PRESS BRIEFING

"A Vision for Change"

- **Person Centred** – service user involvement at all levels. Service users should be partners in their own care.

- **Recovery Oriented** – care plans reflecting services users' needs, goals and potential, addressing community factors which impede recovery.

- **Holistic** – all aspects of mental health: biological (e.g. medication), psychological (e.g. "talking therapies") and social (e.g. housing, employment, education/training).

- **Community-based** – provide services in communities where people live, reduce hospital admissions, more home-based treatments and outreach services.

- **Multi-disciplinary** – in addition to doctors and nurses, have a range of professionals e.g. psychologists, social workers, occupational therapists on all mental health teams.

- **Population-based** – focus on mental health and well-being of the whole population, from childhood to old age

Summary Recommendations of *A Vision for Change*

A Vision for Change details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.

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

- **The mental health service should be organised nationally in catchment areas for populations of between 250,000 and 400,000.** Organisation and management of services within each catchment should be coordinated locally by Mental Health Catchment Area Management Teams and managed nationally by a National Mental Health Service Directorate within the HSE. The National Directorate should be comprised of mental health service managers, clinicians and service user representatives, charged with responsibility to coordinate and implement the recommendations of this report. It is proposed that the Directorate should also establish a national manpower planning and training structure to review education and training needs for the mental health service to ensure that the increased manpower required for the proposed mental health system can be provided.

- Specialist expertise should be provided by community mental health teams (CMHTs) - expanded multidisciplinary teams of clinicians who work together to serve the needs of service users across the lifespan. CMHTs should serve defined populations and age groups and operate from community-based mental health centres in specific sectors throughout re-configured mental health catchments areas. These teams should assume responsibility for self-governance and be accountable to all their stakeholders, especially service users, their families and carers. Some of these CMHTs should be established on a regional or national basis to address the complex mental health needs of specific categories of people who are few in number but who require particular expertise (see Appendix 1).

- To monitor service developments, ensure service equity across the HSE and evaluate performance of CMHTs, it is critical that systems of gathering information on mental health be established locally and nationally. In addition, mental health service research should be encouraged and funded to evaluate the

effectiveness of proposed innovations and to improve our understanding of the unique and changing mental health needs of our community.

- This policy envisions an active, flexible and community-based mental health service where the need for hospital admission will be greatly reduced. It will require substantial funding, but there is considerable equity in buildings and lands within the current mental health system, which could be realised to fund this plan. Therefore, this report recommends that steps be taken to bring about the closure of all psychiatric hospitals and to re-invest the resources released by these closures in the mental health service.

- A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services. Further investment is required to achieve the service structure described in this report. The proposed new workforce will comprise more than 11,000 staff throughout the service. Allowing for the assimilation of all existing posts, the Expert Group has estimated that a total of **1,803** new posts across the services together with a total non-capital investment of **€151 million** per annum in addition to existing funding are required.

- Due to the current non-availability of certain health professionals, investment will be required on an incremental basis, resulting in a proposed non-capital investment of an additional **€21.6 million** each year for the next seven years. An additional €25 million has been allocated to the HSE for mental health services in 2006.

- Significant **capital** investment is also required to provide and equip the proposed new mental health infrastructure. The Report estimates that **€796 million** will be required. There are substantial capital assets in the existing psychiatric hospital buildings and lands which could be used productively for various public and private sector purposes. **The Report recommends that the full economic value of such hospital buildings and lands within the mental health services be assessed and valued.** The value of these assets should significantly counterbalance the capital cost of the new mental health service infrastructure requirement.

- It is estimated that the full implementation of the recommendations contained in this Report will increase the total non-capital spend on mental health expressed as a percentage of total health expenditure to 8.24%, as compared to 6.98% which is the estimated figure for 2005.

Background Information/ Context

Prevalence of mental illness

The number of people affected by mental health problems at any one time is high – about one in four individuals will have a mental health problem at some point in their lives. The WHO has calculated the global burden of disease and found that mental disorders rank second in the global burden of disease, following infectious diseases.

Estimated Economic Cost

The economic costs of mental health problems are also considerable. These were estimated to be at least 3–4% of GNP across the member states of the EU[12]. The total financial cost of mental ill health in Northern Ireland has been estimated at Stg£2.8 billion (approximately €3.7 billion). The Northern Ireland costs of mental illness translated to the Republic of Ireland on a pro rata population basis would suggest a total annual cost of mental ill health of €11 billion.

Progress since publication of Planning for the Future (1984)

A major criticism of current mental health services relates to the standard of accommodation provided for users in the old style mental hospitals, some of which are unsuitable for the delivery of a modern mental health service. Considerable progress has however been made since the publication of Planning for the Future in the development of community based services as an alternative to inpatient care.

Key parameters in Irish mental health services: 1984 and 2004.

	1984	**2004**
In-patients in psychiatric hospitals and units at end of year	12,484	3,556
Long-stay patients (in hospital for more than 5 years)	7,086	1,242
Admissions to psychiatric hospitals and units	28,830	22,279
First admissions to psychiatric hospitals and units	8,746	6,134
Outpatient clinic attendances	200,321	212,644
Day hospital attendances	--	162,233
Day centre attendances	--	413,771
Psychiatric beds	12,484	4,121
General Hospital Psychiatric Units	8	22
Persons in community residences	942	3,065
Day hospital places	--	1,022
Day centre places	--	2,486
Total day places	1,180	3,508

Funding for mental health services

Mental health expenditure accounted for an estimated 6.98% (€766m) of total health expenditure in 2005 and it is estimated that €800m will be spent in 2006.

