by it, viz. Primary Care, Recruitment and Funding. The order that the three thematic headings take is not coincidental – the Committee has realised in the course of its deliberations that primary care, which is vital to the efficient delivery of services, is hampered by problems with recruitment, which is tangled in a complex dynamic with funding. Each of these pieces depends on

each other, and the Committee believes that its conclusions and the recommendations (including recommended actions) it makes in this report based on its analysis of the situation gets close to the nub of the issue.

Two other sections have been extracted from the three thematic headings as their importance warrants special attention. The first is mental health services for minority groups; the second is performance reporting.

People from minority groups still experience major mental health inequalities. The Committee has decided to include a section in the report, as these groups cannot be overlooked. This is especially true of Travellers, whose suicide rates continue to be unacceptably high, and deserve an urgent intervention from the State. These issues are discussed in paragraphs 125 to 137.

In relation to performance reporting, the report concludes with the Committee's findings on performance indicators. The data collected by the HSE and the performance indicators which measure the economy, efficiency and effectiveness of mental health services require updating, and the Committee sets out the case for this in that section. Relevant reporting is essential to understanding where change is needed in the system. These issues are discussed in paragraphs 138 to 146.

The Committee's final report, due to be delivered in October 2018, will put forward its vision for the future of mental health care in this country. This *interim* report represents an important step in this journey and, having made its preliminary assessment of the situation, it is now up to the Committee to focus on the steps that are necessary to achieve positive change and recommend them definitively. We welcome as much engagement from other actors in the sector as possible in reaching those conclusions. It is through the co-operation of everyone working in mental health, all of whom want to see improvement, that we will reach the consensus to make our plans workable.

LIST OF RECOMMENDED ACTIONS TO BE UNDERTAKEN BY THE DEPARTMENT OF HEALTH AND THE HSE AS APPROPRIATE

Engagement with the Department of Health

Action 1: Furnish the Joint Committee with the detailed report that has been completed by the Oversight Body which maps current service provision against A Vision For Change's aspirations without delay [Paragraph 3].

Action 2: The stakeholder consultation planned for next month by the Oversight Body should not proceed until there has been meaningful engagement with the oversight body and with the Joint Committee [Paragraph 5].

Primary Care

Action 3: Develop a realistic plan and timeframe for the provision of 24/7 crisis intervention teams nationally [Paragraphs 45, 70 and 116].

Action 4: Develop a national plan specifically to address capacity in primary care CAMHS services [Paragraph 46].

Action 5: Formulate an action plan to address the lack of cohesion between primary care and mental health services [Paragraphs 16, 36, 50].

Action 6: Outline referral pathways for mental health service users in primary, secondary and tertiary care and to include those presenting with a dual diagnosis [Paragraph 51].

Action 7: Clearly signpost the services that are available in the community, both to health practitioners and service users [Paragraph 51].

Action 8: Reduce the over-reliance on the prescribing of medication by increasing investment in counselling and talk therapies [Paragraphs 35, 53].

Action 9: Assess whether more e-Mental Health services could be offered, and include mental health as a distinct area of work in the e-Health Strategy [Paragraph 58].

Action 10: Roll out an efficient IT infrastructure across the health service with an emphasis on mental health to include a directory of services/managers, e-referrals/appointments and virtual clinics [Paragraph 37].

Recruitment

Action 11: Mainstream mental health training across all health disciplines, including in maternity and neo-natal care [Paragraph 94].

Action 12: Assess the prevalence of practical obstacles to continuous professional development and develop an action plan to minimise these [Paragraphs 83, 97].

Action 13: Urgently and realistically assess whether pay in the health sector is sufficient to attract and retain clinical staff, taking account of the findings of the

Public Service Pay Commission which is due to report on the issue in June. Revisit the Haddington Road Agreement regarding the requirement for clinical staff to work one day per month free gratis. [Paragraphs 74, 81, 99, 103, 124].

Action 14: Provide special subsidised accommodation for health sector staff to alleviate the cost-of-living burden [Paragraphs 79, 104, 105]

Action 15: Promote the use of flexible work patterns to retain workers [Paragraph 106].

Action 16: Promote the positive aspects of working in the mental health sector and the meaningfulness of such a career to young people considering career options, in venues such as schools [Paragraph 106].

Action 17: Amend the Medical Practitioners Act 2007 to allow doctors from other jurisdictions to take up training posts in Ireland [Paragraph 75, 101].

Action 18: The recruitment process needs to be reviewed particularly regarding recruitment being carried out on a national level and lack of backfill for upcoming vacancies [Paragraph 76, 91, 102].

Funding:

Action 19: Prioritise the development of an IT system which will enable efficient sub-speciality expenditure reporting. Until such a system is available, prioritise manual sub-speciality expenditure reporting across the nine CHOs [Paragraphs 107, 108, 109, 110].

Action 20: Increase the proportion of the Health budget allocated to mental health services to the level seen before de-institutionalisation in order to realistically allow for the implementation of A Vision for Change [Paragraphs 112 – 115].

Action 21: Increase the proportion of Health development funding which is spent on mental health and ensure development funding is used in a targeted manner to redress geographical imbalances in spending and service provision [Paragraph 123].

Mental Health Services for People from Minority Groups:

Action 22: Support and fund Traveller specific services, especially Traveller health services which are led and staffed by Travellers [Paragraphs 127 - 139].

Action 23: Create an ethnic identifier for Travellers which can be used to assess health outcomes [Paragraph 130].

Action 24: Ensure training for all health workers so that they are aware of specific issues for and needs of Travellers, LGBTI people and migrants [Paragraphs 125, 128, 133, 136]

Action 25: Establish a specialist health unit for transgender people which would remove the unnecessary reliance on services like CAMHS for gender dysphoria diagnosis [Paragraph 133].

Action 26: Consider removing the need for parental consent for under 18s to access mental health services [Paragraph 134].

Action 27: Integrate mental health supports into the health programme for victims of human trafficking in Ireland [Paragraph 137].

Performance Indicators:

Action 28: Assess the current suite of mental health KPIs, with a view to expanding them so they measure health outcomes as well as weekly/monthly activity [Paragraphs 140, 141, 143]

Action 29: Incorporate patient feedback and quality of care into KPIs [Paragraph 143, 144]

Action 30: Expand data collection to include patient experience outside of in-patient units [Paragraph 142].

Action 31: Assess the feasibility of the development of Electronic Health Records [Paragraph 146].

ENGAGEMENT WITH THE DEPARTMENT OF HEALTH

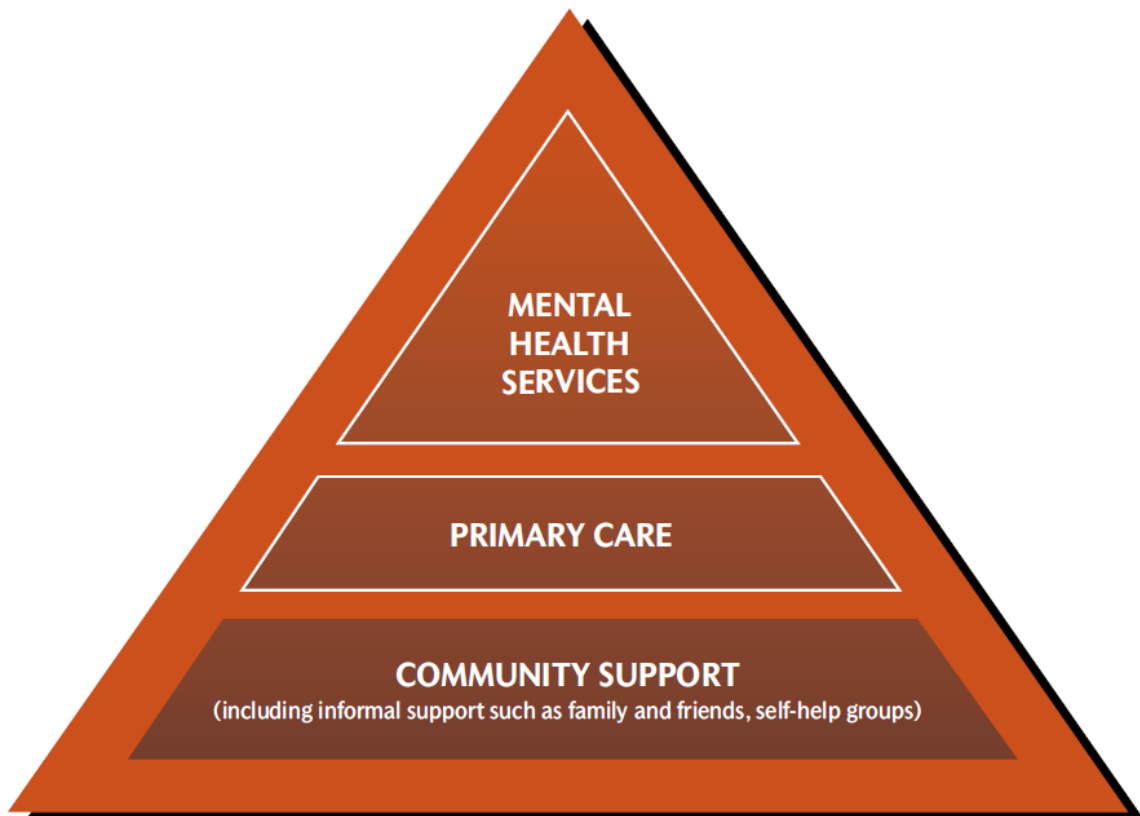
1. Soon after its establishment, the Joint Committee learned that an Oversight Group had been or was being established by the Department of Health tasked with reviewing and proposing an update to the existing mental health policy A Vision for Change. The Joint Committee understood that the group's terms of reference overlapped significantly with those of the Joint Committee. In order to avoid duplication, the Joint Committee sought, on a number of occasions, to engage with this group so as to ensure complementary, rather than divergent, efforts. However, securing meaningful engagement proved difficult and continues to prove difficult. This apparent lack of cooperation was a cause of concern to the Joint Committee.
2. At its meeting of 8 November, the Joint Committee secured a commitment from Minister of State for Mental Health and Older People, Mr. Jim Daly T.D., that the Oversight Group would supply a work programme to the Joint Committee and report to it monthly. Despite repeated requests, the Joint Committee did not receive the work programme of the Oversight Group until 16 March. That work programme, which is undated and has, most likely, been updated very recently, suggests that:
 - The Oversight Group has been active since October of 2017.
 - The Group has been provided with information about current policy actions and recommendations with a view to identifying "possible ways of moving forward" on an on-going basis since its establishment.
 - Sub-committees of the Group have completed pilot work in relation to outcomes and enablers for an effective mental health service in respect of two age groups and their findings have been fed back into the main Group.
 - The Oversight Group has "determined two approaches with which to inform the refresh of A Vision for Change".

- A detailed report mapping the recommendations set out in A Vision for Change against existing Irish mental health services has been completed. The group is currently considering the success of implemented actions, the actions yet to be completed and their current relevance.
 - Other significant work, including work preparatory to a stakeholder engagement process scheduled to commence in April and conclude in June, has commenced.
3. Until it received the Oversight Group's Work Programme, the Joint Committee was unaware that a detailed report has been completed which maps current service provision against A Vision For Change's aspirations (the Joint Committee has not seen this report).
 4. The Oversight Group has been planning a stakeholder consultation which is due to commence shortly. The Joint Committee is concerned at the delay in receiving the work programme and that it omits any reference to the existence or work of the Joint Committee including, for example, its public hearings with stakeholders. The Joint Committee recommends that the stakeholder consultation planned to commence in April 2018 should not proceed until there has been meaningful engagement between the Oversight Group and the Joint Committee.
 5. The Joint Committee is of the opinion that much of the work completed or planned has the potential to pre-empt the work of the Joint Committee. This is a cause of concern as it suggests that the Department of Health may intend to develop its own plan for the future of mental health services without meaningful and timely consultation with the Joint Committee.
 6. The Minister for Health, Mr. Simon Harris T.D., recently described the Oversight Group as being responsible for creating a "blueprint" for the future of mental health services. The Joint Committee's primary objective is to achieve a cross-party vision for the future of mental health services in the state. Setting up a parallel process within or on the part of the Department without the relationship between the two being defined and

without any relationship existing in practice will be wasteful of time and resources at the very least. In extremis, it has the potential to side-line the work of the Joint Committee and make the cross-party political work being done by it redundant.

