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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Human Rights Council Thirty-fifth session 6-23 June 2017

The International Covenant on Economic, Social and Cultural Rights provides a legally binding framework for the right to the highest attainable standard of mental health[1]. That is complemented by legal standards established, among others, by the Convention on the Rights of Persons with Disabilities[2], the Convention for the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child[3] states parties have an obligation to respect, protect and fulfil the right to mental health in national laws, regulations, policies, budgetary measures, programmes and other initiatives.

The right to mental health includes both immediate obligations and requirements to take deliberate, concrete, targeted action to progressively realize other obligations[4]. In terms of the right to mental health, that translates into the development of a national mental health strategy with a road map leading away from coercive treatment and towards equal access to rights-based mental health services, including the equitable distribution of services in the community. For care to comply with the right to health, it must embrace a broad package of integrated and coordinated services for promotion, prevention, treatment, rehabilitation, care and recovery and the rhetoric of "scaling up" must be replaced with mental health actions to "scale across". That includes mental health services integrated into primary and general health care, which support early identification and intervention, with services designed to support a diverse community[5].

The right to health requires that mental health care be brought closer to primary care and general medicine, integrating mental with physical health, professionally, politically and geographically. It not only integrates mental health services into mainstream health care, so they can be accessible for everyone, it ensures that entire groups of people who are traditionally isolated from mainstream health care, including persons with disabilities, receive care and support on an equal basis with others. Inclusion also comes with socioeconomic advantages[6]. Mental health concerns everyone and when needed, services should be accessible and available to all at the primary and specialized care levels.

Progress on A Vision for Change (AVFC) Policy.

In late 2016 the Department of health commissioned an evidence review to inform the parameters of the planned refresh mental health policy in Ireland ten years after the publication of A Vision for Change (AVFC). A number of sources provided material and evidence to inform a stock take of progress on mental health policy goals as articulated in AVFC. These include reports from statutory bodies such

[1] International Covenant on Economic, Social and Cultural Rights, art. 2 (1).
[2] Convention on the Rights of Persons with Disabilities, art. 25 (a) and (b).
[3] Convention on the Rights of the Child, art. 24, and Convention on the Elimination of All Forms of Discrimination against Women, art. 12.
[4] International Covenant on Economic, Social and Cultural Rights, art. 2 (1).
[5] Convention on the Rights of Persons with Disabilities, arts. 25-26, and J. Jaime Miranda and others, "Transitioning mental health into primary care", *The Lancet Psychiatry*, vol. 4, No. 2 (February 2017).
[6] Lena Morgon Banks and Sarah Polack, "The economic costs of exclusion and gains of inclusion of people with disabilities. Evidence from low and middle-income countries", London School of Hygiene and Tropical Medicine (2015), part B, sect. 3.

as the Mental Health Commission, reviews prepared by stakeholders such as Mental Health Reform, and relevant mental health and service statistics.

Overall, there is agreement across the stakeholders on the need for a lot more progress to make the vision of AVFC a reality, along with a range of views on the priorities for attention and the nature and scale of reform required.

The Mental Health Commission's Annual report for 2015 noted

- HSE Mental Health Division Operational Plans show services operating at about 75% of recommended staffing numbers in Vision for Change

- Much needs to be done to ensure the delivery of consistent, timely and high-quality services in all geographic regions and across the full range of clinical programmes and age groups".

- Continuing recruitment difficulties for specific specialist staff; this requires action as a matter of urgency

- Commission stresses the need for the continued development of community mental health services to replace traditional models of inpatient care

A number of other sectoral bodies have also presented their members' perspectives in various ways, including psychiatrists, GPs and psychiatric nurses. They indicate a certain degree of consensus on issues facing the mental health field in Ireland.

