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Foreword by Minister



The Expert Group on Mental Health Policy was established in August 2003 to prepare a national policy framework for the further modernisation of the mental health services. In order to fulfil its terms of reference the Group decided that it must consult as widely as possible. This comprehensive report **SPEAKING YOUR MIND**, prepared by Carr Communications who facilitated the consultation process is a summary of the process. It provides a clear message on how the mental health services should be developed.

The Group advertised in the national newspapers seeking submissions from anybody interested in making known their views on the Mental Health Services, questionnaires were distributed throughout the mental health services and various stakeholders including users of the mental health services were invited to one of two consultation seminars.

Those who contributed to the consultation process were from all areas of the Mental Health Services, service users (people with mental health difficulties), carers, nurses, doctors, Health Boards, counsellors, therapists, voluntary groups, administrators, allied professionals (i.e. social workers, occupational therapists) and other groups. There was a broad general agreement about the kind of Mental Health Service they wished to see in the future.

I welcome this report and I believe that it offers invaluable information and advice on the way forward.

A handwritten signature in white ink that reads "Tim O'Malley". The signature is written in a cursive, flowing style.

Tim O'Malley T.D.,
Minister for State at the Department of Health & Children

Message from the Chair of the Expert Group



I am delighted to present this Report – *Speaking Your Mind* – which, along with *What we Heard*, represents the first results of the work of the Expert Group on Mental Health Policy.

The Expert Group has been charged with the responsibility of preparing a national policy framework for the development of mental health services. The work of the Expert Group is informed by the wide body of knowledge and varied perspectives brought by a diverse membership including a range of professions, voluntary bodies, service providers and service users.

One of the first, and most crucial, steps of the Expert Group was to initiate an intensive consultation process – involving written submissions, questionnaires and consultation days – that would give us a genuine understanding of present service provision and provide us with signposts for the services to be delivered in the future.

This Report – *Speaking Your Mind* – reflects the wide ranging knowledge and expertise that exists among professionals and service providers with regard to mental health issues. The Expert Group is encouraged in its work by the availability of a network of diverse specialisms and the existence of a reservoir of professional research upon which it can draw.

We have encountered an excitement about the possibility of bringing the mental health services to a higher level of achievement and a sense of optimism that we are well-positioned to start that journey.

Now, twenty years on from the last major review of the area, the timing is right to develop a new policy framework that will energise our mental health services to new levels of effectiveness with the user firmly at the centre.

A handwritten signature in black ink that reads "Joyce O'Connor". The signature is written in a cursive, flowing style.

Professor Joyce O'Connor
Chair

Introduction

In the Health Strategy *Quality and Fairness – A Health System for You* (2001) it was recognised that a new national policy framework for the further modernisation of the mental health services was required. In 2003, the Minister for State at the Department of Health and Children, Tim O'Malley, T.D., appointed an Expert Group to formulate this policy. The Expert Group was intended to be 'reflective not representative' of the mental health sector. The members of the group are listed in Appendix 2, page 53.

The terms of reference for the Group are:

- **Prepare a comprehensive mental health policy framework for the next ten years**
- **Recommend how the services might best be organised and delivered and**
- **Indicate the potential costs of its recommendations**

In order to fulfil its terms of reference the Group decided that it must consult with as wide a range of stakeholders as possible and this was done in four ways:

1. Public advertisements were placed in all the national newspapers inviting any interested parties to make written submissions to the Group. The Group received 154 submissions from a range of stakeholders. These included submissions from users of the Mental Health Services (service users), their families and carers, voluntary groups, professional groups and other service providers.
2. Questionnaires were distributed throughout the Mental Health Services to service users. The Group received 369 completed questionnaires.
3. Stakeholders were invited to one of two seminars. One seminar was in Dublin on 27th April, 2004 and the second seminar was in Limerick on 5th May 2004.
4. The Irish Advocacy Network was commissioned to carry out an in-depth survey of service users. This survey will be the subject of a separate report.

The following report is a summary of the first three stages of the consultation process.

The Written Submissions

In October 2003 the Expert Group on Mental Health Policy advertised in the national newspapers. They were looking for submissions from anybody interested in making known their views on the Mental Health Services. The Group received 154 submissions. The submissions varied greatly in length and complexity. They ranged from one page letters to substantial documents on strategic plans.

The submissions were from all areas of the Mental Health Services. There were submissions from service users (people with mental health difficulties), carers, nurses, doctors, Health Boards, counsellors, therapists, voluntary groups, administrators, allied professionals (i.e social workers, occupational therapists) and other groups.

There was a broad general agreement in most of the submissions about the kind of Mental Health Service they wished to see in the future. The three central findings from the submissions, on which there was greatest agreement, were:

- 1. A mental health service where the service user is at the centre of the service**
- 2. The need to look at alternatives to medication for people with mental health difficulties**
- 3. The need for a community based mental health service with people treated in their own homes or in nearby centres rather than in psychiatric hospitals, as was the case in the past**

Many other issues were raised. Many of the submissions raised the same points. These points have been amalgamated under the different themes to cut down on repetition. Naturally, there was some disagreement on various issues. We have tried to reflect this in the summaries. The following is a summary of the submissions.

This summary is a reflection of the content of the submissions.

The submissions are on the Expert Group's website. The website address is:
www.mentalhealthpolicy.ie

The Submissions

All the submissions were read in detail by the Expert Group. The key points in the submissions have been gathered together to reflect the most important issues. Broadly speaking we have put these issues in order of importance as reflected in the submissions. In other words we have put the most frequently mentioned issues first.

THE USE OF MEDICATION

A substantial number of submissions said that there was an over reliance on medication in the treatment of mental health problems. Some service users and their carers wrote about their personal experiences of medication. Invariably these experiences were poor. Many users of the mental health services reported being prescribed medication as a first and only treatment option, rather than as a last resort. They also reported not being offered any other additional support – even when they presented with an awareness of emotional distress as being their primary problem.

For example, one submission stated that admission to psychiatric mental health services is non-therapeutic. If clients are admitted they should be offered support that is a “non-medical model”. The submission said “Current acute in-patient services . . . are often based on restrictive activities, and dominated by drug therapy.”

Most submissions said that as far as possible, we should provide a drug-free approach to mental health problems, with reliance on counselling and psychotherapy in dedicated centres subsidised by state aid. The medical model predominates, sometimes to the exclusion of other, less intrusive or equally effective interventions. Many submissions stated that a comprehensive range of psychological therapies should be provided at primary, secondary and tertiary levels.

It was acknowledged in many submissions that whilst clients/ patients showing signs of mental health problems may well need medication, they may also be helped find meaning in their behaviour and discover more useful ways of behaving through psychotherapeutic interventions.

Numerous groups said that much more research is needed into treatments that provide an alternative to medication. One submission described a centre in the UK where “enlightened GPs prescribe gardening, counselling, exercise, employment training and homeopathy in addition to traditional medicine.”

Whilst alternatives to medication were a consistently strong theme throughout the submissions, there was also a very strong emphasis on the need for a far greater availability of mental health professionals within the community. These were seen as vital to supporting the non-medical model. Particular mention was made of mental health nurses, psychologists, counsellors, occupational therapists and social workers. Several submissions noted that GPs should have ready access to these professionals.

Key health professionals in mental health are psychiatrists. Several submissions said that a very serious effort needs to be made to move professional psychiatric training towards a more holistic and integrated approach to treatment. A feeling reflected in some submissions was that psychiatrists should study mutual help, advocacy and recovery.



What People Said...

"I think every device of education, training, diet and talking therapy should be used in the first instance to treat mental illness. Drugs should be taken out of the front line – especially where young people are concerned."

"I'd prefer if I had proper care in the community and didn't have to come into hospital. I work three days a week and find it difficult to go back to the community and work after a spell in hospital. I feel as if I have 'psychotic patient' written all over my forehead and everyone knows."

"Could the psychiatrists be trained to talk correctly to the patients, and not just give the drugs and run?"