PRIMARY CARE

7. Primary care describes lower complexity healthcare that can be provided in a community setting as opposed to more highly specialised and complex levels of healthcare provision. Joyce O'Connor, Chair of the Expert Group which created A Vision for Change, the intended blueprint for mental health policy and service development from 2006-2016, highlighted to the Committee the below diagram from A Vision For Change, which visually describes the way that mental health care should function, with acute mental health services at the top of the pyramid being reserved for a minority of needs:



8. It is the view of the ICGP that within the Irish mental health system, we are historically spending excessively on hospital based care, administrative overheads, specialised care and pharmacological therapies.

Conversely, we are spending too little on primary care and on holistic talking therapies.

9. A Vision for Change recognised the crucial role of the Primary care sector to mental health care, stating that "Primary care is a very important part of the mental health framework for two reasons:
 - Most mental health problems are dealt with in primary care without referral on to specialist services. Primary care is therefore the main supplier of mental health care for the majority of the population.
 - The GP in primary care is also the main access point to specialist mental health care for most of the population."

GP-led rather than psychiatry-led care is appropriate in the majority of cases, however psychiatry is an important component and specialisation.

10. A Vision for Change set out that the bolstering of mental health supports in primary care should mean greater use of counselling as a treatment option, and the filling of Community Mental Health Teams. Those teams should be comprised of a number of different clinical professionals and act as a crucial liaison in the community for mental health treatment, providing cohesive links between first presentation, primary treatment, and onwards referral if necessary.
11. More recently, the Committee on the Future of Health Care stated in its final report, *Sláintecare*, that it believed that "a significant proportion of mental healthcare can, and should be provided as part of primary care."
12. The first pillar of the 2016 Programme for Government's Health ambitions is "A Decisive shift of the Health Service to Primary Care with the delivery of enhanced Primary Care in every Community." It is the Committee's view that mental health services should form a vital part of this shift, with low complexity care being offered in a Primary setting in the first instance in the majority of cases. This attitude is echoed by stakeholders who have submitted to the Committee and by the HSE, who are tasked with building capacity in Primary Care. However, despite stated buy-in across the

political and operational spectrum, the shift to increased capacity in Primary Care seems difficult to realise.

13. As indicated in the Samaritans submission to the Committee, Sláintecare's recommendations to enable universal access to primary care and GP services are relevant to mental health. Expanded capacity in primary care together with proper integration with mental health services would help ensure appropriate, less costly mental health treatment reaches more people, improving the landscape for mental health treatment. As Jigsaw point out in their submission, the more advanced and capable primary care supports, the less likely it is that inappropriate referrals will be made, clogging up the more expensive secondary and tertiary mental health care systems. Additionally, strong primary care services mean that people with mental health difficulties can be identified and treated earlier. Delays in service mean that problems can get worse over time as they are not treated, at high personal cost to individuals and also creating extra cost burden on service providers. There is a need to educate, train and support our communities to understand and deliver on mental health.
14. In theory, primary care should be the first access point to the system for the great majority of mental health patients, with most of their needs being met at a low complexity level of care. However, the realisation of this is hampered by a failure to bolster mental health services in primary care as set out in A Vision For Change. A 2015 Mental Health Reform analysis found that "there remain significant gaps at primary care level in the delivery of mental health supports." Those gaps in primary care provision had been apparent in 2011 when Mental Health Reform carried out a consultation with service users wherein they complained of:
 - significant gaps in primary care provision
 - dominance of medication as a treatment option
 - lack of referral options for GPs to counselling, psychotherapy and family therapy or Community Mental Health Teams
 - Continued use of Emergency Departments as access points for mental health services

15. Mental Health Reform, in their submission to the Committee, state that “there continues to be a fundamental gap in collaborative working” between primary care and more complex mental health care services.
16. The Irish Nurses and Midwives Organisation point out to the Committee that findings of a HSE survey among mental health and primary care practitioners showed that the level of integration between the two areas was inadequate.
17. Administratively, Primary Care and Mental Health Services are run as two discrete services within the HSE as a result people fall between the different mental health silos with devastating consequences. The Committee understands that administrative divisions have to be made to allow administrative specialisation. However, a lack of proper communication and integration seems to be part of the problem in making primary mental health care available on the ground in many parts of the country. The Psychiatric Nurses Association describe Primary Care and Mental Health Care as “two hard pressed services which often relate poorly to one another.” The Irish Advocacy Network claim that many primary care centres do not have staff with mental health expertise onsite.
18. Stakeholders in their submissions reported difficulties for GPs in referring to mental health services and the desire for more psychological therapies to refer to within the primary care sector. The UCC School of Nursing and Midwifery informed the Committee that mental health services in primary care need to be urgently developed and describe the services available in GP practices and primary care centres as “ad hoc.” Research from the ICGP shows that fewer than 13% of GPs surveyed reported positively on their experiences with Primary Care Teams and states that mental health is poorly reflected and integrated in Primary Care Teams.
19. Ultimately, consistent access to low-cost, low-complexity mental health/wellbeing services seems to be elusive. Community

based/educated supported social prescribers to promote wellbeing and prevent illness.

20. The lack of cohesion between primary care and mental health services often means that the most marginalised people are the most adversely affected in terms of accessing services. It is important to note it can be particularly hard for homeless people with mental health issues to access services in primary care. Also, the shortfall in services which can accommodate dual diagnosis of alcohol/drug misuse and mental health issues is another obstacle to treatment in primary care. The Samaritans informed the Committee that “it can be difficult to determine whether a mental health problem is primary or secondary to alcohol misuse and this can complicate how a person is treated” and the Committee is concerned that this lack of capacity is leading to lack of treatment and people falling between different silos of the mental health system in many cases.
21. Many services also remain accessible only during certain days and times, which does not always reflect the reality of mental health need. The Committee heard from the HSE at its meeting of 30 November 2017 that only 60% of the 114 community mental health teams in Ireland have a 7 day service. If these teams are really to be the bulwark of the service they were envisioned to be in A Vision for Change, Ireland should be working towards a situation where supports are available 7 days a week and 24 hours a day nationally. When these teams are not available for people, pressure continues to build on acute services, especially Emergency Departments which are not properly equipped to deal with mental health crises. Services that don’t have out-of-hours availability can also be inaccessible to people who are worried about holding down jobs, as highlighted to the Committee by the Irish Advocacy Network. The Gardaí, voluntary sector and families have to step in when out of hours mental health services are unavailable.
22. In their submission, SAGE Support and Advocacy highlight research which shows that there is a higher prevalence of depression amongst people with an intellectual disability and that two thirds of adults with depression have a longstanding illness or disability. Clearly, there is a large amount

of overlap between disability and mental health issues. Societal obstacles which confront disabled people are likely to be a large contributory factor to this overlap. Therefore, cross-sectoral work on removing these barriers is needed, but in terms of mental health service delivery, services should be actively seeking to improve accessibility and ensuring that service design meets the needs of disabled people. SAGE are also concerned about the use of psychotropic medication to manage behaviour in intellectually disabled people and point to “a lack of legislative safeguards to prevent the use of sedation purely for the management of a person’s behaviour for convenience within care settings.”

CONSEQUENCES

23. The consequences of the inadequate attempts to (a) increase healthcare provision in the primary & community settings and (b) integrate mental health services into the primary care service sector, are seen in the lack of services available in communities, in the confused pathways to reach the services which are available, in long waiting lists (especially for children's services), and in increased pressure on services designed to meet complex and long-term needs.
24. The lack of access to out-of-hours services across the country, including crisis intervention, means that people cannot receive treatment when the need arises. Mental health needs cannot be shoe-horned into convenient hours and the lack of out-of-hours crisis intervention can exacerbate problems and puts more pressure on other services which may not be best equipped to solve them.
25. More generally, outside of emergency situations which are worsened by limited opening hours, the same dynamic applies to other forms of inaccessible primary care. An inability to access services at primary level doesn't make a problem go away. It does make it more likely to surface in secondary or tertiary care settings, having worsened. This is a contributory factor to long waiting times for psychiatric assessment and treatment. As the UCD School of Nursing, Midwifery and Health Systems point out in their submission to the Committee, currently all referrals to a psychiatric team must be through a GP to a psychiatrist, which may be systemically slowing down waiting times. They recommended that referral practices be reviewed.
26. It is clear that mental health needs which require lower levels of care which can be effectively treated at primary level are being referred into specialist services, which constitutes a failure to work within a stepped care model. The IHCA told the Committee in their submission that "many presentations of unhappiness or distress due to social or personal issues are **inappropriately** referred to psychiatric services." The IACP raise a

related point when they say that “GPs should be able to access counselling / psychotherapy for people without having to go through a psychiatrist.”

27. The Committee also wonder whether every condition that officially requires psychiatric assessment or diagnosis is really necessary. BeLonGTo informed the Committee that young transgender people requiring treatment such as hormones must go through the CAMHS system for diagnosis. This puts unnecessary strain on them as well as adding more work to an already overburdened system, which should be focused on young people who need acute mental health care. An examination of the role of psychiatry in the mental health system will be part of the next phase of work by the Committee.
28. Irish Advocacy Network contend that lack of access to appropriate services diverts people from seeking help. Also, lack of out-of-hours services, is increasing pressure on Emergency Departments. The advocacy organisation says:
29. “Quite often the only place for a person in severe distress during the night time hours or at weekends to go is to their local Accident and Emergency Department. A & E Departments are not equipped to deal with people who are presenting with mental health difficulties. Attending the A & E Department can increase their levels of distress and can also cause distress for other ill patients in the Department.”
30. The ICGP, appearing before the Committee on 14 December 2017, told the Committee that these referral circumstances can be very bad for the patient, who with nowhere else to go is referred into an “exceptionally busy” setting with no relevant specialist onsite.
31. Some of the other effects of the lack of community services which were highlighted by stakeholders include:
 - Deficient accessibility of mental health services for women experiencing violence, because of the way services are designed. (National Women’s Council of Ireland)

- Limited access to old age psychiatry in primary settings requiring, in practice, older people to have to attend hospitals for assessment
 - Geographic variance regarding access to treatment and care from Old Age Psychiatry teams
 - Tendencies in nursing homes to attribute mental health issues to behavioural problems rather than a mental health condition, cutting off access to old Age Psychiatry supports
 - Lack of community care leading to people being inappropriately placed in nursing homes due to mental health issues. (SAGE)
 - Lack of services for 16 – 18 year olds, especially early intervention programmes
 - Health inequality created by the reality that people without the means to pay privately often cannot access talk therapies and counselling services, despite higher suicide rates in areas of socio-economic deprivation. (Samaritans)
32. The above problems constitute a lack of necessary service and contribute to mental health issues being side-lined for women experiencing domestic violence, people in deprived areas, young people and older people.
33. The current systemic design of the supports which are available in primary and community care also creates problematic barriers based on income levels. The gap created in service accessibility for people whose income threshold is above the medical card but who may be struggling to make ends meet is one that affects the health service as a whole, and there are particular manifestations of this in mental health services. A range of organisations which submitted to the Committee called for the expansion of the Counselling In Primary Care (CIPC) scheme beyond solely medical card holders. As Mental Health Reform state, this is needed to “meet the counselling needs of low to middle income individuals with mild to moderate mental health difficulties.” The Committee is of the view that this should also apply to psychotherapy and family therapy.