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A National Descriptive Evaluation Project PNA RCSI

In 2016 The Psychiatric Nurses Association of Ireland (PNA) commissioned the Faculty of Nursing and Midwifery, RCSI to explore the progress of implementation of the "Vision for Change" policy (Government of Ireland, 2006) as experienced by the members of the Psychiatric Nurses Association, (PNA), Registered Psychiatric Nurses (RPNs) who are practitioners within the mental health services in Ireland. **PHASE 1**

This project was a descriptive evaluative project which employed mixed (triangulation) methods (quantitative and qualitative). The project utilised an electronic survey questionnaire. The findings from the on-line questionnaire subsequently informed the collection of qualitative data through Focus Groups that were conducted regionally across the PNA branch network. Services from every county in Ireland participated in the study.

The findings indicated considerable support for a quality policy framework. However very significant concerns were identified that unambiguously demonstrated a lack of implementation or translation of the national policy into reality. The evidence reported indicated that what was identified as best practice in terms of mental health service development and provision has not been implemented in a significant, meaningful, or cohesive way. leading to many gaps in service provision this failure has very significant impact on the quality of mental health service and care available to the Irish public.

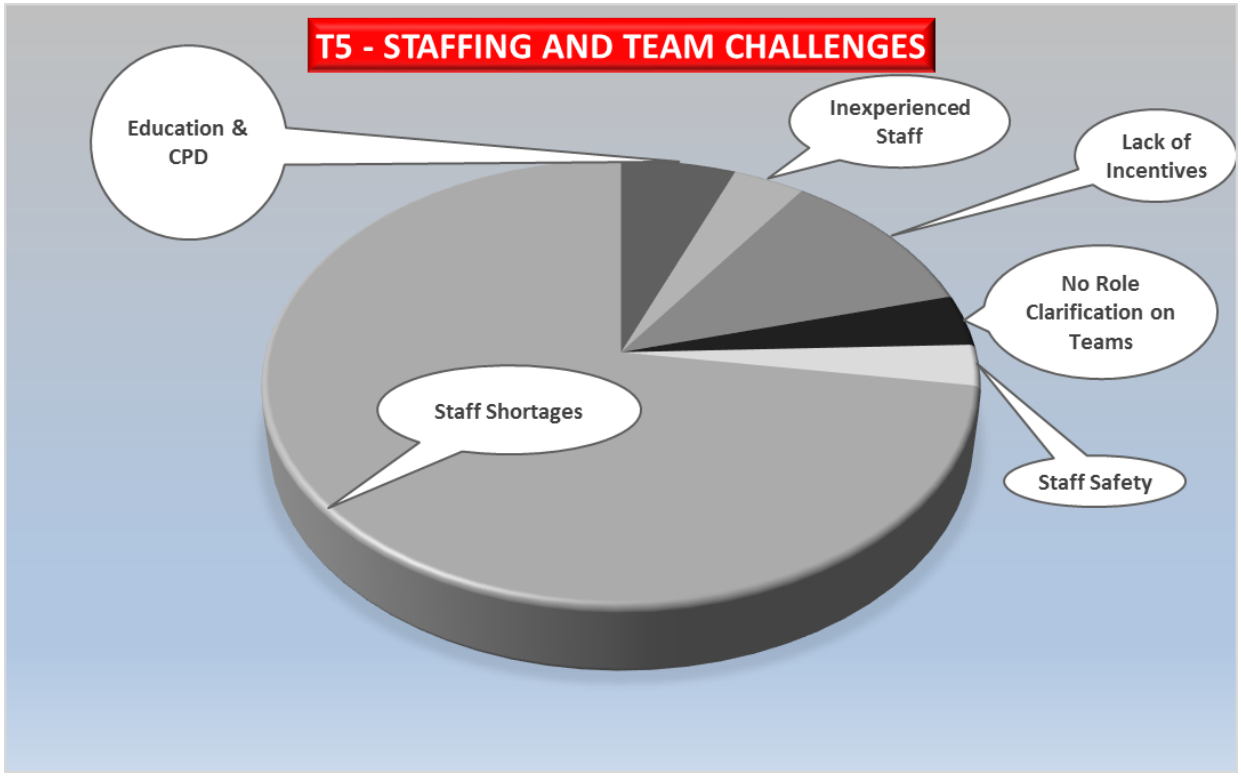
The study found that, while *A Vision for Change* (2006) recommended that the closure of traditional mental health institutions be accompanied by the provision of services in the community to which patients may be transferred, the failure to adequately resource the community-based infrastructure has led to a deficit in patient-appropriate options. This failure has led to a blockage of beds in acute

units and hostels and the placing of patients almost to wherever there is a bed rather than to a unit that best serves their particular needs.