"Five of the top 35 most frequently prescribed medications were for anxiety or depression, amounting to just under 4,000,000 prescriptions, according to statistics from the General Medical Services (Payments) Board. It's time to address what is almost a national drug problem of our own making."



COMMUNITY-BASED CARE

The submissions were very solidly in favour of the principle and practice of using facilities and support networks based in the community where the mental health client lives. There was a spread of views, but the general thrust was very much in this direction. The kinds of services outlined in many of the submissions are described below.

The establishment of a comprehensive primary care service was endorsed by many. This service needs to be supported by a dramatic increase in the number of well trained community mental health nurses. There is also an increasing need for specialised services for those with particular needs, e.g. older people, individuals with an eating disorder, individuals with an intellectual disability and so on.

One of the key elements in providing an excellent community-based service, both rural and urban, is the creation of a Community Mental Health Team. This team should be staffed so that physical, psychological and social interventions are available. Research and best practice indicates that a comprehensive multidisciplinary model of service provision in a range of settings is best. Individuals with mental health difficulties should have access to this team. Specialist early intervention teams and assertive outreach teams, while of proven value, should not be developed at the expense of a flexible multidisciplinary team approach at community level. Mental health promotion was also mentioned as an integral part of mental health services.

However, a true shift to a community orientated model will only occur when we change the culture and systems that presently exist in many areas. This culture is illness-focused rather than person-centred and recovery focused. This culture needs to shift from a focus on mental illness to one of mental health. It will also require a change in mindset from 'institutional warehousing' of the mentally ill to a proactive community integrated approach.

The type of service model outlined above has implications for different professionals involved in these services and these were noted in some submissions. For example, several submissions noted that many experienced psychiatric nurses have no incentive to work in the community and many Clinical Mental Health Nurses (CMHNs) are forced back into management if they want promotion. This means that their nursing skills, developed over many years, are not being used to the greatest effect.

A few submissions also noted that the implementation of the NCHD (Non Consultant Hospital Doctors) working hours directive will have serious implications for providing the level of community based service that people want – as the number of hours NCHDs can work will be severely reduced.



What People Said...

"A move in the right direction would be treatment at home."

"Our Community Mental Health Team, with its home-based treatment team, has demonstrated its ability to provide effective community-based alternatives to inpatient care in the management of acute illness."

"A radical new strategy is necessary to enable the mentally ill to be mainstreamed in Irish society rather than in 'hidden Ireland'."



ORGANISATION AND DELIVERY

Full Strategic Plans for Mental Health Services were received from various Health Boards and other groups. Many of the submissions said that organisation and delivery of services must be developed within a ten-year strategy with targets and resources to match that strategy. All psychiatric services (e.g. Child and Adolescent, Old Age, Intellectual Disability) should be managed under the umbrella of the one management structure - Mental Health Services.

The successful organisation and delivery of a new Mental Health Service will need an inter-agency approach. Many clients are users of other services. The Expert Group should also look at the different services provided by government departments and other agencies to see if they need to be transferred elsewhere, e.g. education, training, employment, accommodation. Many submissions said that any new Mental Health Strategy must be a partnership between service users, service providers and public and private funded bodies. Different points made about aspects of service organisation and delivery are considered here under specific headings.

Primary Care

Mental health care professionals should form a core component of primary care teams and include, among others, a psychologist and a properly trained and recognised counsellor. However, several submissions said that the recent Primary Care Strategy does not go far enough to address the issues of early identification of mental health difficulties. The strategy needed to look at the specific responses needed for those who may be unwell, but not in crisis.

Sector-level Mental Health Services

Several submissions from across all professions said that leadership of multidisciplinary teams should be competency based rather than the unique domain of one discipline.

Acute Inpatient Care

Several submissions suggested that in terms of service organisation and delivery greater clarity is required on the philosophy underpinning moving acute admission psychiatric units to general hospital settings. Any new strategy should also look at the continued existence of acute inpatient units. The delivery of services in hospitals must be audited in line with the standards of best practice being developed by the Mental Health Commission and the Inspector for Mental Health Services.

Service Delivery

Many of the submissions identified a number of key areas that need to be examined to get consistency of delivery and meet the needs of service users/relatives. They are mental health promotion and early intervention, acute service provision, crisis intervention, rehabilitation services and legislation. A couple of submissions also suggested that the Expert Group should undertake a national disability study to form a key part of a national Mental Health Strategy. It was also suggested that the Expert Group should look at a number of different models to help them in their work on developing a new strategy for the Mental Health Services.

Overall Organisational Principles

The different professions should be represented at all levels of management and strategic development, from local level management up to representation in the Department of Health and Children.

Mental health structures and systems should be inclusive of marginalised groups in terms of their design, planning, structures and processes.

There should be a National Mental Health Coordinator to provide leadership and support to advance primary care nationally.



What People Said...

“There was a policy to close down dedicated mental hospitals and integrate treatment centres into general hospitals. I suggest on the contrary that treatment centres like psychiatric hospitals should be beefed up and that new methodologies should be sought, piloted and applied in such centres.”

“The Irish Mental Health care system is a mixture of Victorian asylum care and acute general hospital psychiatric units, with an uneven spread of community facilities across the country.”

“Any new model should have an inbuilt bias to prioritise areas of high psychiatric morbidity and resource them appropriately.”

“I would love to improve the terrible conditions in a lot of psychiatric hospitals. You would not believe the conditions in a subsidised (VHI) hospital compared to the public ones. It’s a disgrace. I know, I’ve seen it.”



TRAINING AND STAFFING

Many submissions from professional groups said that the need to promote, retain and train staff within the mental health services is paramount. This can be addressed in a number of ways including higher salaries for higher levels of skill. Several submissions suggested that clinical nurse specialists should be appointed as psychiatric consultation liaison nurses with the psychiatrist. This would increase job satisfaction. A number of submissions said that a major problem for training was the absence of manpower planning.

In general, the submissions concerned with training in psychiatry felt that it was good but was hampered by the need to fit it around busy clinical demands. However, there is no clear academic training track. Medical schools need to develop senior lecturer posts in psychiatry. Several submissions pointed out that the new NCHD (Non Consultant Hospital Doctors) working hours mean trainees will be less available during core hours. Their available time will be reduced from 80% to 40-60%.

A number of submissions highlighted the following specific issues in training and staffing:

- GPs need adequate training in the psychotherapies
- Direct entry to psychiatric nursing should remain at graduate level
- The possibility of initiating postgraduate specialist courses in psychiatry should be explored
- The regional development of clinical nurse specialist posts in mental health is needed
- Training in multicultural studies would be of benefit
- There is currently only one post on the higher training scheme for specific training in rehabilitation psychiatry. There needs to be more.



What People Said...

"We have a highly motivated staff which needs to be tapped into."

"The professions working in Mental Health are increasingly demoralised and demotivated."

"Recruitment in psychiatry and psychiatric nursing is an ongoing battle, and psychologists, Occupational Therapists (OTs) and other therapists are particularly hard to recruit and retain."



FUNDING

Many submissions said that mental health is the most important aspect of all health. It has a bearing on the cause, direction and outcome of many if not all illnesses such as cancer, heart disease and high cholesterol. The relative budget for mental health should reflect this. Mental health expenditure is disproportionately low when compared with other health sectors. Mental health institutions' conditions are an offence to those who access them. A number of submissions said that there is a disparity in how national funding is allocated geographically, with the eastern region particularly under-resourced.

Non-capital expenditure in mental health services as a percentage of overall health expenditure has steadily decreased in the past 25 years from 13.1% in 1977 to less than 6.8% this year.

Some submissions made specific suggestions as to how funds should be allocated or managed. For example, a couple of submissions suggested that money should follow the patient in the service, and funding should be based on measurable outcomes. Health funding must be used solely for health needs. A clear funding stream needs to be established for community and acute mental health needs. Three-year rolling budgets were also suggested by some. Funding should be biased in favour of socially deprived areas. There should also be Social Welfare funding of community residences and community residential activities.