34. The cliff-edge access to services scenario created by the binary nature of holding a medical card also disincentivises medical card holders from seeking the financial, social and mental benefits of employment. For those who can officially access CIPC, waiting lists are still a problem. The Irish Association for Counselling and Psychotherapy told the Committee at its meeting of 7 February 2018 that "As of the end of April 2017, there were 2,530 clients waiting for counselling nationally, of whom 727 or 29% were waiting less than one month, 1,183 clients or 47% were waiting between one and three months, 489 clients or 15%, were waiting between three and six months and 131 people or 5%, were waiting more than six months."
35. The ICGP point out that less than €10 million euro per year is spent on services such as CIPC and over €400 million per year on psychotropic medication. The IACP refer to a "dominance" of medication in Irish treatment of mental illness and state that medication should not always be the first resort. However, the "dearth" of talk therapy at primary care level often makes it difficult for that form of treatment to be the "first resort." Similarly, the Samaritans have informed the Committee that "the main method of treatment provided in the primary care setting is medication" and they recommend the availability of more options including more counselling, psychotherapy and family therapy, enabled by the expansion of CIPC.

CAUSES

36. A large part of the problem seems to be a lack of clinical professionals in place in community mental health teams and across the primary care spectrum to deliver the services that are needed. Also, communication between different services in the primary setting may be deficient. Integration between primary care and mental health needs improvement.

37. Several stakeholders have criticised the lack of fit-for purpose information technology, and this must be influencing the communication difficulties which exist in the sector. The ICGP specifically mentioned a non-embrace of electronic medical records and administration in secondary care which impedes flow between the tiers, and the non-use of information technology, including email, by Primary Care Teams.

38. In November 2017, the HSE provided the Committee with information on how many whole-time equivalent clinicians were in place in Community Mental Health Teams across the country's nine Community Healthcare Organisations, as compared to how many had been set out as required in A Vision for Change:

General Adult Community Service	Total population	Actual Clinical WTE Oct 17	Vision for Change %
CHO 1	394,333	156	94.2%
CHO 2	453,109	171.6	90.2%
CHO 3	384,998	113.7	70.3%
CHO 4	690,575	258	89%
CHO 5	510,333	164.6	76.8%
CHO 6	445,590	88.8	47.5%
CHO 7	645,293	210.5	77.7%
CHO 8	616,229	188.6	72.9%
CHO 9	621,405	170.9	65.5%

Child and Adolescent Mental Health Services	Population 0 - 18	Actual Clinical WTE Oct 17	Vision for Change %
All CHOs	1,190,502	587.33	56.1%
Psychiatry of Old Age	Population > 65 years	Actual Clinical WTE Oct 17	Vision for Change %
	616,362	306.3	60.5%

39. Given that multi-disciplinary community mental health teams were envisioned by A Vision for Change to play a leading role in the transition to greater service provision in primary care, the lack of filled teams across the CHOs obviously has a negative effect on mental health in primary care. Teams cannot provide the services to if they are missing crucial staff members. They also don't have the presence which would allow them to lead the integration of different stakeholders to engender the cohesive and linked service necessary for the deliverance of shared and stepped care. The problem of recruiting to these teams and the mental health services generally is analysed more extensively in the report's recruitment section.
40. The Samaritans point out an example of this dis-function in realising A Vision for Change because of unfilled teams:

"A Vision for Change advocated a 'shared care model' where primary care teams and community mental health teams work together to ensure that individuals receive timely and appropriate access to treatment and support. In order for this model to work senior members of the Community Mental Health Team (CMHTS) are required to support primary care by providing advice and managing referrals. This process cannot work unless Community Mental Health teams have their full complement of staff."

41. Another possible cause of primary care services operating at a lower effectiveness than they could be is a lack of adequate investment. This is SpunOut's view, and they blame underinvestment for "unsustainable pressure on specialist services such as CAMHS." They say that A Vision for Change did not adequately specify the level of resourcing which would be needed for mental health services in primary care. The Committee is aware that, soon after the publication of A Vision for Change, the overall Health budget experienced years of dramatic cuts, and that overall Health expenditure is only beginning to approach 2008 levels now (with a higher population). However, investment in Mental Health was cut to a lower percentage in crisis years and retains that lower proportion and this needs to be addressed.
42. Another problem which may create a challenge to individuals being matched with the most appropriate services for them is a lack of awareness of all the services which actually exist, both on the part of individuals and clinical professionals. Aware in their submission highlight the "limited awareness of mental health services available" and emphasise that the HSE have a responsibility to ensure that GPs are informed about the programs they are funding either fully or partially (such as Aware's own Life Skills Programmes) so that they can refer individuals to suitable programs. Referral services need to be simplified and made more visible.
43. The Chief Officer of CHO 8, also referred to an under-investment in physical infrastructure. He told the Committee, at its meeting of 24 January 2018, that "The rate of capital investment in permanent clinical accommodation has not kept pace with staffing increases in our mental health teams across the region. Delays in the development of primary care centres in key urban areas have resulted in an over-reliance on leased or shared accommodation. This gap impacts on productivity and staff retention."

POTENTIAL SOLUTIONS

44. Many proposed solutions to the problems in making primary care a consistently available setting in which to access mental healthcare, offered to the Committee by groups who have made submissions, involve increasing the staff in the primary care setting. It would be unreasonable for primary care to be working fully as expected with the staff shortages highlighted above. The Committee feels that increasing staff must form a significant portion of a suite of solutions which aims to make primary care central to the delivery of mental health services. This faces its own challenges, which are set out at length in this report's recruitment section.
45. Additionally, Family Carers Ireland has recommended that Home-Based Crisis Intervention Teams be rolled out nationally so that individuals experiencing a mental health crisis can be treated in their own homes across all nine CHOs. As well, increasing coverage to 24/7 mental health services in the community should be a realistic target for all nine CHOs, and this can only be achieved by significantly increasing clinical staff in the community system.
46. Given the special vulnerability of children and the very poor rates of CAMHS team fulfilment in various CHOs (and consequent distressing waiting list figures for children waiting to access mental health services), the Committee wishes to echo UCC School of Nursing and Midwifery's assertion that community based primary care CAMHS services need prioritised investment and development, including the level of attention of a full service plan.
47. The Psychiatric Nurses Association make the case that the increased provision of Registered Psychiatric Nurses as part of the primary care model of care would alleviate demand in the sector and enable "the application of interventions in a targeted fashion." Similarly, the UCD School of Nursing, Midwifery and Health Systems argues that an enhanced role for mental health nurses in primary care (as there is in the UK) could help to facilitate rapid access to mental health services, and they call for

this to include prescribing functions and out-of-hours availability. Until such a time as out-of-hour availability can be guaranteed, separate areas with mental health staff should be considered for A&E Departments since that is where mental health emergencies are presenting, with nowhere else to go. The UCC School of Nursing and Midwifery call for increased mental health services in Primary Care Centres and GP Practices to be achieved by developing psychiatric nurse led services in these environments.

48. Another aspect of increasing provision in primary care, as identified by the ICGP, is an increase of allied health professionals (counsellors etc.) in primary care settings for GPs to refer to. Dr. Tighe from the University of Limerick calls for all GPs and Practice Nurses to have access to on-site or local counsellors or mental health nurses. Mental Health Reform recommends that each Primary Care Team has a minimum of 1 dedicated mental health post. All of these recommendations orbit the same general point; mental health specific clinical staff are not embedded in primary care services as they need to be; broadly, the solution lies in increasing mental health specialist staff across the primary care settings that are there.
49. More staff to address the deficiency in dual diagnosis care are also needed. People who suffer from drug or alcohol dependency and have mental health needs can “fall through the cracks” and find it difficult to access appropriate treatment. In many cases, primary care is the appropriate setting for this dual diagnosis to be treated, but the framework and capacity for doing so needs to exist in primary care settings. Mental Health Reform state that primary care services should facilitate dual diagnosis care and that operational procedures need to be revised to ensure this. The Samaritans told the Committee that suicide risk should be assessed as part of screening for harmful drinkers as a matter of course, which would be an encouragingly pro-active approach to dual diagnosis. The Samaritans also point out to the Committee that VFC recommended that specialist adult teams be established in the community for dual diagnosis.

50. Further efforts to embed mental health services in the primary care system should be made. In this vein, the ICGP recommend that the functioning of primary care teams be reviewed, with input from mental health practitioners. The Committee's work in the area of primary care thus far has illuminated a widespread view that mental health care does not form a significant enough part of the work of primary care; therefore an active and on-going review of the assimilation of mental health into primary care teams may be necessary to improve that. For Mental Health Reform, the successful implementation of a shared care approach between primary care and mental health requires a National Action Plan.
51. As well as the need for increased mental health specialist staff presence in primary care settings, it is also the case that there is improvement needed in the whole process of referral and of patients' journeys within the primary setting or from the primary to secondary or tertiary setting. University departments involved in training mental health nurses have stated that much clearer and definitive protocols and referral pathways, defined nationally and universally applicable, should be developed for mental health disorders. UCD also point out that current referral practices need review as it may not be necessary for all referrals to psychiatric teams to have to go to a psychiatric doctor through a GP. The INMO has also recommended referral pathways, including for practice nurses to have access to mental health specialist nurses. The ICGP also calls for an appraisal of referral pathways as they seem "disjointed." Those referral pathways should be matched by public information campaigns and clear signposting of services available in primary care settings so that people know the pathways and referral options which are available to them. Similarly, A&E Departments and the Gardaí may benefit from better signposting on where to refer people in mental health difficulties.
52. Insufficient IT systems and the delays and inefficiencies they are creating also need solutions which look to integration across services. Systems should be integrated between primary, secondary and tertiary care and the ambition should be to institute a direct booking system between services, as seen in Macedonia (UCD School of Nursing, Midwifery and Health Systems). According to a number of stakeholders who submitted to

the Committee, information gathering, ideally based around electronic health records, and efficient use of IT systems across administration would help to remove obstruction and wastage, and foster cohesion and integration across the services.

53. The needed expansion of counselling in primary care is a theme that features largely in submissions to the Committee. Counselling, psychotherapy and family therapy in Primary Care is a well-regarded scheme. Its availability only to those who hold a medical card means it is not fulfilling its potential as a real alternative to medication and referral to secondary and tertiary services. Expansion of this service is an obvious place to start in terms of fulfilling more mental health needs at the primary level. Even if not through CIPC, talk therapies and counselling in general should be expanded in the primary sector. As Jigsaw point out, talk therapy does not necessarily need to be within a medical model and services which provide counselling, psychotherapy and family therapy in primary care should also be supported without medical referral.

Embedding in the community:

54. Mental health is an integral part of a person's life, and it must fit into individuals' lives holistically. Services should reflect this too, especially in primary care, a great advantage of which is community linkage and closeness to where people are living their lives. In this respect, working with other settings in the community also needs to be considered part of the solution for improving mental health services. Stakeholders submitting to the Committee recommended the development of school liaison services and prevention work in schools. The Irish Association for Infant Mental Health draw the Committee's attention to the importance of mental health from the earlier years, so mental health programs for younger school children and in crèches, as well as for at risk families in the community, should also be looked at. There is no screening for infants/toddlers/parents with regard to emotional wellbeing and this needs to be addressed.
55. The Samaritans recommend the development of onsite counselling in homeless accommodation. The Committee feels that this is especially

important for individuals who may be in a very difficult and precarious position and would benefit from the ease-of-access which onsite counselling provides. The Samaritans also recommend that discharge practices which may be discharging people with mental health issues from hospitals and prisons back into homelessness be reviewed.

56. Nursing homes would also benefit from the development of onsite counselling services, as pointed out in SAGE's submission, and they also recommend a broadening of the remit of Mental Health Services for Older People to ensure that older people who need help with their mental health can access it.
57. The Committee is extremely interested in "social prescribing", a phenomenon described by the ICGP when they appeared before the Committee on 7 February 2018, in which doctors can point people towards organisations in the local community which provide social outlets in line with the individuals' interests and needs.
58. e-Mental Health is a growing service type that presents an opportunity for mental health services to efficiently supplement through the use of technology. This can include peer-to-peer mental health forums, as recommended by Jigsaw, and online counselling. The Aware Life Skills Online programme (based on Cognitive Behavioural Therapy) has been shown to have a positive effect in reducing depression.
59. However, as Irish Rural Link points out, the effectiveness of such services in rural areas depends on the availability of broadband. Mental Health Reform recommend that Mental Health form a distinct area of work in the E-Health Strategy, and the Committee sees the value in doing this to ensure that Mental Health is mainstreamed in this burgeoning area.
60. A number of the solutions proposed by stakeholders' submissions focus specifically on funding and costs as it relates to primary care. According to the UL Department of Nursing and Midwifery, the medical card gap which creates difficulty in accessing services could be tackled by either (a) putting in place a specific system to allow people to access mental health interventions like counselling for free, or (b) by making people with long-

term mental health issues medical card holders. The IACP proposed that reform of the PRSI system should include benefits such as counselling. The College of Psychiatrists press the need to move the funding model from mental health services from a hospital bed model to a community clinical supports model. SpunOut call for a “rapid expansion” of funding for primary care mental health services.