The report of this study identifies deficits in specialist, outreach and crises service provision stemming from the failure to adequately resource the community-based infrastructure, as well as inequalities in service provision within and between regions.

While the study participants identified a multiplicity of prerequisites for the full implementation of A Vision for Change, their top three priorities were identified as: comprehensive staffing and resourcing of community-based services and increased crisis housing facilities inclusive of 24/7 crisis teams.

Staffing and Team Challenges Figure 1



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High level findings include:

- 67% of respondents indicated that they do not have a fully staffed community based multi-disciplinary rehabilitation and recovery mental health service.
- 3 out of every 4 respondents (75%) indicated that within their services they do not have fully staffed community based multi-disciplinary mental health services to ensure home based treatment is the main method of treatment delivery.
- Just 38% of respondents indicated that they have a fully staffed community based mental health teams within their adult mental health service.
- 66% do not work within a well-trained, fully staffed community based multidisciplinary community mental health team.
- While 78% of respondents have access to in-patient admission facilities, 45% did not have access to 50 beds per catchment area. (The challenge reported nationally is access due to occupancy of over 100% within the acute in-patient units, delayed discharges which are primarily attributed to a lack of alternative community based facilities, a lack of rehabilitation beds, a lack of availability of crises or step-down beds and a lack of regional ICRU services.)

Crisis Intervention/Outreach Services:

The most significant service deficiencies are the lack of crises services, assertive outreach and ICRU services.

- 74% of respondents do not have access to a crises house service based on the VFC framework.
- 79% said that their service did not have an Assertive Outreach Team based on the VFC framework.
- A further 40% indicated a lack of access to residential units within the recovery and rehabilitation service.
- 73% of respondent's report that their services do not have access to regional ICRU beds