A number of submissions made suggestions along the lines that the Government should (a) sell off property held by some of the larger and older mental health establishments to private developers. This should only be done on the basis that the money secured from such sales would be ring-fenced for capital funding of new community based mental health care services, and (b) the Government should utilise Government owned land banks and /or buildings for new community based housing and day facilities.

Several submissions said that budgetary accountability is essential for mental health services to plan, manage and develop effectively. Accountability should ensure that different projects are assessed objectively. For instance, when a mental health project has proved successful, local health boards should provide continued funding, subject to the project fitting into an overall service plan.

While many submissions did not make a direct statement on funding, they pointed out areas where there were gaps in funding. For example, there are significant deficits in the level of service provided for special populations – forensic psychiatry (people in prison), the elderly, children, adolescents, intellectual disability, eating disorders and neuropsychiatry, homeless people, refugees, cultural or ethnic groups, travellers and many others.

“

What People Said...

“A well-developed Community Mental Health Nursing service may appear expensive to develop initially, but it will be significantly more cost effective than inpatient institutional-based care.”

“In 2003 an acute inpatient bed at a psychiatric unit in Dublin, cost €94,000, compared to the CNS/CMHN salary of €43,308 (and that’s max of scale!)”

”

LEGAL ASPECTS

Where it was mentioned in submissions, the Mental Health Act, 2001 was broadly welcomed. It was felt that the Act should be implemented without delay. This would bring Irish mental health law into line with Europe relating to the detention of mentally ill patients. It was noted that definitions of mental illness and disorder should be consistent in Irish legislation in order to ensure harmonisation of practice and implementation between government agencies – i.e. there should be a detailed definition of a disorder as defined in the Mental Health Act, 2001. A legal advocate should be made available to every person admitted involuntarily. Full information about the person's rights under Mental Health legislation should be conveyed in an understandable manner.

However, there were some concerns about the Mental Health Act, 2001. Specifically, there was a concern that implementing the Act will consume even more of consultants' time as second opinions are required on a seven-day basis, with clear implications for cover and on-call arrangements. One submission noted that the section of the Mental Health Act, 2001 dealing with the detention of adolescents should be revisited. It is not in agreement with the recommendations of the National Children's Strategy.

Several submissions mentioned the importance of rights-based legislation. It was felt that any new mental health policy must be enshrined in comprehensive, rights-based legislation. Rights-based disability and mental health legislation is needed to give full effect to the Government's human rights obligations.

A number of submissions had concerns about the Criminal Law (Insanity) Bill, which is now before the Oireachtas. It was felt that this Bill needs substantial amendment if it is to be workable. The Bill should stipulate that provisions only apply to non-violent offenders. On a related area, some submissions said that they hoped that the Court Diversion Schemes – and also police station liaison schemes, could be extended throughout the country. A model for therapeutic law already exists in the Drug Court.

Two separate issues were mentioned in the submissions. The first of these was that civil legislation should be provided so that Community Treatment Orders are available to those who relapse and place themselves at risk. The second issue was that the Law Reform Commission and the Mental Health Review Board should communicate with mental health NGOs (Non Governmental Organisations) to discuss areas of serious concern.

Finally, it was emphasised that the effects of the Mental Health Act, 2001 and the future effects of the Criminal Law (Insanity) Bill must be considered in the context of planning mental health service delivery.

“

What People Said...

“People with severe emotional distress are the only citizens who can have their liberty taken away and be institutionalised or incarcerated without being convicted of a crime.”

“They are the only citizens who can routinely be forced to submit to medical treatments against their will.”

”

STIGMA

A considerable number of submissions mentioned stigma and mental health. Repeatedly they said that people suffering from mental health difficulties experienced considerable stigma. This stigma also extends to professionals in the area of mental health.

There is a broad lack of awareness of mental health realities. The 'culture of silence' has helped create significant barriers for people who wish to use the mental health services. Some submissions felt that stigma can be particularly strong in rural areas because people see users going into psychiatric services and there may be less confidentiality in these situations. Mental health needs to be integrated into ordinary medical centres in order to reduce stigma.

Several submissions mentioned that any new mental health policy framework must prioritise changing public attitudes towards people living with a diagnosis of mental illness. Stigma needs to be tackled on a number of fronts. The submissions came up with many different suggestions ranging from school based modules on mental health to public awareness campaigns. Some other suggestions included encouraging high profile people, who have received psychiatric treatment, to let others hear about this part of the reality of their lives. As one submission said "Garreth O'Callaghan (radio presenter) has the public flocking to hear him speak."

One submission summed up the sentiment in this area by observing that "a mental health system that has mental health as its goal, not mental illness as its obsession, is far more likely to counter stigma."

MENTAL HEALTH IN CHILDREN AND ADOLESCENTS

The need for special psychiatric facilities for children and adolescents was highlighted in several submissions, especially in light of the increasing incidence of depression and suicide in this group. Special adolescent services should be developed to cover 14-18 years olds. Currently this service covers only up to age 16. Quite depressed children and adolescents, aged 16 – 18, can be missed at the moment. Some submissions said that there was a need for more psychiatrists and other mental health professionals specialising in Child and Adolescent Psychiatry.

Several submissions mentioned different methods of dealing with children and adolescents experiencing mental health difficulties. For example, home-based assessments and monitoring of teenagers with major psychiatric disorder where possible, especially where parents do not wish a child to be admitted to hospital. Systemic Family Therapy was mentioned several times as being appropriate for working with families in difficulty, particularly young children and adolescents. The system focuses on working with the family.

PSYCHIATRY OF LATER LIFE

A number of submissions dealt specifically with the need for mental health services for older people. The needs of this group of the population will become more acute in future years as the number of people over 65 years is projected to increase substantially.

A number of submissions said that psychiatry of later life services should be set up in catchment areas that have no access to such services at the moment. Other issues in this area were:

- all psychiatry of later life services should come under the umbrella of psychiatry
- standardisation of nursing structures
- the development of a framework to inform future service development.

FAMILIES/CARERS/CHILDREN

A sizeable number of submissions were sent by carers or families of service users. Almost all of them described bad experiences in the mental health services.

A number of these submissions said that more respite care is needed. The social life of carers needs consideration.

There needs to be more ongoing contact/meetings with family members of people with a mental illness. This is especially true when the person lives at home.



What People Said...

“I looked after her for years, but nobody ever asked me how I was feeling or coping.” (A carer who looked after his wife with mental health difficulties)



WOMEN

A number of submissions dealt with the mental health needs of women. In general, it was felt that policies, strategies and government initiatives on mental health should address the area of gender, in order to ensure that the distinct needs of both women and men are targeted.

Women have varying mental health needs, depending on their different lives, circumstances and experience. Any Mental Health policy should be equality proofed according to the grounds laid out in the Equal Status Act 2000. Greater awareness of the particular needs of women in the areas of depression, alcohol, drug abuse and social problems is needed.

One submission felt that the Expert Group should consider the issue of male violence against women in intimate relationships, and make recommendations on how it should be most appropriately addressed by mental health services.



What People Said...

“One woman described how she was referred to a doctor who diagnosed that she was suffering from depression. She was then referred to a psychiatrist and ended up in a psychiatric hospital. No one asked why she was depressed”



INTELLECTUAL DISABILITY

A number of submissions said that there was no clear picture of the mental health needs of people with an intellectual disability. They suggested that the Expert Group should ensure that research is done on this group in order to establish the extent and range of their needs. Without such a picture it is difficult to define and assess the needs of people with a dual diagnosis (people with an intellectual disability who also have mental health difficulties).

It was felt that people with an intellectual disability should not be excluded from accessing mental health services because of the level of their disability. Other needs for specific services were outlined in submissions which dealt specifically with the area of dual diagnosis.

SUICIDE

Suicide was expressed as an area of great concern in several submissions, especially in the light of Ireland's escalating suicide rates.

Suicide prevention is not solely in the domain of mental health services. It impacts upon all care groups within the health services. The mental health policy must extend beyond mental health alone to create formal links with all areas involved in suicide prevention – community care, child and family services, health promotion, public health, drugs services, acute services and education.



What People Said...