RECRUITMENT

61. Staff are the central pillar of any health service. This is true of Ireland's mental health service and thus the recruitment and retention of staff (especially clinical staff) is an important area of the Committee's work. It is well known that Ireland faces difficulties in recruitment and retention of mental health staff, as the HSE acknowledge. At the Committee's meeting of 22 November 2017, Anne O'Connor, Director of the HSE's Mental Health Division said:

"Staff recruitment in mental health continues to be a significant challenge, resulting in the underdevelopment of mental health teams in certain areas which then impacts on access, targets and waiting times. The lack of availability of suitably qualified staff also contributes to inadequate out-of-hours services."

62. It is also a recurrent theme of stakeholder submissions and presentations to the Committee. Securing a sustainable flow of clinical recruits who are incentivised to stay in Ireland's mental health services long-term has a strong case for being the single most important challenge which needs to be met by Government and the HSE to provide the robust, world-class mental healthcare service which Ireland deserves.
63. The Chief Officer of CHO 9, told the Committee at its meeting of 24 January 2018 that "the single biggest challenge for mental health services in terms of recruitment is mental health nursing."
64. The HSE also informed the Committee that as of November 2017 that there were over 700 unfilled development posts (one third nurses, one third AHPS and remainder across Medical, Patient Care and Admin), and that as well as development posts (which expand staff numbers) "the HSE National Recruitment Service are also in the process, at any one time, of recruiting and appointing nearly 600 replacements posts nationally in mental health services."

65. There is also a geographic unevenness to the types of professionals which are most needed in different parts of the country. As the Chief Officer of Community Healthcare Organisation 1 told the Committee on 18 January 2018, CHO 1's main challenge is in recruiting psychiatrists whereas the eastern part of the country has more difficulty in recruiting psychiatric nurses.
66. According to the Irish Hospitals Consultants Association there is an overreliance on national HSE panels to recruit front-line mental health staff, rather than creating panels for specific posts.

CONSEQUENCES

67. The consequences for mental health services of continual understaffing, and a seeming inability to reach sufficient staffing levels, are obvious – reduced service provision, long waiting lists, non-clinically led referrals and decision making, increased pressure on staff, “vicious circle” effects as difficult working conditions caused by understaffing help to repel potential recruits and drive existing staff to leave the services. As the College of Psychiatrists of Ireland stated in its submission to the Committee, “currently many consultant posts across the country are vacant or shored up by long-term locums, who are often not experienced enough or trained appropriately for the posts they hold,” with the consequence that “service development is not as clinically driven as it should be and ultimately patients are not getting the expert service they require and deserve.”
68. The most startling service area in which the gaps in provision are felt is in Child and Adolescent Mental Health Services. The Committee views the mental health of children as being particularly important; therefore it is incumbent on the State to ensure responsive and meaningful services to children as soon as they experience any mental health difficulty. Unfortunately, this is currently far from being realised and this is a reflection of particularly low clinical staffing figures in CAMHS. The IMO told the Committee that their GPs describe the situation in CAMHS as

“heart sink” and the IHCA directly connect overlong waiting times for assessment in the area with staff shortages; “The relatively low level of Child and Adolescent Psychiatrists and the general shortage of frontline resources has resulted in unacceptably high numbers of children on CAMHS waiting lists with waiting times that are too long.”

69. As the Psychiatric Nurses Association highlight, A Vision for Change set out the need for four Intensive Care Rehabilitation Units, each providing 30 beds to enable care for individuals with severe and enduring mental illnesses. The PNA's 2016 study found that there are no such units, and that Assertive Outreach Teams are sparse and poorly resourced. These are further examples of shortfalls in service which the obstacle of poor recruitment and retention contributes to.
70. As well, as explored in this report's section on Primary Care, it is clear that lack of sufficient staffing coverage in community settings increases pressure on acute services. Multiple stakeholders have pointed out that the dearth of out of hours services in particular puts pressure on Accident and Emergency units, as people with mental health needs often present there inappropriately due to having nowhere else to go. This creates additional stress and risk for A&E staff, other patients, and people with mental health needs and their families. This should be avoided by 24/7 dedicated mental health services, prioritising the known peaks i.e. Thursday night through to Sunday morning in each of the 9 Community Healthcare Organisations.

CAUSES

71. A Vision For Change was published just before Ireland's recent financial crisis. This obviously impacted the ability of the HSE and Government to implement its recommendations, particularly around staffing numbers. Aside from the inability to secure funding to implement the staffing increases which were recommended, funding to maintain services was cut, leading to drastic measures which affected the Health service and mental

health services in a particularly destructive manner. Financial Emergency Measures in the Public Interest (FEMPI) cuts and the embargo on recruitment have created lasting issues for recruitment of health staff in this country. As St. Patrick's Mental Health Services highlight in their submission, "the recruitment embargo in 2010 and 2011 disproportionately and indiscriminately reduced the availability of professional mental health service staff."

72. Although the recruitment embargo has been lifted, the health service faces a different problem, with the HSE endeavouring to recruit more but experiencing difficulty in doing so. The embargo years are causative to this situation, as many young graduates emigrated during that period, and this contributed to deteriorating working conditions which have made Irish mental health services less attractive to potential recruits.
73. The HSE has informed the Committee that results of surveys it has carried out with Irish mental health medical staff working abroad, to understand factors influencing their likely return to posts in Ireland, found that not only pay but also conditions were the factors i.e. pleasant & safe environments for users and staff, reasonable rosters etc. As the INMO put it, nursing and psychiatric nursing are "demand driven services, characterised by low remuneration, high stress work environments, poor staffing levels associated with unsatisfactory working conditions and a poorly controlled working environment. These issues are consistently reported as the causative factors for the decisions of nurses to leave our services." The IMO also highlighted work-life balance as an issue in their evidence to the Committee at its meeting of 14 February 2018, stating that "junior doctors here are still expected to work outside the European working time directive limits and we have difficulty in applying the maximum 24-hour shifts."
74. Conditions and salary levels arising out of the recruitment embargo and FEMPI years have led to a situation that the PNA call "a culture of graduate emigration." Although working conditions are an important element of the large flow of skilled emigrants in the sector, so is pay

disparity between Ireland and other recruiting jurisdictions, and this can be starkly numerically illustrated:

Staff Nurse Salary Minimum Point of Scale (all figures presented as purchasing power parity* ratio) in main destination countries for Irish Nurses)

Country	Hours P.W.	Min-point	Hourly Rate
Canada	37.5	53078	27.13
Australia	38	41844	21.10
Ireland	39	33908	16.66
United Kingdom	37.5	32404*	16.56
+ High Cost Area Supp Max 20%		38885	19.87

*(2nd point of band 5 salary scale – all nurses commence employment on the 2nd point of the salary scale in recognition of nursing degree qualification and are recruited to areas where the high cost area supplement automatically applies.)

Source: Psychiatric Nurses Association

75. The IHCA have stated that the practice of appointing non-specialists as temporary consultant psychiatrists instead of doctors who are fully trained as specialists is undermining the safety and quality of service user care and is in breach of the HSE's recruitment rules and the medical practitioners Act, 2007.
76. The IHCA have also stated that there is an overreliance on national HSE panels to recruit front-line mental health staff, rather than creating panels for specific posts.
77. The INMO highlighted to the Committee that "within the competing countries, Ireland is the only country that pays nurses significantly less than the comparator Allied Health Professional grade." The Committee

feels that this should be reviewed, as nurses are a highly qualified and essential component of our health service, including mental health.

78. Pay is not solely measured by comparison to other jurisdictions who are competing for Ireland's highly sought after graduates. Importantly, pay impacts on a worker's quality of life. Nurses' salaries as compared to the cost of living (especially the cost of accommodation), across Ireland but especially Dublin, are very relevant to recruitment difficulties and the increased attraction of jurisdictions where pay is better able to meet essential living costs. The problem of uneven living costs is explicitly tackled in the United Kingdom through the High Cost Area Supplement.
79. The Chief Officer of CHO 6 told the Committee that exit interviews with nurses have revealed that the cost of accommodation in Dublin is one of the biggest factors contributing to loss of staff.
80. Staff are the backbone of the mental health service and if they are experiencing difficulty in meeting their basic needs, such as accommodation, we cannot expect our service to be fit for purpose.
81. Uncompetitive salaries as compared to other jurisdictions are also an issue for consultant psychiatrist positions. The IHCA emphasise that new entrant Consultant contracts are on salaries up to 48.5% less than provided for in the 2008 contract. This is a dramatic generational change in pay that discourages newly qualified consultants from embedding their careers in Ireland.
82. The Committee invited the Minister for Finance and Public Expenditure and Reform to appear before it numerous times to discuss the difficulties regarding terms and conditions including pay. Each time the Minister was unavailable.
83. As well as stretched services creating stressful working conditions and a perceived low level of remuneration, a lack of opportunities for meaningful professional development has been identified as a barrier to attracting and retaining clinical workers within Ireland's mental health system.

Professional development is essential to maintaining the suitability of our services and it is also important to the career meaningfulness and satisfaction of individual clinicians. While it may be difficult to release individuals for such training when the services are so stretched, failure to encourage professional development causes attrition in the long run:

“When they go abroad, Irish nurses get promoted very quickly and they get into specialist posts. There is a lack of specialist posts here. There is no 24-7 community crisis service which nurses would embrace. Their prospects are being stunted.” – Peter Hughes, Psychiatric Nurses Association, evidence to the Committee on 1 February 2018

Agency and private sector

84. Currently, as recruitment is difficult, some of the consequent gaps in service provision are being covered by the HSE paying private sector Agency staff. This is problematic as it costs the exchequer more than direct HSE employment would and creates a less reliable, structured system of employee-employer relations. The rate of pay to Agency rather than HSE workers is higher and, as well as this, the private sector companies which provide the service of placing Agency staff obviously receive a payment from the HSE. The total pay bill for mental health staff for 2017 was €614m of which Agency Staff accounted for €45m or 7.3%.
85. At its meeting of 30 November 2017, the Committee heard from the HSE that when a nurse moves from an agency arrangement to being directly and permanently employed by the HSE, the value to the HSE is 16%.
86. This is clearly a significant impact on the budget of the mental health services, and it is money that should be contributing to building a sustainable and permanent cohort of staff for the mental health services. The expenditure on agency staffing is an over-inflated cost which ideally should instead be used to improve remuneration for the permanent workforce.

87. Also, private sector healthcare opportunities can be more lucrative for potential recruits than a HSE contract. As the PNA highlight, "St. Patrick's Hospital, Dublin starts all graduates on the 2nd point of the scale" as well as offering a "€3,000 welcome package." These nurses are not subject to the pension levy. The PNA state that "Morell Health Care Service Ltd, Kildare, a private company that provides nurses to the HSE pays nurses €25.00 per hour, which is equivalent to €50,700 per annum."
88. This dynamic results in a situation where the State invests heavily in the education of nurses and doctors, yet there are two main loss points which obstruct the return on investment – emigration and loss to the domestic private sector. In the latter case the State continues to invest in those clinicians' work but at a higher rate, some of the surplus expenditure translating into private revenue.
89. The Committee is pleased that the HSE conducts recruitment campaigns. However these campaigns should be backed by substantial advantages to working for the HSE in Ireland. The Committee notes that the resulting fewer than 15 hires for mental health as a result of the Bring Them Home campaign illustrates that campaigns alone will not suffice. According to the PNA, UK relocation allowances exceed Bring Them Home packages. Campaigns must be backed by meaningful factors which make Ireland an alluring place to work and live for psychiatric nurses and other clinical professionals.
90. The PNA also claim that the HSE recruitment process can encounter significant delays, often taking as long as 6 months. Practical aspects of the process like this which could act as a deterrent need to be looked at with urgency, as Ireland's mental health services cannot afford to lose potential recruits through delay.
91. The need to face recruitment challenges head on with a willingness to deploy radical solutions is made even more acute by the demographics of clinicians in the field. 34.2% of psychiatric nurses are over 50, 25% of GPs are over 60 which has massive implications for the workforce as these professionals approach retirement.