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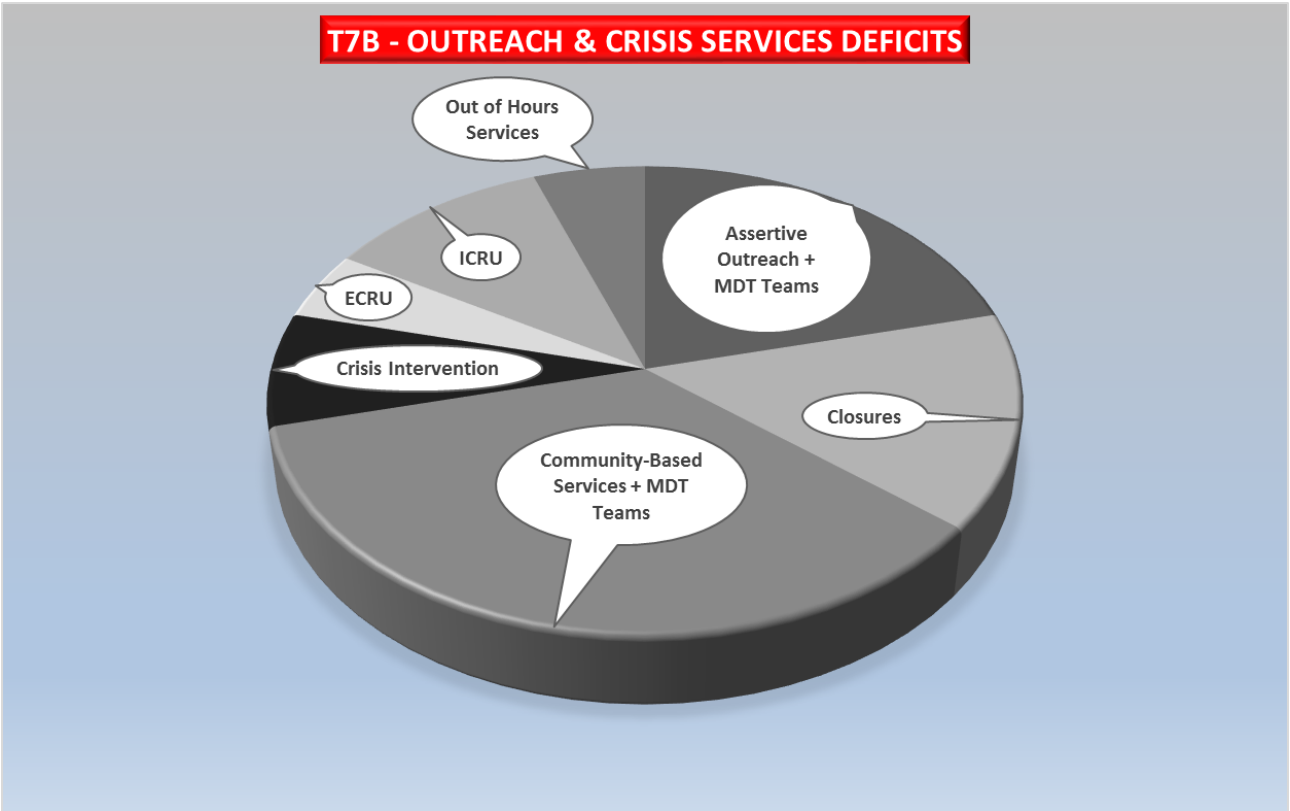
Deficits in Assertive Outreach and Crisis Services Figure 2



Severe staff shortages emerged as the most striking deficiency in the functioning of the mental health services, impacting on all levels of service provision -this theme continued in 2017 when Phase 2 of this study was undertaken to evaluate the impact of A Vision for Change (2006) (VFC). The purpose of this **second phase** was to map the current specialist services available in full or part at regional level relative to the VFC such as Child and adolescent Mental Health Services (CAMHs), addictions services and other specialist areas of practice on service provision.

Participants clearly identified and linked 15 deficits in Child and Adolescent Mental Health Services (CAMHS) that directly impact on CMHTs mostly underpinned by staff shortages. Figure 2 shows the deficits cited.

****of note figures reported in February 2017, cited 2,520 on CAMHs waiting lists, -an increase of 44% in one year, 10% waiting more than 12 months.*

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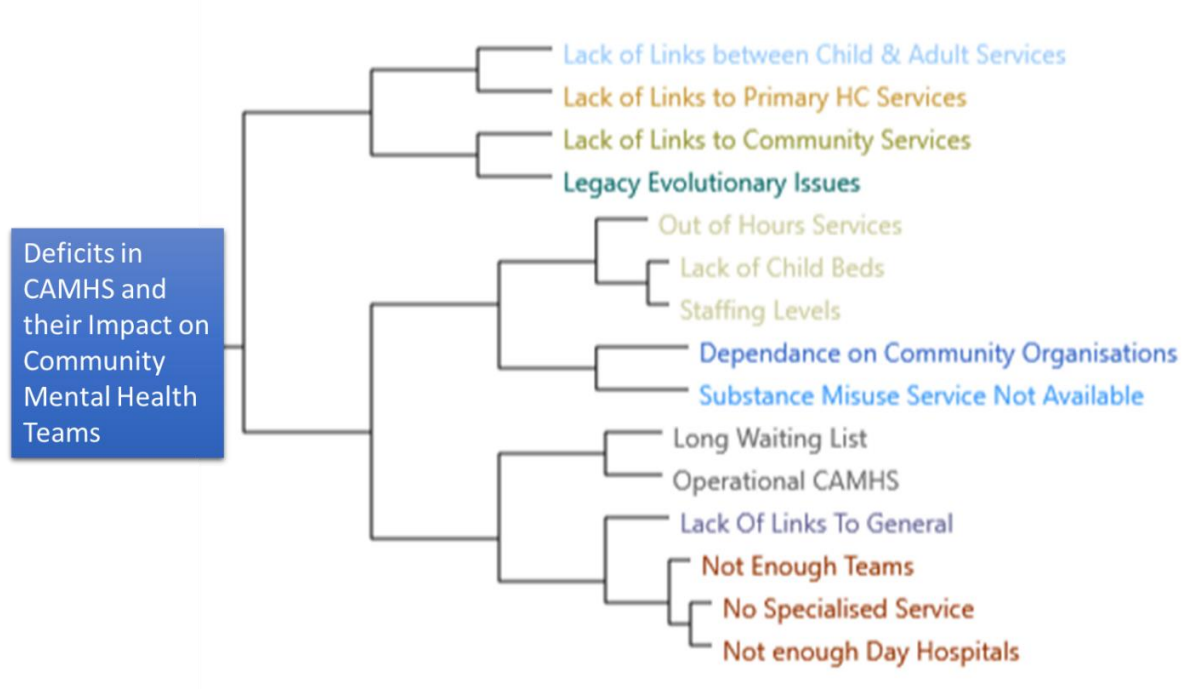
CAMHS CMHTs Deficits Table 3