“Suicide is the leading cause of death among young Irish people and Ireland has the second highest youth suicide rate of the 30 OECD countries”



HOUSING/FACILITIES

Housing and accommodation for people experiencing mental health difficulties featured in many submissions. Many suggestions were made including the provision of group homes to develop more independent living skills and so avoid institutionalisation. Those homes should be linked into other resources in the community to avoid isolation from that community.

Other suggestions included:

- Residential care for people with emotional difficulties. These should be mid-way between GPs and psychiatric hospital facilities
- The Club House model (a self regulating therapeutic community)
- Therapeutic communities
- Specialist hostels



What People Said...

“Very happy. Really enjoyed living in a hostel as had great freedom to get involved in cooking and everyday things.”



PRISONS

Some submissions were concerned that the Expert Group should be aware of the pressing need for improved quality and quantity of services for mentally disordered offenders in prison. The provision of mental health services to the prison population needs to be declared a priority.

There is a high rate of suicidal behaviour in prisons. Training programmes are needed for prison personnel to help them to improve early identification, intervention and prevention of suicide and other mental health difficulties.

One submission said that the Central Mental Hospital buildings, in Dublin, have now been condemned twice. Suitable new buildings will have to be self-financed by the sale of all, or part, of the Dundrum campus.

One submission said that they hoped that in future mental health professionals in all disciplines might wish to spend part of their undergraduate training in the Central Mental Hospital.

OTHER SUBMISSIONS

A number of other submissions were made. The following is a brief snapshot of some of them (the full submissions can be seen on the Expert Group website – www.mentalhealthpolicy.ie).

Eating Disorders: There needs to be an audit of all existing services before developing a strategic response to the treatment of eating disorders.

“Eating disorders such as anorexia and bulimia . . . have the highest rates of mortality for any psychiatric condition.”

AD/HD: Services for children and adults with AD/HD are seriously deficient. Parents report a hugely disparate experience with professionals dealing with the disorder.

Autism: It is recommended that the Expert Group should be more specific and more prescriptive in reference to developing a range of assessments and treatment facilities. People with autism require services from other disciplines – education, training, sheltered and open employment and housing. Their psychiatric needs may not be paramount.

Travellers: The recommendations made in the National Traveller Health Strategy should be implemented. A holistic approach needs to be adopted if the mental health needs and expectations of the traveller community are to be met. Interdepartmental collaboration and a multidisciplinary approach are needed.

Transgender: Clear treatment guidelines need to be established in the Department of Health and Children for people with Gender Identity Disorder.

Drug Misuse: There is an emerging challenge in terms of alcohol abuse and drug misuse (especially cocaine abuse) which will place strains on services.

The emerging issue of dual diagnosis (addictions and mental health difficulties) will require closer liaison between Addiction Psychiatry and Mental Health Services.

Expert Group: Two submissions referred to the composition of the Expert Group. One of these submissions said that the Expert Group appears to represent the professions, rather than the users.

Questionnaires

Although anyone was free to send a submission to the Expert Group (and 154 were received), we wanted to make sure it was made as easy as possible for service users to have their voice heard. For this reason, a second part of the consultation process was undertaken. Over 1,300 questionnaires were distributed to mental health services throughout the country. These were given to service users, carers and their families and others in contact with the mental health services.

The Expert Group received 369 completed Questionnaires in response to this part of the consultation. The details below show that most of the responses were from service users (63%). Other details on the gender breakdown, age group and general location of respondents are also shown. There was a fairly even split between female/male, most were in the 19-69 age group and there was a good spread of location, although urban areas were possibly a little over-represented.

Is this submission from:		
A service user	233	63%
A relative / carer	57	15%
Those who didn't answer this question: 22%		
Gender		
Male	151	40%
Female	169	46%
Those who didn't answer this question: 14%		
Age group		
Under 18	3	1%
19-44	150	41%
45-69	152	41%
70 and over	19	5%
Those who didn't answer this question: 12%		
Where you live		
City	154	42%
Town	106	29%
Village	35	9%
Rural	42	11%
Those who didn't answer this question: 9%		

General Summary of Questionnaires

The following was the central question of the questionnaire:

Have your recent experiences of mental health services been good, bad or mixed?		
Good	132	36%
Bad	37	10%
Mixed	176	48%

Those who didn't answer this question: 6%

Most respondents had a mixed experience of the mental health services. Space was given on the questionnaire for people to describe their good, bad and mixed experiences in more detail and to suggest changes and improvements to services. The figures and percentages below deal with specific points raised in this part of the questionnaires.

GOOD EXPERIENCES

42% of people surveyed described staff attitudes as being a part of their good experience. This was the single biggest response from those surveyed. Other areas highlighted as being good were counselling (5%), secure environment (3%) and general support and services (18%).

BAD EXPERIENCES

Ironically the attitude of staff drew the biggest negative response (19%) and of those who described staff attitudes as bad, 10% of them also described it as good. The next most common negative remark was in relation to staff availability. 18% of those surveyed mentioned the difficulty in getting to see staff as part of their 'bad' experience of the mental health services. 9% of people mentioned medication in the context of their bad experiences.

Other negative experiences included:

- Lack of freedom – 7%
- Stigma – 4%
- Food – 3%
- Seclusion – 2%
- Lack of medical staff to communicate to carer/family – 6%
- Confidentiality – 3%
- Hospital conditions – 5%
- Difficulties with mental health problems versus learning disabilities – 2%
- Suffered violence at the hands of staff – 1%
- Lack of after care – 6%

CHANGES

Aftercare/Community-based services

The most frequent suggestion for change came under the heading of aftercare / more community-based services. 24% of those surveyed highlighted this as an area that needs change and over three-quarters of these people were carers or relatives.

In the proposed areas for expenditure section, 23% of people highlighted community-based services and aftercare as the area most in need of investment.

In all, aftercare / community-based services were mentioned a total of 196 times by those surveyed in the areas of bad experience, changes and priorities for money.

Other suggested changes

- Programmes implemented to reduce stigma - 19%
- More funding to mental health services – 18%
- More staff (doctors, nurses and occasionally administrators)– 18%
- Less reliance on medication - 13%
- More money given directly to service users – 10%
- More support for carers and families – 11%
- More beds – 6%
- Some programmes aimed specifically at young people – 5%
- Transport is an area in need of change – 3%

EXTRA MONEY FOR:

New buildings – 19% of those surveyed mentioned this in relation to new buildings, but equally in regard to refurbishment and redecoration. Requests for entirely new premises were uncommon.

12% want to see money spent on programmes to address / reduce stigma.

17% would like money invested in more social activities for service users.

6% of those surveyed would like further investment made into research on mental illnesses.

Other proposals

- More employment schemes developed – 9%
- More accommodation made available to people with mental health problems – 16%
- More education programmes – for service users AND the public at large –developed – 12%
- Inter-service co-operation needs to be changed and improved – 4%
- More service user involvement with the mental health services – 4%
- A 24-hour / seven-day service brought online – 5%



What service users and their carers said...



Good attitude of staff

“The staff have been very caring and sympathetic.”

– Female service user, age 45-69

“Up until now I am satisfied with the treatment my family member(s) received in Dublin and Galway. The psychiatrists and PSWs (Psychiatric Social Workers) were most kind and helpful.”

– Unspecified

“Doctors and nurses were very caring and helpful, the day hospital is a great asset to be able to attend.”

– Female service user, age 19-44

Counselling

“One to one counselling is good and so is group therapy.”

– Male service user, age 19-44

Support

“My medication was always available to me and the nurses were co-operative. The day-centre is also beneficial – there should be another few around the city.”

– Male service user, age 19-44

“There should be more Government support for families of psychiatric patients, more on-call nurses.”

– Male service user, age 19-44

Employment schemes / support

“The support, listening and practical help I received in getting a job were all helpful.”

– Female service user, age 45-69

Transport

“The community mental health centre provided a bus service four days a week which gave me somewhere to go and helped me get back into a daily routine.”

– Female service user, age 45-69

Education

“More awareness in schools should be raised and those with mental health issues should be allowed special education.”

– Female service user, age 45-69

Availability of staff / access

“In crisis situations there is no immediate access to a psychiatrist.”