In 1997 expenditure on mental health services was €326m.

Appendix 1 - Key Recommendations for implementation of Report

In-patient care

- one acute in-patient unit per catchment area of 300,000 population with 50 beds to be used as follows:
  - 35 beds for general adult mental health services, including six close observation beds
  - eight beds for mental health services of older people (sub-unit)
  - five beds for mental health services for people with intellectual disability (sub-unit)
  - two beds for people with eating disorders (may be amalgamated in one unit per region of six beds)
- this acute in-patient unit should be located in the 'Major' or 'Regional' hospital, while taking into account the location of existing units (can be provided in two units of 25 beds each)
- one crisis house per 300,000 with ten places
- four intensive care rehabilitation units (ICRU) – one in each of the four HSE regions, with 30 beds each
- two high support intensive care residences of ten places each, in each HSE region (a total of eight residences with 80 places nationally)
- one unit with 30 beds per 300,000 population for continuing care/challenging behaviour for mental health services for older people
- ten rehabilitation beds in intellectual disability residential centres which have approved centre status
- 100 in-patient beds nationally for 0–18 year olds, in five units of 20 beds each
- ten-bed national secure unit for children and adolescents
- ten-bed national secure unit for those with intellectual disability

Child and adolescent mental health services

- two multidisciplinary CMHTs per 100,000 population
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care as appropriate for children and adolescents aged 0–18 years and covering the day hospital in each catchment area
- one additional multidisciplinary team in each 300,000 catchment area to provide paediatric liaison mental health services
- one day hospital per 300,000
- 100 in-patient beds nationally for all aged 0-18 years, in five units of 20 beds each

Adult mental health services

- one multidisciplinary CMHT per 50,000 population, with two consultant psychiatrists per team
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care; home-based care; crisis house; day hospital; early intervention etc.
- one acute in-patient unit per 300,000 population with 35 beds*
- one crisis house per 300,000 with ten places
- four intensive care rehabilitation units (ICRU) to be provided – one in each of the four HSE regions, with 30 beds. Each ICRU to be staffed by a multidisciplinary team with additional nursing staff
- two high-support intensive care residences of ten places each in each HSE region (a total of eight residences with 80 places nationally)
- two Early Intervention Services be provided on a pilot basis

**see details of in-patient provision in section 8.13*

Forensic mental health services

- one multidisciplinary CMHT per HSE region
- based in, and operating from, community mental health centres
- providing court diversion services and liaison and support for local gardaí and for other mental health services in the region
- two multidisciplinary teams for children and adolescents nationally – one to be based in a ten-bed secure unit for children and adolescents and one to be a community based resource
- one national intellectual disability forensic mental health team and national unit to provide secure care to those with intellectual disability

Mental health services for older people

- one multidisciplinary CMHT per 100,000 total population
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care, with an emphasis on home assessment and treatment if possible, and on maintaining the older person in their community
- eight in-patient beds in the general acute in-patient unit
- one day hospital per 300,000 population with 25 places specifically for mental health services for older people, with a possibility of additional sessional or mobile day hospitals in rural areas
- one unit with 30 beds per 300,000 population for continuing care/challenging behaviour

**see details of in-patient provision in section 8.13*

Intellectual disability mental health services

- two multidisciplinary CMHTs for adults with intellectual disability per 300,000 population
- one multidisciplinary CMHT for children and adolescents with intellectual disability per 300,000 population
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care, with an emphasis on home assessment and treatment if possible, either in the individual's family home or at a residence provided by an intellectual disability service
- five acute beds in the acute in-patient unit*
- one day hospital per 300,000 with ten places
- ten rehabilitation beds in intellectual disability residential centres which have approved centre status

**see details of in-patient provision in section 8.13*

Forensic mental health services

- one multidisciplinary CMHT per HSE region
- based in, and operating from, community mental health centres
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Mental health services for the homeless

- two multidisciplinary CMHTs for Dublin, one for North Dublin and one for South Dublin.
- based in, and operating from, community mental health centres
- providing assessment, treatment and care on an assertive outreach basis
- one crisis house of ten beds for those not requiring admission to acute psychiatric beds
- the use of acute psychiatric beds if required, from the overall complement for the Dublin area
- two day centres and one day hospital should also be provided for these teams

Substance misuse mental health services

- one multidisciplinary CMHT per catchment area of 300,000
- these teams to work closely with the forensic CMHT, the adult CMHT and substance misuse services in the community to ensure appropriate referral and provision for individuals with co-morbid substance misuse and mental illness
- two consultants already work with adolescents with substance misuse and co-morbid mental health problems. These consultants should have full multidisciplinary teams. Two additional teams should be provided to ensure provision of one team per 1 million HSE region to serve this group.

Mental health services for people with eating disorders

- one multidisciplinary CMHT per HSE region for adults (a total of four nationally)
- these teams to work closely with the general adult CMHTs and primary care to provide advice and support for cases being treated at these levels of the mental health system
- six beds in the regional in-patient unit should be available to these teams
- a national tertiary referral centre for children and adolescents with a full multidisciplinary team should be developed

Liaison mental health services

- one multidisciplinary liaison team per Regional hospital (roughly one per 300,000 – 13 nationally)
- two multidisciplinary teams providing a national neuropsychiatry service
- one national neuropsychiatric unit with six to ten beds
- one perinatal mental health resource to be provided in a national maternity hospital