92. As well as mental health clinicians such as psychiatric nurses and psychiatrists, a sufficient number of GPs and practice nurses are also needed to deliver primary care mental health services to optimise service provision at the lowest complexity level of care. FEMPI and the GMS contract are obstacles to recruitment in this area. General Practice will be essential to a properly functioning primary mental healthcare service, alongside the fulfilment of Multi Disciplinary Teams as outlined in A Vision for Change. In complement to this, the personnel deficiencies in areas like occupational therapy, social work and those providing talk therapy in each CHO should be analysed and made part of the recruitment strategy for the future of mental health care.

POTENTIAL SOLUTIONS

93. The shortage of clinical professionals obviously leads to calls for training in greater numbers. The Committee welcomes such calls for increases of student numbers, although on its own this is not a remedy for unsustainable levels of loss of graduates to emigration.
94. The University of Limerick's Department of Nursing and Midwifery has also pointed out in their submission that, due to the interdisciplinary nature of primary care, it is necessary to incorporate mental health education across all health disciplines. In particular, with increasing evidence that mental health is important from the earliest age, mental health competency should be focussed on in maternity and neonatal care, and in areas where the clinician will treat young children.
95. Jigsaw recommend that course places be increased not solely for psychiatric nurses, but in all relevant disciplines, including allied health professional roles. Importantly, expanded allied health professional courses should "include a greater emphasis on mental health, thereby facilitating a smoother/quicker transition for graduates into mental health service positions."
96. UCD School of Nursing, Midwifery and Health Systems also point to the success of their Higher Diploma program which facilitates general nurses

in attaining a mental health qualification. The expansion of this method of education for mental health services should be considered.

97. This also feeds into the issue of continuous professional development. UCC recommends an increased focus on defined career pathways for psychiatric nurses. UCD also calls for incentives and allowances to encourage the pursuit of professional development. Flexibility and time demands also need to be ensured so that formal professional development is a realistic option for nurses in all settings. In particular they recommend that “educational programmes should be developed specifically targeting mental health workers with options in research and practice innovation / implementation science / strategy so that capacity building in this area takes place with frontline staff.”
98. Dr. Tighe, of UL’s Department of Nursing and Midwifery, made a submission to the Committee in which she recommended that psychiatric nurses should be enabled to screen individuals and refer them to psychiatrists and psychologists where the need is identified. As part of a defined framework for career advancement this proposal should be considered, as psychiatric nurses clearly have much expertise to contribute to the mental health services, and that should be utilised.
99. The issue of pay for mental health clinicians is obviously relevant to tackling problems in recruitment and retention. The PNA advocates for the realignment of nurses salaries onto a higher scale:

“Having regard to the comparable minimum qualifications (Honours Degree) and the role and responsibilities the Therapy Grades Salary Scale should be applied in its entirety to Nursing.... The development of the Staff Nurse scale in this way would enhance recruitment and retention.”

ANP/CNS’s/Nurse Prescribers/Nurse led teams need to be rapidly increased.

100. Similarly, the ICGP have argued for a new contract with better remuneration as a solution for recruiting more GPs. The current GP contract for the Medical Card System is now almost 40 years old. There is

no provision in the contract for GPs to provide on-going care for long term conditions, including mental health conditions, many of which require and benefit from continuity of on-going care. Making progress in this regard will enable a new and continually evolving contract for general practice to be put in place. Despite marked increases in the National GP Training Programme, shortfalls in GP/Practice Nurse recruitment remain, significantly relating to uncertainty among young GPs and newly qualified nurses.

101. The Irish College of Psychiatrists state that a change in the Medical Practitioners Act 2007 has excluded doctors from countries - such as, for example, India - that previously supplied candidates for training posts, many of whom stayed to take up consultant posts. This could be addressed by a simple amendment to the legislation.
102. In addition, the recruitment process for consultants needs to be fit for purpose. For example, recruitment for a vacant post should start months before a consultant is due to retire instead of after he or she has retired.
103. The Minister for Health informed the Committee, at its meeting of 28 February 2018, that Government has commissioned a "phase two" of the Public Service Pay Commission to look "specifically at health recruitment and retention" which is due to report in June. The Committee looks forward to that report and hopes that it will help to address shortfall in remuneration in the sector which is contributing to recruitment difficulties.
104. Since accommodation is the greatest cost in most people's lives, and the difficulty in sourcing accommodation in many locations around Ireland is an encouraging factor toward emigration, the Committee also thinks that the UCD School of Nursing's proposal that "practical measures up to and including the temporary provision of accommodation or a public service weighting / allowance may be considered" is very sensible. If public service pay cannot adequately meet accommodation costs, the State may need to take a more active role in the securing of housing for in-demand public servants if it wishes to keep them in the country.

105. The PNA also argued for the provision of accommodation for hospital staff as an alleviating factor to the difficulties nurses face in meeting costs of living with current levels of remuneration.

"In the United Kingdom, the NHS is building 20,000 units for staff as we speak.... We could add some staff accommodation to major construction projects. These units could be provided to staff for a specific period at a subsidised rate, particularly in the large cities."

106. Other recruitment-based solutions which have been proposed, either to increase the numbers who wish to work in the mental health service, or to fix problems manifesting in the services include:

- Encouraging the greater use of flexible working patterns to facilitate people who may not be able to work full time due to life circumstances.
- Begin assigning psychiatric nurses to Accident and Emergency units to better manage mental health patients who present there. As discussed in the Primary Care section of this report, lack of out-of-hours services mean that Accident and Emergency, an inappropriate setting, is managing mental health cases to everyone's detriment. This inappropriate treatment could be mitigated against by making appropriate personnel available in the setting.
- As Jigsaw points out to the Committee, more work can be done in promoting the positive aspects of working in mental health as a field where staff can genuinely make a huge positive difference to people's lives. It is meaningful work and this should be emphasised – in general nursing and medicine courses, in allied health professional courses, and in schools when young people are considering their career options.
- In view of increasing levels of homelessness in Ireland, more dedicated Community Mental Health Nurse posts for homeless people should be sanctioned and recruited for.

FUNDING

107. Early in its work, the Committee identified funding as an important stream to analyse, to identify how funding is being spent and whether it needs to be increased. The Committee believes that in order to gain a clear picture of expenditure, possible deficiencies and areas of improvement, it is necessary to identify expenditure by sub-speciality within Mental Health Services. Knowing how much is being spent on children's services in a given area, or on specialist services for eating disorders, is essential to be able to assess the delivery of those services in that area. However, the Committee was dismayed to learn, at its first meeting with representatives of the HSE, that they were not capable of sub-dividing Mental Health budgets in this way.
108. This was represented as an IT systems shortfall. The Chief Financial Officer of the HSE told the Committee: "The specific answer is we do not have the systems to do that. It is not that we do not want to do it."
109. The HSE insist that they are able to account for every euro spent, and provided full sets of accounts to the Committee to prove this. This being the case, the Committee believes that it should be possible for the HSE to account for its expenditure by sub-speciality, by manually tallying the amounts spent by all specialities, although this would not be as quick and efficient as an IT system with this in-built capability.
110. The Committee subsequently engaged with a lower tier of management within the HSE, the Chief Officers of all nine Community Healthcare Organisations around the country, and sought the information from them. They were able to provide this expenditure information for 2017 to varying levels of detail, and one indicated to the Committee that the full exercise would require six months and dedicated staff to complete. The Committee recommends that the Minister for Health require that this task be carried out by all CHOs for 2017 and for all subsequent years, until an IT system is implemented that can do it more efficiently. The Committee feels that this project merits the dedication of resources to it, because knowing the manner in which money is being spent is essential to understanding our mental health services.

111. What follows is the expenditure reporting by sub-speciality provided to the Committee by each of the nine CHOs. CHO 5 (encompassing Carlow, Kilkenny, Wexford and Waterford) provided the greatest level of detail. The Committee wishes to thank all of the CHOs for their work in getting the information they were able to the Committee in time for this report.

SUB-SPECIALITY EXPENDITURE IN EACH CHO

CHO 1 – encompassing Donegal, Sligo, Leitrim, Cavan and Monaghan.

	Expenditure			Agency breakdown		
	2015	2016	2017	2015	2016	2017
	€	€	€	€	€	€
CAMHS	Actual	Actual	Actual	Actual	Actual	Actual
Total Sligo / Leitrim	1,553,386	1,531,700	1,347,122	0	245,461	397,046
Total Donegal	1,670,043	1,626,148	2,304,319	0	1,888	305,721
Total Cavan/Monaghan	1,532,891	1,528,324	1,974,125	73,430	94,940	164,983
Total Regional	0	0	0			
Total CAMHS	4,756,320	4,686,171	5,625,566	73,430	342,289	867,750

	2015	2016	2017	2015	2016	2017
	€	€	€	€	€	€
Psychiatry of Later Life	Actual	Actual	Actual	Actual	Actual	Actual
Total Sligo / Leitrim	1,149,252	1,250,099	1,506,477	0	670	-670
Total Donegal	991,692	866,427	912,557	0	35,347	0
Total Cavan/Monaghan	1,664,727	1,815,608	1,908,583	21,041	5,862	3,833
Total Regional						
Total Psychiatry of Later Life	3,805,670	3,932,134	4,327,617	21,041	41,879	3,163

2015	2016	2017	2015	2016	2017
€	€	€	€	€	€

General Adult	Actual	Actual	Actual	Actual	Actual	Actual
Total Sligo	20,875,170	21,028,051	22,116,441	90,163	330,212	510,421
Total Donegal	21,261,913	21,154,168	22,281,399	417,745	380,126	729,693
Total Cavan/Monaghan	17,824,021	17,653,524	19,190,692	976,208	593,735	692,480
Total Regional	0	0	67,068			
Total	59,961,105	59,835,743	63,655,600	1,484,115	1,304,073	1,932,595

	2015	2016	2017	2015	2016	2017
	€	€	€	€	€	€
Total	Actual	Actual	Actual	Actual	Actual	Actual
Total Sligo / Leitrim	23,577,808	23,809,850	24,970,040	90,163	576,343	906,798
Total Donegal	23,923,648	23,646,743	25,498,276	417,745	417,362	1,035,415
Total Cavan / Monaghan	21,021,639	20,997,456	23,073,400	1,070,679	694,537	861,296
Total Regional	0	0	67,068	0	0	0
Total CHO1 MHS	68,523,095	68,454,049	73,608,784	1,578,587	1,688,241	2,803,508

CHO 2 – encompassing Galway, Mayo and Roscommon.

CHO 2 - Mental Health Expenditure	2015	2016	2017
	€m	€m	€m
CHO 2			
Galway	42.74	44.22	47.86
Mayo	27.37	29.94	30.45
Roscommon	12.58	14.12	14.25
Total Mental Health services (Exc CAMHS)	82.69	88.28	92.56
Child & Adolescent Mental Health Service **	10.80	10.69	11.35

Total Expenditure	93.49	98.97	103.90
% Increase		5.9%	5.0%

CHO 3 – encompassing Clare, Limerick and North Tipperary.