– Unspecified

“They changed doctors often and I had to be seen by a different one.”

– Male service user, age 45-69

“Sometimes it can be a bit difficult to get an appointment with the relevant doctor. The fact that the staff are always changing – due to different shifts – means that you sometimes get different doctors.”

– Unspecified

Bad attitude of staff

“A patient would benefit very much by being treated as a person or human being and spoken to with respect.”

– Female service user, age 45-69

24/7 service

“Accessibility on a 24-hour basis is very poor.”

– Male service user, age 19-44

Staff assessments

“There is a lack of tolerance for criticism. The doctors and staff don’t expect it and it is not accepted and taken on board. Patients feel if they criticise they will be discriminated against.”

– Male service user, age 19-44

Programs to reduce stigma / address stigma

“The Government could help to break down the stigma surrounding mental health issues, so barriers could be broken down by mental health groups.”

– Unspecified

“Less stigma to mental disorders.”

– Female service user, age 19-44

“I feel that mental illness should be talked about more openly, in the public eye, so they can have a better understanding.”

– Female service user, age 19-44

“More education to make people aware that people with mental health problems have an illness just like anyone with a physical problem.”

– Female service user, age 19-44

“A major initiative is needed to tackle the stigma associated with mental health and the associated discrimination experienced by people with mental health difficulties.”

– Female service user, age 19-44

“There needs to be more money given to create more community involvement and awareness.”

– Male service user, age 19-44

Medication

"I feel the medication is good but it makes us put on a lot of weight and I eat more. This affects my self image negatively."

– Female service user, age 19-44

"Being drugged was a bad experience. I was forcefully held down and injected to keep me sedated."

– Unspecified

(part of bad experience) "The over prescription of drugs and the over reliance on the medical model."

– Male service user, age 19-44

"Drugs should not be the first treatment automatically. Intensive group therapy – for less acute patients – would be extremely beneficial."

– Female service user, age 45-69

Lack of freedom

"The hospital feels like a prison because we are locked in!"

– Female service user, age 19-44

Accommodation

"Appropriate supported accommodation e.g. 1-2 person flat with access to support when required."

– Female service user, age 19-44

"More funds are needed for housing and independent living schemes."

– Male carer, age 70+

Funding

"I think there could be more money for CPNs (Community Psychiatric Nurses) so that you could call to the clinic any day of the week if you needed to talk to some of them and not just on Monday and Wednesday."

– Male service user, age 45-69

Confidentiality

“More space for when you’re talking to doctors and everybody involved in your recovery. A little privacy goes a long way.”

– Female service user, age19-44

Aftercare / community based services

“On discharge, follow up care is vital.”

– Female carer, age 45-69

“More activities and pursuits, interests and hobbies for people who have left hospital and are stabilised and need things to occupy their day.”

– Unspecified

“A community, home-based service would minimise the disruption to a person’s life of becoming mentally unwell. It should reduce the stigma and mean that people might seek help earlier.”

– Female service user, age19-44

More support for carers and families

“There needs to be more support and information available for carers.”

– Male carer, age 45-69

“We find that there is a lack of information given by the medical consultants to us as carers. It’s not possible to have private discussions with the medical team in the absence of the patient which at times can lead to embarrassment for the service user. Upon monitoring the progress of a patient’s well-being, a procedure should be put in place whereby the input and opinions of the carer are included.”

– Female carer, 70+

Service user involvement with service delivery

“I believe attitudes of staff and the general public to mental health service users and the associated stigma will only change when service users are employed within and offering services to other users, e.g. developing peer counsellors etc. within multi-disciplinary teams.”

– Female service user, age19-44

The Consultation Seminars

THE PUBLIC CONSULTATION SEMINARS

The third part of the consultation process was the hosting of two public consultation seminars. People who had made submissions and other interested parties were invited to one of two seminars. The first was held in Dublin on 27th April, 2004 and the second in Limerick on 5th May, 2004. The Minister for State at the Department of Health and Children, Tim O'Malley opened both seminars and members of the Expert Group also attended the seminars. Approximately 200 people attended.

The seminars were workshop based. There were two workshop sessions in the morning and two in the afternoon. The themes for the workshops were based on the submissions and questionnaires received by the Expert Group. The issues that appeared most frequently in the submissions and questionnaires became the workshop topics.

There were 13 different workshop groups in Dublin and 10 in Limerick. Where possible each workshop group included representatives from the different stakeholders e.g. a service user, a nurse, a counsellor, a carer, a member of a voluntary group, a psychiatrist, an occupational therapist and so on. Each workshop had an experienced facilitator and note taker working with them.

Because two issues were the focus of so many submissions the Expert Group decided that the morning workshop sessions would concentrate on just these two. The first of these was entitled "*Offering More Than Medication*" and the second was "*Building a Community Based Service*".

Each topic had a number of questions related to it. These questions were simply intended to generate discussion and were not intended to be a rigid agenda. As many of the same points were made in the different workshops they have been amalgamated under each heading.

All of the comments reported in the following section reflect those made in the workshops.

OFFERING MORE THAN MEDICATION

At present, drug treatment is the only treatment available for many people with mental health difficulties. How do we change this?

There is a growing awareness among both service users and service providers that drugs are simply one form of treatment for people with mental health difficulties. They are not the only answer and indeed a number of drugs have “worrying side effects.”

There are many alternatives to medication such as psychotherapy, counselling, self help groups, and so on. The full range of treatments should be available to GPs as they are the first person seen by most people with mental health problems. GPs also need more training in identifying mental health problems and selecting the appropriate type of treatment. Currently medication is the only option many GPs have ready access to.

A multidisciplinary team, available at primary care level, would help provide a better service to people with mental health problems. This team should be non-hierarchical and “should not be psychiatrist led.” Any treatment given should be reviewed every six months.

Service users need to be actively involved in their own care. Professionals and service users should act in partnership to decide a treatment plan. The family or carer of the service user should be involved as appropriate.

Hospital admission should be seen as a last resort. If a patient is admitted to hospital then there should be a phased system of discharge with a fully developed individualised care plan.

Far more research is needed into the whole area of mental health. Research in the past has tended to concentrate on medication, now there is need for research into alternatives. This kind of research will need independent funding and not funding by drug companies. Research needs to be driven by the needs of the service user.

There needs to be far more focus on prevention. “We need to promote a recovery model where quality of life is the goal.”

The National Treatment Purchase Fund (NTPF) has no provision for Mental Health patients.

BUILDING A COMMUNITY-BASED SERVICE

People with mental health difficulties should ideally be treated within their own community. How do we ensure this?

One of the most important things for people with mental health difficulties is to be accepted in their own community. The stigma attached to mental health problems means that many people are afraid of people with such difficulties. It is important for people with mental health difficulties to be able to establish community links through sports clubs, drama clubs and similar activities. Service users also need life-skills training.

Support and information is needed for the families, friends and neighbours of those with mental health difficulties. Families should be looked on as partners in the treatment of the service user. The partnership model works best where the professional, voluntary and community groups work together and where there is true understanding of the needs of the service user. The families and carers of service users also need as much information as possible on the various services available and they need to be able to access respite care.

The system needs to be less paternalistic. People can look after themselves. But they do need a well thought out recovery plan. Every service user should have a booklet containing GP contact details, recovery plan, employment details/wishes, medication details and medical history.

Multidisciplinary teams are needed to help the service user achieve full social integration, but "first class accommodation is needed" if community care is to be successful. It would be a great help if "mental health advice clinics were set up." People need access to help 24 hours a day, seven days a week.

The service user should have a choice about the services he / she wants to access. It can also be difficult for the service user to maintain confidentiality in the community, especially in rural areas.

HOW TO BUILD AND ENCOURAGE TEAM WORKING

Team working is often cited as an essential for good mental health services. But what does it mean and how can it be made to work?

There was broad agreement that multidisciplinary teams are the way forward. There were a number of different views as to who should be on these teams. There was a general consensus that teams should be composed of service users, psychiatrists, psychologists, carers, nurses, social workers, occupational therapists, and others as required.