CAMHS CMHTs Deficits	Focus Groups Contributing	Contributions Made
	7	161
Staffing Levels	7	33
Lack of Child Beds	7	24
Not Enough Teams	5	20
Out of Hours Services	5	18
Lack of Links to Primary HC Services	2	10
Lack of Links between Child & Adult Services	4	9
Substance Misuse Service Not Available	2	9
No Specialised Service	5	9
Not enough Day Hospitals	5	8
Legacy Evolutionary Issues	2	7
Lack of Links to Community Services	1	3
Dependance on Community Organisations	2	3
Long Waiting List	3	3
Lack Of Links To General	3	3
Operational CAMHS	2	2



Six of eight focus groups described mental health services provision for ID patients to be non-operational in their location. Seven focus groups reported non-operational or dysfunctional or partly functional mental health services being available in the context of forensic services to this vulnerable group leading to inappropriate placements. Lack of specialist services, shortage of teams, lack of staff and beds, a dependence on external services and poor liaison between mental health and ID services were cited as the causes of such services being inadequate and certainly non-operational in the context of VFC.

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ID MH CMHTs Deficits Table 4

ID MH Services	Focus Groups Contributing	Contributions Made
	8	133
Non-operational ID MH Service	6	22
No Specialist Service	6	20
Not Enough Teams	5	16
Lack Of Beds	5	15
Lack of Staff	4	12
Dependance on External Services	6	10
Lack Of Liaison Between MH Services and ID Services	5	9
No CAMHS	4	8
Lack of Funding	4	6
Liaison Between MH Services and ID Services	2	5
Lack Of Day Hospitals	3	4
Public Access	1	4
ID Services Available	2	3
Long Waiting Lists	2	2

The concept of inappropriate placements cited in the discussion on child and adolescence mental health service repeated itself in the dialogue concerning forensic services. As with other services, the reasons outlined for this gap between VFC and the current status of mental health service provision included: no specialised services, lack of beds, conflict between prison and mental health services, complete absence of forensic services in some locations, and lack of staff. No regional group reported fully operational forensic services as being available in their area

The single biggest recurring issue concerning homeless mental health services provision was lack of discharge support, creating a dependence on community organisations which was ad-hoc at best.

The biggest concern expressed when discussing provision of services for substance misuse patients was the lack of cohesion between addiction and mental health services leading to an over dependence on external services caused by lack of staff, lack of teams and lack of specialist services.