	2015				2016				2017			
	Pay	Non Pay	Income	Total	Pay	Non Pay	Income	Total	Pay	Non Pay	Income	Total
General Adult	39.479	10.085	-0.570	48.994	41.530	9.522	-0.534	50.518	43.022	10.094	-0.562	52.554
CAMHs (incl S38's)	3.916	0.596	-0.001	4.511	4.330	0.434	0.000	4.764	4.753	0.657	-0.003	5.408
Old Age Psychiatry	4.204	0.477	-0.071	4.611	4.381	0.707	-0.085	5.004	4.332	0.445	-0.060	4.718
MHID (Incl S38's)	2.001	0.352	0.000	2.354	2.030	0.080	0.000	2.110	2.246	0.213	0.000	2.459
Total	49.600	11.511	-0.641	60.470	52.271	10.744	-0.619	62.396	54.354	11.410	-0.625	65.139

CHO 4 – encompassing Cork and Kerry.

Cork and Kerry Mental Health Services			
	2015 spend	2016 spend	2017 spend
Adult Services	95,079,500	96,043,667	102,662,616
CAMHS Services	10,009,188	12,501,325	12,710,719
Later Life Psychiatry	Costs included under Adult Services		
Overall Total Cork and Kerry	105,088,689	108,544,992	115,373,335

CHO 5 – encompassing Carlow, Kilkenny, Wexford and Waterford.

Service	2015 Spend	2016 Spend	2017 Spend
Addiction Services	219,546	221,895	230,821
Advancing Recovery in Ireland	81,164	82,032	85,332
Child & Adolescent Services (CAMHs)	7,279,029	7,356,911	7,652,855
Counselling in Primary Care	763,080	793,677	802,269
Clinical Placement Co-ordinator	77,979	78,813	81,983
General Adult Services	45,454,198	45,940,537	47,788,568
Infection Control	107,363	108,512	112,877
Liaison	1,112,374	1,124,276	1,169,502
Mental Health Intellectual Disability	5,247,930	5,304,081	5,517,446
National Counselling Service	751,852	736,316	790,465
Peer Support	98,808	99,865	103,882
Rehab & Recovery	17,547,598	17,735,350	18,448,782
Suicide Prevention	453,740	458,595	477,042
Psychiatry of Later Life	12,545,287	12,679,516	13,189,569
Grand Total	91,739,947	92,720,376	96,451,393

CHO 6 – encompassing Wicklow, Dun Laoghaire and Dublin South East.

Table 1b - CH East (formerly CHO6) - Financial summary by CAMHS/Adult Services

Heading	CHO6 Statutory			SJOG			TOTAL CHO6			Total Act % Split	Total Bud % Split
	2015 Act (€k)	2015 Bud (€k)	2015 Var (€k)	2015 Act (€k)	2015 Bud (€k)	2015 Var (€k)	2015 Act (€k)	2015 Bud (€k)	2015 Var (€k)		
CAMHS	0	0	0	9,149	9,718	(568)	9,149	9,718	(568)	17.4%	18.6%
Adult	29,382	29,701	(318)	14,019	12,899	1,120	43,401	42,600	801	82.6%	81.4%
Grand Total	29,382	29,701	(318)	23,168	22,617	551	52,551	52,317	233	100.0%	100.0%
Heading	2016 Act (€k)	2016 Bud (€k)	2016 Var (€k)	2016 Act (€k)	2016 Bud (€k)	2016 Var (€k)	2016 Act (€k)	2016 Bud (€k)	2016 Var (€k)	Total Act % Split	Total Bud % Split
CAMHS	0	0	0	9,181	10,043	(862)	9,181	10,043	(862)	16.6%	18.8%
Adult	31,391	30,239	1,152	14,752	13,172	1,581	46,143	43,410	2,733	83.4%	81.2%
Grand Total	31,391	30,239	1,152	23,933	23,215	719	55,324	53,453	1,871	100.0%	100.0%
Heading	2017 Act (€k)	2017 Bud (€k)	2017 Var (€k)	2017 Act (€k)	2017 Bud (€k)	2017 Var (€k)	2017 Act (€k)	2017 Bud (€k)	2017 Var (€k)	Total Act % Split	Total Bud % Split
CAMHS	0	0	0	9,343	9,849	(506)	9,343	9,849	(506)	16.1%	17.3%
Adult	32,399	33,520	(1,122)	16,221	13,497	2,724	48,620	47,018	1,602	83.9%	82.7%
Grand Total	32,399	33,520	(1,122)	25,564	23,346	2,218	57,963	56,867	1,096	100.0%	100.0%

CHO 7 – encompassing Kildare, West Wicklow, Dublin West, Dublin South City and Dublin South West.

	2015	2016	2017	
General Adult	64,619,774	68,303,375	71,165,808	81%
Child & Adolescent	11,473,813	12,637,354	12,060,121	14%
Later Life	2,798,332	3,255,755	4,113,833	5%
Central			170,408	0%
Grand Total	78,891,918	84,196,484	87,510,171	100%

CHO 8 – encompassing Louth, Meath, Westmeath, Longford, Offaly and Laois.

Midlands Louth Meath CHO	2015	2016	2017
Mental Health Expenditure	€	€	€
General Adult	70,132,281	73,962,914	79,069,291
CAMHS	9,177,795	11,314,275	11,158,347
Psychiatry of Later Life	3,358,112	3,580,304	3,852,978
Total Mental Health	82,668,188	88,857,493	94,080,615

CHO 9 – encompassing Dublin North, Dublin North Central and Dublin North West.

CHO DNCC Mental Health	2015	2016	2017
	000	000	000
CAMHS	6,801	7,772	9,967
General Adult*	76,664	76,818	80,276
POA**	8,806	8,203	9,203
Grand Total	92,271	92,793	99,446
Budget	92,429	92,622	100,163
% Increase	3.3%	0.2%	8.1%
Variance	-158	171	-717
CHO DNCC Mental Health Intellectual Disability	(Funded via Social Care)		
MHID	29,513	29,071	29,896
MHID Budget	29,021	29,104	29,836
MHID Variance	492	-33	60
St Vincent's Hospital Fairview (Data extracted from IMR's submitted by SVHF)			
Pay	12,417	12,800	12,826
Non Pay	3,297	3,565	3,428
Gross Expenditure	15,714	16,365	16,254
Income	- 2,225	-2,128	-2,021
Net Expenditure	13,489	14,237	14,233
Budget	13,432	14,290	14,295
Variance	57	-53	-62
Footnote <i>* Include in General Adult are the following costs: Shared Campus Costs, Adult Homeless Service, External Placement Costs, Training / Education Costs, Medication / Pharmacy Costs.</i> <i>**Spend in POA reduced by €602,000 between 2015 and 2016. The main contributing factors were as follows: Non-Pay - reduced by €356,000 mainly due to a reduction in the POA External Placement costs between 2015 and 2016. Pay - reduced by €247,000 mainly due to a reduction in permanent Nursing staff costs and a reduction in Medical Agency.</i>			

OTHER FUNDING MATTERS

112. The HSE's 2018 Operational Plan states that the budget for Mental Health Services is €917.8 million. This is 6.3% of the total operational Health budget of €14.6 billion. This is well below the 8.24% recommended in A Vision for Change in 2006 and the 10% minimum recommended in Sláintecare in 2017.
113. As the Psychiatric Nurses Association pointed out in their submission to the Committee, the percentage was previously higher. Successive mental health policy documents have advocated a move away from psychiatric hospitalisation and the development of community services as an alternative. However, while it seems that many in-patient beds were removed, the alternative treatment arrangements have not been adequately developed, as the Primary Care section of this report outlines. The following tables, provided by the PNA, illustrate starkly the under-investment in Mental Health which took place in tandem with the destruction of the old asylum system.

	1984	2004	2016
Mental Health Service in Patient Beds	12,484	4,173	1,002

Mental Health Budget as a % of Health Budget.

1984	2004	2015
14%	7.34%	6%

The incidence of mental ill health appears to have increased substantially along with our population and the budget clearly does not reflect this. An assessment

needs to be carried out on the adequacy, effectiveness and value for money on all spending in mental health services.

114. The Committee wishes to make clear that it is in no way opposed to the de-institutionalisation policy which has been pursued in recent decades. However, the funding which had gone to the closed institutions should have been diverted to new community based services for mental health. As the percentage of funding for mental health within the overall health budget has dropped by over half, it seems that that funding has instead been diverted into other areas of the health system. This does not indicate a parity of esteem for mental health with physical health, and leads to questions about whether mental health is neglected in terms of investment.
115. The Committee also notes that, by international comparison, Ireland's proportionate expenditure on Mental Health is low, with Mental Health Reform in their submission citing funding levels of 13% in Britain and Canada and 11% in New Zealand.
116. Mental Health Reform state in their submission that increased funding is needed year-on-year just to maintain current services. Therefore, if funding continues to remain at 6% of the overall health budget, it is difficult to see how the development of badly needed services, such as 24/7 crisis coverage and greater levels of CAMHS assessment can be achieved, or how A Vision for Change could ever be implemented.
117. Mental Health Reform also point to another consequence of this underinvestment in mental health – the corresponding cost to society of mental health problems. In their submission, they cited the Healthy Ireland Framework report which estimated that the economic cost of mental health problems in Ireland is €11 billion per year, much of which is related to loss of productivity.
118. The Committee is also concerned that the mental health budget is distributed unevenly geographically, with the amount received per CHO not necessarily seeming to correspond to the populations of those areas.

119. As the IHCA wrote in their submission: "Significant disparities in the allocation of funding and resources persists, with CHOs of similar population size allocated different budget allocations and staffing. For example, CHO 7, with a population 674,071, was allocated an operating budget of €80,120 m in 2017 and has a WTE complement of 827.7. With a similar population of 664,543, CHO 4 was allocated €110,751m last year and employs 1,407 WTEs – a 70% difference in staffing."
120. Similarly, the Irish Medical organisation pointed out that: "Donegal Mental Health Services which cover a rural population of 160,927 with high levels of depression and high proportions of elderly people receives a budget allocation of €136m per capita and has one approved centre and three adult community mental health teams compared to Mayo Mental Health Services which has a rural population of 130,425 but receives a budget allocation of €200m per capita and has four approved centres and five adult community mental health teams."
121. As well, in looking at the breakdowns supplied by CHOs and displayed in the previous section, the Committee sees disparities between expenditure in different service areas, with different levels of spending on Child and Adolescent services across different areas. The College of Psychiatrists recommended in their submission that, given the unacceptable waiting lists affecting CAMHS services, 25% of funding should be dedicated to developing this service. The reality does not approach this figure, and there is a large geographical disparity of investment across the CHOs. As of 2017, the lowest percentage of total mental health budget investment in CAMHS was 7.6% in CHO 5, rising to 22.5% in CHO 6. However, the average across all CHOs was only 11.2%.
122. Representatives from the HSE, when asked by Committee members about such funding disparities, explained the problem by the "legacy" nature of the budgeting system. The funding in place in geographical areas and service areas is often determined by the services which are pre-existing and not necessarily based on greatest need. Funding patterns also seem to go back to the era of psychiatric institutions even though these are not as relevant to service provision anymore. As Anne O'Connor told the

Committee – “Kildare is the most poorly resourced part of the country, and it has suffered as a result of not having a psychiatric institution. There is no great legacy value in that area in terms of resources.”

123. The Committee is sympathetic to a reluctance to cut pre-existing services and does not necessarily advocate removing services that are working in order to ostensibly achieve a more equal distribution of resources in a blunt manner. However, the use of development funding or funding for new services, is where financial decision makers do have the flexibility to redress the balance. The Committee therefore feels that development funding should be targeted to ensure a fairer geographic balance of services as they develop over the coming years. It should also be assessed whether sufficient development funding to expand services is being allocated to mental health – The IHCA in their submission point to 21.7% of 2018 development funding going to the Primary Care Reimbursement Service, with just 7.6% being allocated to mental health services.
124. Lastly, the Committee wishes to make a point around clinicians’ levels of pay and funding. The Committee was told by the HSE that “funding is not the issue” in terms of recruitment, meaning that the funding is in place and can be availed of if the required recruits can be attracted. However, in a very real sense, the Committee believes that funding is an issue, in that if the pay offered was higher, more recruits could be attracted. According to the HSE, roughly 80% of the HSE’s costs are pay, so pay increases will obviously have ramifications for the health service’s budget. In this regard, the Committee awaits the report of the Public Service Pay Commission on recruitment and retention in the health sector, as referenced in the Recruitment section of this report. The Committee also urges Government to consider subsidised accommodation for health workers, as advocated for by the PNA, as an alternative model for using funding to improve recruitment and retention.