Clarity of roles and good communication are vital to good team work. Team leaders should have the necessary leadership and management skills. There should be regular meetings. Some submissions suggested that each member of the team should take it in turn to chair the meeting.

Team members need to feel valued as individuals and should be encouraged to share their skills with one another.

Each team needs to have clear goals. The most important goal is to provide the best possible care for the service user. The team should look for feedback from the service users and their carers.

People on the team may need training in management and team working skills.

HOW TO REDUCE STIGMA

The social and public stigma attached to mental illness is a major issue for all those involved with mental health services. What can be done about it?

The stigma attached to mental illness came up throughout the workshops. This stigma affected both the service users and the service providers.

Stigma creates fear and so makes it very difficult for people to seek help if they need it. This is often made worse by the media who use negative and emotionally charged words to describe mental illness.

It can be harder for people in rural areas to cope with stigma because they are known by their community. This also affects their families and carers.

One of the best ways of tackling stigma is to educate children from a very young age to accept mental illness.

Overall, stigma needs to be tackled through education and media campaigns. People, especially well known people, need to talk more openly about their experience of mental illness. The term 'mental health' is far more positive than 'mental illness'.

HOW TO INVOLVE SERVICE USERS IN DECISIONS ABOUT THEIR CARE

Service users often feel excluded from any meaningful involvement in decisions or discussions concerning their care and treatment. How could this be addressed?

Service users need to be actively involved in their own care. This means that service users should be actively involved in decision making and work with the health professionals. They should have real choices. This will build confidence and empower people.

Peer support is vital for service users. Current or past service users could help out new service users on a one-to-one basis or in groups.

It is very important that families and carers are involved in all stages of treatment if the service users want that. However if the service user wants confidentiality then that must be respected.

Service users need to become self advocates. Sometimes advocacy groups can be seen as 'meddling and interfering'. Service users should also be involved in policy making.

There needs to be an effective complaints procedure for service users who are unhappy with their care.

PROFESSIONAL STAFF – RECRUITMENT AND RETENTION ISSUES

Significant difficulties have been experienced in recent years in recruiting and retaining professional staff for the mental health services. What measures could be taken to address this?

The general view was that there is often low morale amongst mental health professionals. This is caused by a number of factors – grading structures, chronic lack of resources, lack of involvement in decision making, lack of role clarity, lack of clarity in services (services described as chaotic by some people), staff not being used to their full potential, increase in violence towards staff, no clear career progression. Some participants spoke of 'abuse, disrespect and harassment experienced through the hierarchical structures.' Mutual respect between service providers would be good for morale.

All of the above can make it difficult to recruit staff and even more difficult to retain them. Many posts in the mental health services are not filled. Several suggestions were made to cope with this problem – utilise the private sector for headhunting to fill posts, fill vacancies from abroad if necessary. There is also a cap on recruitment in some areas. This cap makes it very difficult to plan services effectively.

There are barriers to entry to the professional grades. These need to be 'normalised to involve less qualified people.'

PROFESSIONAL STAFF – EDUCATION AND TRAINING ISSUES

Enhanced education and training of professional staff is regarded as a key requirement for the future development of the mental health services. What needs to be done?

As always, funding is a problem. Funding is needed to provide the kind of training required for health professionals.

GPs need much more training in mental health issues such as symptom recognition and relapse prevention. There should be integrated training for nurses, GPs and other health professionals. Training should be ongoing and not just finish when someone qualifies.

SUICIDE PREVENTION

Suicide has become a serious problem in Ireland in recent times and the continuing rise in the incidence of suicide, particularly among young males, is a cause of considerable concern. What should be done about it?

We need to put in place effective methods of identifying people at risk of suicide. There are a number of ways this could be done - there should be a Suicide Prevention Co-ordinator in every mental health service area, and community based youth workers need to be trained to identify people at risk. Professionals in the front line, like GPs, also need special training in this area.

Education is vital in suicide prevention and this needs to start in school. Young men need to learn to express their feelings. The drink and drug culture contributes to suicides. However, the focus should not be entirely on young men. Older people in isolated communities are often at risk.

When people are discharged from care after a suicide attempt there is often no follow up. They simply return to the same set-up that caused their emotional distress in the first place. There needs to be a comprehensive follow up service and access to a 24 hour suicide helpline.

HOW TO SUPPORT CARERS AND FAMILIES

Carers and families of people with mental health difficulties often report feelings of isolation and frustration and a lack of information about what is happening to their loved one. How can they be better supported?

Carers and families are fundamental to the successful treatment of people with mental health difficulties. They need information and education to help them. Above all they need support. This support could be through the provision of respite care, home help or training in dealing with a person with mental health difficulties.

Carers also need to be involved in the decisions affecting the care of the person with mental health difficulties. However, if the service user does not want their carer/ family involved then that should be respected.

Mental health professionals need to be more open with carers / families. They need to share information, consult and listen to them. Many carers / families said they would like psychiatric nurses to make house calls. They felt it would be far better for everyone if the service user was seen in their own home.

NEED FOR SERVICES

In planning and developing mental health services, it is important to adopt a needs-based approach. What are the community's needs (as distinct from the professional or service providers' needs) for services?

Just as with carers / families of service users, communities need to be involved in supporting people with mental health difficulties. Communities can have negative views of people with mental health difficulties. Sometimes they are afraid of them.

Service users, almost without exception, say that they would prefer to be treated within their own community. For this to be successful communities need to be educated on how to deal with their community members experiencing mental health difficulties. Health professionals, such as GPs, are part of this community. They too need to be educated. Service users would also like to have access to things like meaningful employment, crèches and social housing in their own community.

MENTAL HEALTH PROMOTION

Mental health promotion is widely acknowledged as being of importance in maintaining the general population's mental health. How should it be progressed in future?

Mental health promotion is fundamental to helping improve people's mental health. This promotion should start in school and it should be part of the whole social picture. There needs to be an active mental health promotion campaign using the media and high profile people who have experienced mental health difficulties.

Effective mental health promotion needs to identify the right messages to give to a wide range of audiences e.g. school children, teenagers, lone parents, people living alone and so on.

People also need to be trained in self awareness to help them identify their own mental health difficulties. Teachers and others need to know how to identify children and adolescents suffering from emotional distress.

Mental health promotion should also include non-nationals such as asylum seekers. Many of these people arrive in Ireland suffering from emotional distress. They need to know that help is available. The community needs to be aware of the emotional distress of many asylum seekers and other non nationals.

HOSPITAL-BASED CARE

For many service users, the experience of being in hospital is not a positive one. For professionals, working in the hospital environment can often be a stressful or difficult experience. How can things be improved?

When patients are in hospital they need holistic treatment, including therapeutic interventions.

There should be individualised assessment and recovery plans for each patient and patients should be involved in them. Every patient also needs a discharge plan for when they leave hospital. There are too many readmissions. Nurses should be allowed to make home visits.

Patients need better facilities. There should be fewer communal wards and bathrooms should be nearby.

Patients also need areas to meet one another, chill-out rooms (to be alone), access to making tea and coffee when they need it. The boredom factor needs to be addressed.

Families and carers should be properly briefed by the hospital on the service they provide. More information is needed and must be more readily available.

ACCESS TO SERVICES

Access to the mental health services when they are needed is an important issue. How can access be improved?

Mental health services should be available to everybody who needs them. But people need to know what services are available. Health professionals, such as GPs, also need to know what services are available.

Awareness of mental health services is needed throughout the community and should start with raising awareness in schools.

Services need to be integrated so that people with mental health difficulties have a co-ordinated service. People who use the mental health services should also get a chance to give feedback on the level of service they receive.

Mental health services should be free. Some services are not covered by VHI.

MENTAL HEALTH NEEDS OF MINORITY GROUPS

Minority groups such as travellers, refugees and asylum seekers have particular needs when accessing mental health services. Irish speakers and ethnic minorities also have particular language needs. How can these various needs be addressed?