Substance Misuse MH Provision Deficits Table 5

Substance Misuse MH Provision	Focus Groups Contributing	Contributions Made
	8	81
Lack of Cohesion Between Addicion and Mental Health Service	4	15
Dependance on External Services	4	11
Lack of Staff	4	10
Lack of Teams	5	10
No Specialist Service	3	10
Operational Substance Misuse Service	3	8
CAMHS Service Not Available	3	5
Lack of Links with Primary Care	2	4
Service existed Priour VFC	3	4
No Substance Misuse Service	1	2
Detox Service	1	1
Lack of Links with Forensic Service	1	1

The combined effect of lack of beds, lack of staff and lack of specialised services rendered four of the eight focus groups to declare their location to be non-operational when it came to eating disorder mental health service provision.

Eating Disorders MH Provision Deficits Table 6

Eating Disorders MH Provision	Focus Groups Contributing	Contributions Made
	8	108
Lack of Beds	7	22
Non-operational Eating Disorders MH Provision	4	21
Lack Of Specialised Service	5	17
Lack of Staff	6	14
Public Access to Specialised Services	4	13
Not Enough Teams	5	11
Dependance on External Services	2	3
No CAMHS	2	2
Partial Eating Disorders	1	2
Lack Of Resources	1	1
Long Waiting List	1	1
No Out Of Hours Service	1	1

Conclusion

The report concludes that unless the community-based mental health service is fully staffed and resourced the system will continue to malfunction and fail to meet the needs of its users, people with mental health needs and mental illness, an already vulnerable cohort in Irish society.

The Mental Health Division Operational Plan 2017[7]

The Mental Health Division Operational Plan 2017 sets out the framework and actions that Mental Health services will put in place over the course of the year. It also identifies areas of increasing demand for mental health services, particularly among those aged >65 and < 25 and identifies the more specific potential risks to the delivery of this Operational Plan for Mental Health Services.

These include:

- The capacity to recruit and retain a highly-skilled and qualified medical and clinical workforce, particularly in high-demand areas and specialties.
- The capacity to exercise effective control over pay and staff numbers in the context of safety and quality, regulatory, volume and practice driven pressures.
- The budget and staffing assigned to Mental Health provides for an expected level of service demand. There is a risk that continued demographic pressures and increasing demand for services will be over and above the planned levels thus impacting on the ability to deliver services.

[7] Mental Health Division Operational Plan 2017

- The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information systems constraints.
- The capacity for programme management and change management of the mental health services due to both a shortage of these skill sets and the need to continue to deliver "business as usual" i.e. our core services.

The Workforce plan represents the current challenges faced by the MHD such as the potential for additional budget constraints, increased workload, rising costs, employee recruitment and retention, and the transfer of organisational knowledge. The greatest internal challenge that faces the Mental Health Division workforce is to recruit new talent while retaining current staff to support the transformation underway in the division.

Recruiting and retaining motivated and skilled staff remains vital for the delivery of increasingly demanding and challenging mental health services to an expanding and varying demographic population. This challenge is even greater now as the Health Reform Programme requires significant change management, organisation redesign and organisational development support.

Mental Health Nursing Workforce Position

MH Nursing	Dec 11	4,813
	Dec 12	4,628
	Dec 13	4,572
	Dec 14	4,591
	Dec 15	4,705
	Dec 16	4,755

Mental Health Division Operational Plan 2017[8]

In reply to parliamentary questions from Fianna Fáil Deputy James Browne, the HSE said there were 10,815 members of staff in mental health services in Ireland August 2017 about 78pc of the recommended staff level set out in 2006 A Vision for Change (AVFC) which set out to overhaul mental health policy nationally. The HSE figures reveal that only 93 new staff were recruited this year despite soaring demand in all areas of mental health services.

The Vision for Change programme set out, 10 years ago, a need for 12,778 members of staff to work in the area.

In May 2017 the Minister for Mental Health Helen McEntee TD referred to "The biggest challenge in that is the staffing numbers. *"Funding is not really the issue, we could have €100m allocated tomorrow but if you don't have the trained staff then you're going to have to try and spend it elsewhere,".*

[8] Ibid

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