MENTAL HEALTH SERVICES AND PEOPLE FROM MINORITY GROUPS

125. It is important to give special consideration to people from minority groups which can be affected by unique issues. Firstly, people in minority groups can be at higher risk of experiencing mental health problems due to discrimination they have experienced or because of other social determinants. Exacerbating this, service design, which often may be done with the needs of the majority population in mind, is often not suitable for their needs.

TRAVELLERS AND ROMA

126. With the above in mind, the Committee feels that it is extremely important that a greater emphasis should be placed on Traveller mental health by service providers. Representatives from Pavee Point appeared before the Committee on 14 February 2018 and outlined some specific issues which affect the Traveller community. Pavee Point's presentation and submission to the Committee cited disturbing statistics contained in the findings of the All Ireland Traveller Health Study which quantify the scale of the health and mental health problem which the Travelling community faces. Pavee Point quote the findings of the All Ireland Traveller Health Study in the following figures:

“Travellers experience a 6 times higher suicide rate, accounting for approximately 11% of all Traveller deaths; when disaggregated by gender and age, this rate was:

7 times higher for men and most common in young Traveller men aged 15-25; and

5 times higher for Traveller women.

It is important to note that these figures are reflective of confirmed suicide cases by the General Register Office and do not take into

account external causes of death such as alcohol or drug overdose, which accounted for almost 50% of all Traveller male external causes of death.

Traveller men are living 15 years less than settled men and Traveller women are living 11 years less than settled women. The mortality rates among Traveller men is four times higher. The rate of mortality of Traveller women is three times higher than that of women in the settled community, and that of infants, or children under one year of age, is four times higher. The evidence indicates that Travellers are dying at much higher rates at all ages and across genders, with 97% of Travellers not living to their 65th birthday.

60% of Travellers reported their mental health in the preceding 30 days as not good, compared with 20% of the settled population.

53% of Travellers "worried about experiencing unfair treatment" from health providers.

66.7% of service providers who agreed that discrimination against Travellers occurs sometimes in their use of health services."

127. It is clear from the above figures that there is a mental health crisis in the Travelling community, and that the design and delivery of mental health services are failing Travellers, much more so than any other segment of the population. Worry about unfair treatment is a deterrent to Travellers accessing mainstream service. The Traveller Counselling Service also refers to a "lack of cultural inclusivity in mental health services." Services which are specifically designed for Travellers' needs and which, crucially, are led and staffed by Travellers, are needed to improve this situation.
128. The fact that so many Travellers worry about receiving unfair treatment from health providers, and that this is backed up by surveyed health providers, the majority of whom agree that that concern is justified, is obviously a deterrent for Travellers to seek treatment and presumably has an impact on Travellers' poor health outcomes. Patrick Kavanagh of Pavee Point told the Committee that if Travellers had access to the same services as the settled population, health outcomes would be better. As well as the

justified fear of discrimination, mainstream service design is not always inclusive of Travellers. As Patrick Kavangh told the Committee;

“When it comes to accessing services, what I hear is that they are not meeting Travellers where they are at. Travellers have low levels of educational attainment; things like filling in forms and reading and writing can be enough to make them walk away. We must be respectful and mindful that what might work for one community might not work for another. As the primary health care and mental health care workers throughout Ireland, these are the things we are trying to do to work with the services to help them to identify this.”

129. Pavee Point told the Committee that Traveller health has not received any new moneys since 2008. They highlight that cutbacks to Traveller services during the recession have not been rectified and many services, such as a Youth Programme and educational services which mitigate against social determinants of poor mental health, have been cut back. This makes it very difficult to provide services and to implement strategies aimed at improving Traveller health. 83% of Travellers receive their health information from Traveller primary health care projects (peer-led, culturally appropriate projects) and it is important that these are kept operating and expanded with adequate funding. There is a need to explore the possibility of introducing programmes to encourage Travellers to participate in specific mental health education/training with a view to increasing the number of Travellers who access mental health services.
130. Pavee Point also call for the introduction of an ethnic identifier for Travellers so health outcomes can be tracked and data can be compiled to assess on-going health trends. This was recommended in the national Traveller health Strategy 2002 – 2005 and yet progress on implementing it does not seem to have been made. Ideally, this identifier should be developed in tandem with a Health Identifier across the population (as outlined in the Performance Indicators section of this report) but work on a Traveller Ethnic Identifier for data collection should begin imminently, outside of an all-population version, if the latter is likely to be delayed.

131. Pavee Point also called attention in their submission to the fact that over half of Roma respondents to a needs assessment survey reported frequent mental distress, with discrimination, unemployment and lack of social protection identified as sources of stress. A high rate of respondents reported lack of access to a GP due to lack of ability to pay or a medical card. This indicates that many Roma people do not have access to basic health, including mental health services.

LGBT PEOPLE

132. Representatives from BeLonGTo gave evidence to the Committee on 14 February 2018. They told the Committee that regular surveying of the young people who use their services shows that mental health issues repeatedly appear as the number one issue which respondents have needs around. They highlighted that the 2017 LGBTI Ireland report found that:

LGBTI young people have three times the level of self-harm, experienced three times the level of attempted suicide and are four times more likely to experience severe or extremely severe stress, anxiety and depression.

Among LGBTI young people aged between 14 and 18, 56% have self-harmed and 70% have had suicidal thoughts.

A strong link was found between a young person having experienced LGBTI-based bullying and serious mental health difficulties.

133. The problems which affect mental health services, such as gaps in service provision and long waiting lists, affect LGBT people as they do everyone. However, additional barriers to access manifest when mental health workers are not aware of particular issues faced by LGBTI people. This is especially acute in the barrier to transgender people accessing health

care. A diagnosis of gender dysphoria is necessary for trans people to access health care and legal recognition. Young people who need this diagnosis are referred to CAMHS because of a lack of specific services which could meet this need. CAMHS is meant to be a service for young people with acute mental distress. Many transgender young people who must go through the CAMHS system for a gender dysphoria diagnosis are not distressed; therefore this arrangement is putting additional stress on an over-stretched service. As well, this can have a significant negative impact on young people's lives who may be confronted with long waiting lists at a crucial time when they need access to health care such as hormone blockers. A specialist unit which could provide this service, as well as other mental health services for transgender people if required, would solve this problem.

134. BeLonGTo also highlighted to the Committee their view that the requirement for 16 and 17 year olds to have parental consent in order to access mental health care is problematic. This removes autonomy for all people of this age, but for LGBTI young people who have not come out to their parents it can act as a significant barrier to accessing needed care.

MIGRANTS

135. Migrant Rights Centre Ireland also gave evidence to the Committee which set out some of the specific challenges faced by migrants in Ireland regarding mental health issues and accessing services to deal with them. They cited the 2015 Cairde report which showed a correlation to migrants reporting negative mental health and a lack of supports and services they can access.
136. Migrants often experience racism and discrimination when they try to access services. Lack of appropriate linguistic and cultural awareness in services can create barriers and amplify stigma. On top of this, people with precarious legal status can find it very difficult to access services which are actually open to them. To access services from the HSE a

person needs to be ordinarily resident in the State and this is determined by the HSE by the type of legal status that a person has in the country. At service providers' discretion services may be still be provided (at the risk of incurring extra costs) however even in this case, the inability to disclose legal status to clinicians becomes an unspoken burden which negatively affects outcomes. As Rashmi, a young undocumented person, told the Committee:

"If someone finds the resources to be able to sit down in front of a mental health care practitioner, he or she cannot mention his or her legal status because of a fear about the consequences. This undermines the healing process and the positive impact counselling and therapy could have. Growing up undocumented means that it is impossible to plan for the future and live the life we want. From the youngest age, the future is deeply uncertain. Progressing to third level education is unlikely because of the fees and paperwork barriers involved. Employment options are very limited and someone must settle for the work he or she can manage to find. That is a far cry from young people's aspirations and capabilities. This has a hugely negative effect on a person's well-being, sense of self-worth, self-esteem and confidence. It is also a huge loss in human potential."

137. The Committee was also dismayed to hear from Migrant Rights Centre Ireland that victims of trafficking in Ireland are referred to a health programme that is limited to physical health, despite the specific traumas such victims undergo which impact their mental health. It is the Committee's view that specific mental health supports should be integrated into this health programme.

PERFORMANCE INDICATORS

138. Analysis of the performance reporting done by the Mental Health Services is an important aspect of the Committee's work, as effective performance reporting should guide the development of services. Carefully designed performance indicators should capture the essential metrics by which our services should be judged, and should therefore be able to guide decision makers as to where improvements in the services are most needed. They should have an "evidential impact on quality," (IHCA) their thoroughness meaning that the facts illustrated by them can be easily applied to decisions around financing, accountability arrangements and regulation (World Health Organisation quoted by the IHCA).
139. The HSE's Mental Health KPI Metadata, which is publicly available, lists the Key Performance Indicators which are used to measure performance in the sector. All stakeholders who included analysis of performance measurement in their submissions to the Committee agreed that the metrics currently in use could be improved. Mental Health Reform state that "international evidence shows more widespread and detailed usage of performance indicators in mental health services than is currently the case in Ireland." For the PNA, the current suite of KPIs do not capture "the most vital aspects of patient and family experience."
140. The Key Performance Indicators which are used by the HSE provide information across the CHOs and across different areas of service (General Adult, CAMHS, Psychiatry of Old Age) about how many people are waiting for their first appointment over a certain length of time. This is important data to have and the Committee welcomes this reporting but, as several stakeholders have pointed out to the Committee, these do not measure health outcomes of service users. The UCD School of Nursing, Midwifery and Health Systems recommend a "re-focus from volume and supply driven healthcare to patient centred clinical and personal outcomes."
141. There are a number of deficiencies within the current set of performance indicators which neglect a focus on outcomes. As the Health Research Board state, admissions figures represent events rather than people. This means that each admission is recorded separately and activity in units is

the focus of measurement rather than the prevalence of mental illness or the effectiveness of treatment. The IHCA argue that an indicator which comprised a ratio of first admissions to re-admissions would be a meaningful measurement. A reduced rate of readmission would go some way towards indicating the effectiveness of treatment.

142. It is also problematic that, according to the Health Research Board, data collection is currently limited to in-patient units. Given the enduring policy aspiration of making primary and community care central to mental health care, data needs to be collected around service provision in this sector in order to assess its performance.
143. The KPIs currently in use focus heavily on the first appointment and the waiting time for it. This focus does not capture data on the interventions which were used or the demand for interventions. Expansion of indicators to include an intervention based focus might help to illuminate the clinical picture as opposed to an administrative viewpoint of the "appointment." The point has also been made to the Committee that the "recovery model of care" has been held up as being the underpinning driver of health services, but it is hard to track the meaningfulness of this in service delivery without a focus on recovery rates in performance reporting. Another issue is that the views of service users are not reflected in any on-going performance indicator. Service user surveying should be incorporated into the performance measurement suite and service users should be invited to participate and be central to all performance analysis and planning
144. Also, the current suite of performance measures do not measure quality of care, and in a truly reflective suite of measures this concept should be included against performance data. The PNA say that "the quality indicator profile should include person centredness, safety, equity and effectiveness." As the Seanad Public Consultation Committee on Children's Mental Health Services heard, there is no data on aftercare for children who are placed in Adult Psychiatric Units, so the effects (short-term and long-term) of this aspect of service delivery (which in and of itself is reflected in performance reporting) is unknown.