Minority groups have specific mental health needs. For example a large proportion of homeless people have mental health problems; Traveller women have high rates of depression; refugees and asylum seekers can be suffering from trauma. Mental health difficulties can often be triggered by discrimination. The mental health services need to be aware of bias and prejudice.

Refugees and asylum seekers may have different cultural views on mental health. Health professionals need to be aware of these. They also need excellent interpreters if they are to receive the level of care they need. Information leaflets in various languages are needed. Irish language speakers should also have access to mental health care in their language of choice.

MENTAL HEALTH IN PRIMARY CARE

Most people with mental health difficulties are first seen by their General Practitioner. What can be done to improve the primary care services available to those with mental health difficulties?

The first person most people with mental health difficulties see is their general practitioners (GP). GPs need to be more aware of the available mental health services. There also needs to be much better communication between the GP and these services. Both the GP and the mental health services need to have better contact with the voluntary sector.

GPs need more training in dealing with people with mental health difficulties. They should not routinely prescribe medication. They should refer people to the appropriate mental health services.

Ideally there should be a specialised team in a general practice who can provide help for a person suffering from mental health problems.

MENTAL HEALTH SERVICES FOR CHILDREN, ADOLESCENTS AND PEOPLE WITH INTELLECTUAL DISABILITIES

How can we address the mental health needs of children, adolescents and people with intellectual disabilities?

Children with behaviour problems need intervention as soon as possible. Parents, carers and teachers need training to spot the early warning signs. If psychological intervention is required then it should be looked at very carefully and monitored. Every effort should be made to avoid giving children medication. There are lots of other therapies that could be tried like behavioural therapy, creative art therapy, etc.

Every child has a right to the highest attainable level of care. Children and adolescents need to be educated about mental health in school.

There needs to be a cross-departmental approach e.g. Departments of Health and Children, Education and Science, Justice, Equality and Law Reform, etc.

There also needs to be a service for those who fall between the 'child' and 'adult' category.

When it comes to intellectual disability, people are seen as having either an intellectual disability or a mental illness. The mental health services need to realise that it is possible to have both. Some people fall between two stools and end up getting no treatment at all, or all of one and none of the other.

Attitudes and approach should be age-specific i.e. adults with intellectual disabilities should not be treated like children, as this can affect their mental health.

No matter what age they are, people with intellectual disabilities should have access to the mental health services. Communication between the services for intellectual disability and the services for mental health needs to be greatly improved.

Services should be provided locally in accessible, multi-purpose centres. Service should be available at all-hours. "Mental health difficulties don't just exist from 9 o'clock to 5 o'clock." There should also be appropriate support for carers and families including respite care.

MENTAL HEALTH SERVICES FOR OLDER PEOPLE

How can we address the mental health needs of older people?

The elderly population is increasing significantly giving rise to a higher percentage of older people with mental health difficulties such as Alzheimer's, dementia and depression.

Elderly people need to be able to access services near where they live as it is often difficult for them to travel. Day care rather than hospital care should be available and support systems need to be in place for those who need home care. Families also need support especially when caring for the elderly at home. They also need access to respite care. Sheltered care needs to be available. Elderly people should also be aware of alternative therapies.

Elderly people often experience bereavement and after the loss of a life partner many of them do not socialise very much. Professionals need to be trained in dealing with bereavement.

Professional staff need specific training for dealing with the elderly. They need to be aware of their physical health needs as well as their mental health needs.

MENTAL HEALTH SERVICES FOR PRISONERS

How can we address the mental health needs of prisoners and those before the criminal justice system?

Prisons need to be much more centred on rehabilitation and less punitive. It is clear that the current punitive system is not working as there are a far greater proportion of prisoners suffering from mental health difficulties than there are in the general population. This could of course be due to the fact that many people are in prison because they had mental health problems that led to crime. The situation is not helped by the fact that there is a very low number of forensic psychiatrists.

When prisoners are released from prison they need a structured support system otherwise they will simply return to the same environment that created their difficulties in the first place. Housing and education would provide some of the supports needed.

MENTAL HEALTH SERVICES FOR HOMELESS PEOPLE

How can we address the mental health needs of homeless people?

It is difficult to know whether being homeless causes mental health problems or whether mental health problems lead to homelessness. Whatever the reason, being homeless makes it very difficult for people to access mental health services. If they require ongoing medication this can be very difficult.

People can find themselves homeless for a variety of reasons such as drug addiction, alcoholism, disability or lack of family ties. People are often treated for some of these conditions and then discharged back into the community with no follow up service in place. People in this situation need proper housing with the appropriate supports. Some voluntary agencies are providing models of the kind of care such people need.

MENTAL HEALTH SERVICES FOR REHABILITATION AND LIAISON

How can we address the mental health needs of people who need rehabilitation or those in acute hospitals?

Community based rehabilitation services are needed for people discharged from hospitals or other institutions. This service should be home based as families are crucial to successful rehabilitation. Sometimes support housing and hostels are the appropriate place to provide this care.

People in rehabilitation need the support of a multidisciplinary team who put together a pre-discharge plan. The preparation of this plan should include the person with mental health problems, their family, health professionals, voluntary groups and so on. This plan should be reviewed regularly.

An essential part of rehabilitation is re-education for the person with mental health difficulties, including education in life-skills. A mentor or life coach would be very useful. Employment can also be very important for a person's rehabilitation and a network of employers should be established.

MENTAL HEALTH SERVICES FOR ALCOHOL AND DRUG ADDICTION

How can we address the mental health needs of those addicted to alcohol or drugs?

The use of alcohol is very engrained in our culture. We need to have a far greater awareness of alcohol misuse. We need a major social change in our attitude to alcohol. There is still a tendency to cover up alcohol and drug misuse and early intervention is crucial for successful treatment.

Alcoholism should be taken away from the mainstream psychiatric services and self referral should be available. Support is also needed for the families of those misusing alcohol.

Just as with alcohol misuse, there is a great need for support for people who come off drugs. This support needs to come from the health professionals but also from the community. People need support in many different areas such as housing and education.

MANAGEMENT STRUCTURES

Are there aspects of the existing management structures and practices within the mental health services which hinder rather than enhance the ability to provide the best service?

The existing management structures need to be far more consultative and less dictatorial. A more democratic system of management would result in far greater efficiency. Primary health care needs to be developed in parallel with specialist care.

No matter what management system is in place people need to remember that the service user is at the centre of it. He/she should be involved in policy making and planning in a real way. Whatever management structures are put in place they need to be accessible and user friendly. Crucially, they also need to be audited.

DEVELOPING MODELS OF BEST PRACTICE, RESEARCH AND AUDIT

There is widespread support for the development and dissemination of best practice in mental health care. How can this be facilitated?

It is now clear that accountability, evaluation and monitoring need to be an integral part of the mental health services. Guidelines and standards need to be established and there needs to be a clear audit system to ensure these standards are met. Any audit system should assess service user outcomes, and service users and their families must be actively involved in the audit.

Substantial research needs to be done to establish what is exactly best practice. We should look at other countries and see how they have developed their models of best practice. There needs to be balance between medical and psychological approaches. Research into mental health in general needs to be increased and seen as vital to improving services.

Mental health professionals need ongoing training to ensure they continue to provide the best possible care. Training in rural areas could be done via outreach or video conferencing.

ACCOUNTABILITY / MEASURING SUCCESS

The Expert Group on Mental Health will be making recommendations for a new Mental Health Policy Framework for the next ten years. How will the success of the Policy be measured?

In order to measure the success of the policy clear performance indicators should be set. Some of these indicators will be: reduced admission levels; increase in the number of therapists; service users' satisfaction with the service; reduction in the number of suicides; increased staffing levels and so on.

An independent committee should be set up to monitor the new Policy.

An independent complaints system needs to be established that is easy to access. Complaints must be followed through.