145. Moving to a health outcome based model of performance reporting, and the collection of data on outcomes, may in the long-term grant the ability to move to an outcome based model of funding, which has been advocated for by some stakeholders. In this scenario, the inputs to the services (funding) and the outputs (performance indicators) would both be focussed on patient clinical outcomes, which could help to re-orient the service towards that. This may help to reduce inefficient activity as opposed to a model where activity solely seems to be the main driver of inputs and outputs.
146. A number of stakeholders have stated that for KPIs to reflect important elements which are currently being missed, a Unique Health Identifier or Electronic Health Record is required. This is especially true of the overall health outcome of service users which obviously takes time and follow-up to ascertain. A Unique Identifier would enable analysis of readmission rates and of outcomes over the course of people's lives. Such performance measurements get much closer to the nub of the effectiveness of mental health services as opposed to measuring activity. According to the Health Research Board, it would also facilitate much faster processing and dissemination of data. Such a system was recommended in A Vision For Change. Jigsaw recommends the use of performance monitoring pre and post intervention based on patient outcome, but also using longitudinal studies, which require tracking individuals' health over long periods of time. Better data collection of individuals' experience should also enable the use of disaggregated data on variables such as gender, socio-economic status, etc., which would allow service design to see which groups are accessing services, which groups may be experiencing barriers, and to make sure staff are appropriately trained for the cohorts they are encountering.

APPENDIX 1 TERMS OF REFERENCE OF THE COMMITTEE

That, notwithstanding anything in Standing Orders—

(a) Dáil Éireann noting—

- (i) the pressures on mental health services, the waiting times for services, and the need to improve services in certain parts of the country,
- (ii) the consensus that the 2006 policy 'A Vision for Change' charts the best way forward for mental health services, and
- (iii) the fact that, eleven years after its publication, 'A Vision for Change' is not yet fully implemented,

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

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

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

- (i) the current integration of delivery of mental health services in Ireland;
- (ii) the availability, accessibility and alignment of services and supports (including the work of the National Task Force on Youth Mental Health and the Youth Mental Health Pathfinder Project);
- (iii) the need to further develop prevention and early intervention services;
- (iv) the significant challenges in the recruitment and retention of skilled personnel; and
- (v) the efficacy of establishing a permanent Mental Health Oireachtas Committee;

- (d) the Joint Committee shall, having carried out the examination at paragraph (c), and taking account of the Department of Health review of 'A Vision for Change', make recommendations on how best to align Ireland's mental health services and supports to increase availability and accessibility, recruit and retain personnel and complete the implementation of 'A Vision for Change' in order to provide a more integrated mental health service of the highest quality;
- (e) the number of members of the Committee shall not exceed 15, and the members shall be appointed as follows:
 - (i) four members appointed by the Government,
 - (ii) four members appointed by Fianna Fáil,
 - (iii) two members appointed by Sinn Féin, and
 - (iv) one member each appointed by the Labour Party, Solidarity-People Before Profit (Sol-PBP), Independents 4 Change, the Rural Independent Group and the Social Democrats-Green Party Group;
- (f) the Ceann Comhairle shall announce the names of the members appointed under paragraph (e) for the information of the Dáil on the first sitting day following their appointment;
- (g) the quorum of the Joint Committee shall be eight, at least one of whom shall be a member of the Dáil, and one a member of the Seanad;
- (h) the Joint Committee shall elect one of its members to be Chairman;
- (i) the Joint Committee shall have the powers defined in Standing Order 85(1), (2), (3), (4), (5), (7), (8) and (9);
- (j) the Joint Committee shall produce an interim report, which shall contain its proposed work schedule, within two months of its first meeting in public; and
- (k) the Joint Committee shall make its final report to both Houses of the Oireachtas by 31st October, 2018, and shall thereupon stand dissolved."

APPENDIX 2 MEMBERSHIP LIST

Joint Committee on the Future of Mental Health Care

Deputies:

John Brassil (FF)
James Browne (FF) [Vice-Chair]
Pat Buckley (SF)
Joe Carey (FG)
Marcella Corcoran Kennedy (FG)
Seán Crowe (SF)
Dr. Michael Harty (RIG)
Alan Kelly (LAB)
Gino Kenny (S/PBP)
Catherine Martin (SD/GPG)
Tony McLoughlin (FG)
Tom Neville (FG)
Fiona O'Loughlin (FF)
Thomas Pringle (IC4)
Anne Rabbitte (FF)

Senators:

Máire Devine
Frank Feighan (FG)
Joan Freeman (IND) [Chair]
Colette Kelleher (IND)

Gabrielle McFadden (FG)

Jennifer Murnane O'Connor (FF)

Notes:

1. Committee established by order of the Dáil of 13 July 2017
2. Seanad members announced 20 July 2017
3. Deputy Joan Collins replaced Deputy Mick Wallace on the 28 September 2017
4. Deputy Mick Barry discharged and Deputy Gino Kenny appointed to serve in his stead by the Fifteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann 12 December 2017.
5. Deputy Joan Collins discharged and Deputy Thomas Pringle appointed to serve in her stead by the Sixteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann 13 February 2018
6. Deputy Mary Lou McDonald discharged and Deputy Seán Crowe appointed to serve in her stead by the Eighteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann 6 March 2018

APPENDIX 3 PUBLIC LIST OF WITNESSES

Date	Witnesses	Debate
19 October 2017	Mr. Hugh Kane, Chair, Oversight Group on 'A Vision for Change'	Transcript
22 November 2017	- Ms. Anne O'Connor, National Director of Mental Health, HSE - Mr. Stephen Mulvany, Chief Financial Officer and Deputy Director General, HSE - Mr. Jim Ryan, Head of Operations and Service Improvement, Mental Health Division, HSE - Ms. Yvonne O'Neill, Head of Planning, Performance and Programme Management, Mental Health Division, HSE	Transcript
30 November 2017	- Ms. Anne O'Connor, National Director of Mental Health, HSE - Mr. Jim Ryan, Head of Operations and Service Improvement, Mental Health Division, HSE - Ms. Yvonne O'Neill, Head of Planning, Performance and Programme Management, Mental Health Division, HSE - Mr. Philip Dodd, National Clinical Advisor and Group Lead, Mental Health Clinical Programmes, Mental Health Division, HSE - Mr. Liam Hennessy, Head of Mental Health Engagement, HSE	Transcript
14 December 2017	- Prof. Joyce O'Connor, Former Chairperson of the Expert Group on Mental Health Policy - Dr John O'Brien, ICGP Vice President and Incoming ICGP President - Dr Brian Osborne, Assistant Director, Mental Health Programme, Irish College of General Practitioners (IGCP)	Transcript

	• Dr Brendan O'Shea, Director, Postgraduate Resource Centre, Irish College of General Practitioners (IGCP)	
18 January 2018	• Mr. John Hayes, Chief Officer, Community Healthcare Organisation Area 1 • Mr. Pdraig O'Beirne, Area Director of Nursing for Cavan/Monaghan, Community Healthcare Organisation Area 1 • Mr. Tony Canavan, Chief Officer, Community Healthcare Organisation Area 2 • Mr. Liam Fogarty, Head of Finance, Community Healthcare Organisation Area 2 • Mr. Bernard Gloster, Chief Officer, Community Healthcare Organisation Area 3 • Dr. John O'Mahoney, Executive Clinical Director, Community Healthcare Organisation Area 3 • Mr. Ger Reaney, Chief Officer, Community Healthcare Organisation Area 4 • Ms. Sinead Glennon, Head of Mental Health Services, Community Healthcare Organisation Area 4 • Ms. Aileen Colley, Chief Officer, Community Healthcare Organisation Area 5 • Dr. Stephen Browne, Executive Clinical Director, Community Healthcare Organisation Area 5 • Ms. Martina Queally, Chief Officer, Community Healthcare Organisation Area 6 • Ms. Antoinette Barry, Head of Mental Health Services, Community Healthcare Organisation Area 6	Transcript
24 January 2018	• Mr. David Walsh, Chief Officer, Community Healthcare Organisation Area 7 • Mr. Brendan McCormack, Executive Clinical Director, Community Healthcare Organisation	Transcript

	Area 7 • Mr. Pat Bennett, Chief Officer, Community Healthcare Organisation Area 8 • Mr. Siobhán Mc Ardle, Head of Mental Health Services, Community Healthcare Organisation Area 8 • Ms. Mary Walshe, Chief Officer, Community Healthcare Organisation Area 9 • Ms. Angela Walsh, Head of Mental Health Services, Community Healthcare Organisation Area 9	
1 February 2018	• Mr. Peter Hughes, General Secretary, Psychiatric Nurses Association • Mr. Niall O'Sullivan, National Vice Chairperson, Psychiatric Nurses Association • Ms. Caroline Brilly, Industrial Relations Officer, Psychiatric Nurses Association • Ms. Aisling Culhane, Research and Development Advisor, Psychiatric Nurses Association • Dr. Matthew Sadlier, Consultant Psychiatrist, Irish Medical Organisation • Dr Ray Walley, General Practitioner, Irish Medical Organisation • Ms. Vanessa Hetherington, Assistant Director, Policy and International Affairs, Irish Medical Organisation	Transcript
7 February 2018	• Mr. Ray Henry, Chair, Irish Association for Counselling and Psychotherapy • Ms. Lisa Molloy, CEO, Irish Association for Counselling and Psychotherapy • Dr. David Murphy, Associate Professor, University of Nottingham • Dr. John O'Brien, ICGP Vice President and	Transcript

	Incoming ICGP President • Dr Brendan O'Shea, Director, Postgraduate Resource Centre, Irish College of General Practitioners (IGCP) • Dr Brian Osborne, Assistant Director, Postgraduate Resource Centre with special responsibility for mental health	
14 February 2018	• Ms. Pablo Rojas Coppari , Policy and Research Officer, Migrant Rights Centre Ireland • Ms. Rashmi, Migrant Rights Centre Ireland • Mr. Patrick Reilly, Pavee Point Traveller and Roma Centre • Ms. Brigid Quirke, Pavee Point Traveller and Roma Centre • Ms. Moninne Griffith, Executive Director, BeLonG To • Mr. Dylan Donohue, BeLonG To	Transcript
28 February 2018	• Mr. Simon Harris T.D., Minister for Health	Transcript
7 March 2018	• Dr. Roy Browne, Consultant Psychiatrist, Irish Hospital Consultants Association • Dr. Kieran Moore, Consultant Psychiatrist, Irish Hospital Consultants Association • Dr. Donal O'Hanlon, Consultant Psychiatrist, Irish Hospital Consultants Association • Mr. Martin Varley, Secretary General, Irish Hospital Consultants Association • Dr. John Hillery President, College of Psychiatrists of Ireland • Ms. Miriam Silke, Chief Executive, College of Psychiatrists of Ireland • Dr. Miriam Kennedy, Director of Communication	Transcript

	and Public Education, College of Psychiatrists of Ireland • Dr. Róisín Plunkett, Chair, Trainee Committee and Trainee Psychiatrist (Higher Specialist Trainee)	
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APPENDIX 4 LIST OF SUBMISSIONS

Submissions can be viewed online at:

<http://www.oireachtas.ie/parliament/oireachtasbusiness/committees/list/futureofmentalhealthcare/presentationsandsubmissions/>

Alzheimer Society of Ireland

Ana Liffey

Aware

BeLonG To

College of Psychiatrists of Ireland

Department of Nursing and Midwifery, University of Limerick

Exchange House National Traveller Service

Family Carers Ireland

Fórsa

Health Research Board

Irish Medical Organisation (IMO)

Irish Nurses and Midwives Organisation

Irish Advocacy Network

Irish Association for Counselling and Psychotherapy

Irish Association for Infant Mental Health

Irish Hospital Consultants Association

Irish Rural Link

Jigsaw

Men's Voices Ireland

Mental Health Ireland

Mental Health Reform

National Women's Council of Ireland

Pavee Point Traveller and Roma Centre

Psychiatric Nurses Association

SafeyNet Primary Care

Sage Advocacy

Samaritans

School of Nursing, Midwifery and Health Systems, University College Dublin

School of Nursing and Midwifery, UCC

Simon Communities in Ireland

SpunOut

St Patrick's Mental Health Services

Traveller Counselling Service