Appendix 1

Submissions were received from:

- Alzheimer Society of Ireland
- Amnesty International (Irish Section)
- Association of Community Mental Health Nurses of Ireland
- Association for Psychoanalysis and Psychotherapy in Ireland
- Aware
- Ballyfermot Mental Health Association
- Bodywhys
- Butler, E. – Community Child Care Leader
- Boyle, B.
- Carlow / Kilkenny Adult Mental Health Service, Department of Systemic Psychotherapy
- Cassidy, I.
- Central Mental Hospital – Dr. H. Kennedy
- Centre of Nurse Education, Directors – James Connolly Memorial Hospital, Tallaght Hospital, St. Ita's
- Cluain Mhuire Service
- Conference of Religious of Ireland (CORI)
- Cooley Environmental and Health Group
- Cork Advocacy Network, Resource Centre Working Group
- Cork City Development Board
- Counihan, S. – Lecturer in Mental Health and Learning Disability Nursing
- Crowe, K.
- Crumlin and District Mental Health Association
- Deady, R. – Lecturer in Psychiatric Nursing
- Department of Health and Children, Dr. M. Mulcahy
- Department of Justice, Equality and Law Reform
- Disability Federation of Ireland
- Drug Treatment Centre Board
- Dublin South District, Services for Older People
- Durcan, P.
- East Coast Area Health Board
- Eastern Regional Health Authority
- Eastern Regional Health Authority, Directors of Nursing
- Eastern Regional Health Authority, Occupational Therapy
- EVE (Eastern Vocational Enterprises)
- Family Therapy Association of Ireland
- Federation of Voluntary Bodies, North East Region
- Fisherfolk Consulting, Social Services Consulting
- Galway, NUI, Department of Health Promotion
- Grogan, B.
- GROW
- HAIL (Voluntary Housing Association)
- Hanlon, J.C.
- Hayes, T. – Community Mental Health Nurse
- Heads of Discipline - Occupational Therapy, Social Work and Psychology Managers
- Heads of Psychology Services Ireland
- Hospital Pharmacists Association, Ireland
- IMPERO (Irish Mental Health Patients' Educational and Representative Organisation)
- Institute of Public Health in Ireland
- Irish Association of Creative Arts Therapists
- Irish Association of Consultants in Psychiatry of Old Age
- Irish Association for Counselling and Psychotherapy
- Irish College of Psychiatrists, Faculty of Adult Psychiatry

- Irish College of Psychiatrists, Child and Adolescent Psychiatry
- Irish College of Psychiatrists, Forensic Psychiatry Section
- Irish College of Psychiatrists, Learning Disability Section
- Irish College of Psychiatrists, Psychiatry of Old Age
- Irish College of Psychiatrists, Psychotherapy Services
- Irish College of Psychiatrists, Substance Misuse Section
- Irish Council for Psychotherapy
- Irish Dietetic and Nutritional Institute
- Irish National Council of ADHD Support Groups (INCADDS)
- Irish Prison Services
- Irish Psychiatric Association
- Irish Psychiatric Training Committee
- Irish Translators and Interpreters Association
- Kerry Mental Health Services, St. Finan's Hospital
- Killeen McCarthy, M.
- Killilea, J.
- King, H.
- Laois / Offaly Mental Health Services
- Lakeview Unit, Naas, Clinical Director et al
- Leonard, A.
- Lennon, M.
- Living Life Voluntary Counselling Centre, Wicklow
- Lucena Clinic Child and Adolescent Mental Health Services
- Maddock, M.
- Mayo Mental Health Services
- McCarthy, M.K.
- McMahon, D.
- Melly, P.
- Mental Health Association, Ringsend, Dun Laoghaire, Bray, Wicklow
- Mental Health Ireland
- Mental Health Managers' Group
- Mental Health Nurse Advisory Forum
- Mental Health Nurse Managers Ireland
- Mental Health Services for Older People, Limerick
- Merlin Park Regional Hospital, Galway
- Midland Health Board
- Midland Health Board, Child Psychiatry Services
- Midland Health Board Consultant Psychiatrists
- Midland Health Board, Health Promotion Service
- Midland Health Board, Psychological Services
- Midland Health Board, Psychiatry of Intellectual Disability
- Milner, D.
- Mullen, K.
- National Council for the Professional Development of Nursing and Midwifery
- National Disability Authority
- National Forensic Mental Health Service
- National Health Promoting Hospitals Interest Group, Mental Health Services
- National Federation of Voluntary Bodies
- National Suicide Research Foundation / National Suicide Review Group
- National Training and Development Institute, Wexford
- Ni Neachtain, M.
- North Eastern Health Board, Mental Health Services

- North Eastern Health Board, Specialist Rehabilitation Services
- Northern Area Health Board – Addiction Services
- Northern Area Health Board
- Northern Area Health Board, Department of Psychiatry of Old Age
- Northern Area Health Board, National Group of Health Promotion Managers and Mental Health Promotion and Suicide Prevention
- O'Donoghue, B.C.
- O'Donovan, H.
- Pavee Point, Travellers Centre
- Physicians for Social Responsibility
- Psychiatric Nurses Association of Ireland
- Psychiatry of Old Age Nurse Education and Development Group
- Psychological Society of Ireland
- RehabCare
- Ryan, H.
- Ryan, G.
- Schizophrenia Ireland
- Shaolin Wahnam Ireland
- Simon Communities of Ireland
- Sli Eile Housing Association Ltd., Cork
- Social Workers in Adult Mental Health
- South Eastern Health Board, Mental Health Review Group
- South Eastern Health Board, Regional Suicide Resource Officer
- Southern Health Board, Department of Strategy and Planning / Programme Manager's Office
- Southern Regional Group of Mental Health Occupational Therapists
- South Lee Mental Health Services, Cork – I. McSwiney
- South West Counselling Centre
- South Western Area Health Board – Rogan, M.
- South Western Area Health Board, Addiction Service
- St. Ita's School of Nursing
- St. James's Hospital, Department of Psychology, Jonathan Swift Clinic
- St. Loman's Hospital, Palmerstown – Hughes. P. / Nugent, M.
- St. Loman's Hospital, Palmerstown, Rehabilitation Executive Team
- St. Patrick's Hospital – Professor P. McKeon
- STEER Mental Health
- Steward, R. and McGuinness, F.
- Transgender Equity Network, (Gender Identity Disorder)
- Trust, Homeless People – Dublin
- Tus Nua – Ballymun
- University College Cork, H. Dip. Psychiatric Nurses
- University College Cork, BSc. Student Psychiatric Nurses (2002 intake)
- University College Dublin, School of Nursing and Midwifery
- Waterford Institute of Technology, Department of Nursing and Health Sciences
- Western Health Board, Resource Officer for Suicide Prevention
- West Galway Mental Health Service
- Western Society for Autism
- White, G.
- Women's Aid
- Women's Health Council

Appendix 2

The members of the Expert Group are:

- Professor Joyce O'Connor, President, National College of Ireland (Chairperson)
- Dr. Tony Bates, Clinical Psychologist, St. James's Hospital, Dublin
- Dr. Edward Boyne, Psychotherapist, Dublin & Galway
- Mr. Noel Brett, Programme Manager for Mental Health and Older People, WHB
- Dr. Justin Brophy, Consultant Psychiatrist, Wicklow
- Mr. Brendan Byrne, Director of Nursing, Carlow Mental Health Service
- Ms. Kathy Eastwood, Social Worker, University College Hospital, Galway
- Ms. Mary Groeger, Occupational Therapy Manager, North Cork – SHB
- Dr. Colette Halpin, Consultant Child & Adolescent Psychiatrist, MHB
- Mr. Michael Hughes, Director of Nursing, Wicklow Mental Health Service
- Dr. Mary Kelly, Consultant Psychiatrist (Intellectual Disability), Brothers of Charity, Limerick
- Dr. Terry Lynch, GP and Psychotherapist, Limerick
- Mr. Paddy McGowan, President, Irish Advocacy Network
- Ms. Bairbre Nic Aongusa, Principal, Mental Health Division, Department of Health & Children
- Dr. John Owens, Chairman, Mental Health Commission
- Mr. John Saunders, Director, Schizophrenia Ireland
- Mr. Cormac Walsh, Nursing Administrator, St. Brendan's Hospital
- Dr. Dermot Walsh, Mental Health Adviser, Department of Health & Children