The Report

1. Introduction

1.1 This report is an evaluation, conducted in accordance with the guidance for Value for Money and Policy (VFMP) Reviews[3], of the efficiency and effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services in Ireland.

Setting the Scene

1.2 The World Health Organisation (WHO) estimated that 450 million people worldwide experience mental health difficulties[4] or that one quarter of those using health services have a mental health problem, many of which are undiagnosed. Mental health problems are among the most important contributors to the global burden of disease and disability. Of the ten leading causes of disability worldwide, five are psychiatric conditions: univocal depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia and obsessive-compulsive disorder[5]. It is essential therefore that Ireland should have a quality and responsive mental health service.

1.3 Mental health services in Ireland began in the 18th Century with the establishment of the first asylums, one in Dublin, St Patrick's founded by Dean Swift and one in Cork, founded by Dr William Saunders Hall Aran. The Prisons Act of 1787 established four lunatic wards in the Houses of Industry; one each in Dublin, Cork, Waterford and Limerick, and also established the concept of inspection of mental health service under the Inspectors General of Prisons. The 19th Century began with a recommendation in 1804 for the building of four provincial asylums in Ireland, each to have 250 beds. Legislation was enacted to establish asylums for the "lunatic poor" in Ireland.

1.4 The common view at that time was that insane people should be sent to asylums, where most would have to stay for life. If necessary, individuals were treated under compulsion and detained. Even at this early stage, concern over wrongful detention was identified, although for the purpose of protecting the sane rather than for the benefit of the service users. The Mental Treatment Act 1945 put the treatment and delivery of services to people with mental health problems on a statutory basis. The establishment of the Mental Health Commission and Inspectorate by the Mental Health Act 2001 strengthens this legislative position in respect of delivery of service and the Quality Framework[6] firmly places the need to deliver quality services on the agenda.

Irish Mental Health Services

1.5 In the context of this evaluation, Long-Stay Residential Care is defined as individuals using residential mental health services in hospital, rehabilitation settings, supported accommodation, group homes and HSE provided independent living, for more than one year and one day. *'A Vision for Change' (2006)*[7] - further defines the main categories of long stay individuals as:

[3] Department of Finance, 2006
[4] WHO 2003
[5] Liimatainen & Gabriel 2000
[6] Mental Health Commission 2007
[7] Department of Health and Children 2006

Long-stay in-patients	Individuals who have been continuously in mental hospitals for prolonged periods of a year or more.
Discharged long-stay service users	Individuals who were previously discharged from long-stay wards and who now live in staffed community residences or supported housing in the community.
New long-stay service users	Individuals who, in recent times, have passed from acute to long-term care. Some have been retained in hospital for long periods because of the nature and severity of their illness. Some are long-stay on acute units, though in some services they are transferred to long-stay wards.

1.6 In an era of significant change, mental health services in Ireland are driven by a variety of factors such as funding, treatment developments and international mental health best practice standards, as well as through national strategic planning dating from the *Report of the Commission of Inquiry on Mental Illness* (1966), *Planning for the Future* (1984) and *A Vision for Change* (2006). A substantial transformation in Irish mental health services has taken place, requiring an examination of the range of services provided in the light of changing demographics[8], needs and focus. Service providers have an increased responsibility to ensure service provision achieves its objectives and meets the criteria of equity, accessibility and quality, in a cost effective way. These four performance attributes are essential parts of the Value for Money and Policy agenda for the mental health services.

1.7 Ireland is in a unique position in the world of having a smaller population today than in the 1800s, (approximately 7 million before 1845), based on national census figures. The current demographic trend between 2002 and the 2006 national census shows an 8.1% increase in population growth from 3,917,203 to 4,239,848[9] with regional increases of 6.7% in Dublin Mid Leinster, 11.5% in Dublin North East, 7.7% in the South and 7.3% in the West[10].

1.8 This growth in population places increased burdens on service providers and requires exploration of the ways in which current services are provided. Long stay residential care is delivered in a variety of settings crossing both community and in-patient. This evaluation report contributes to the consideration of the degree to which previous policies have been implemented and identifies current gaps in service provision, as measured against the objectives set out in '*A Vision for Change*' (2006).

Terms of Reference for the Evaluation

Value for Money and Policy Initiative

1.9 The VFMP Review Initiative is part of a framework introduced to secure improved Value for Money from public expenditure. The objective of the initiative is to analyse Exchequer spending in a systematic manner and to provide a basis on which more informed decisions can be made on priorities within and between programmes. VFMP Reviews are undertaken under

[8] The population as per the 2006 census of 4,239,848 is an 8.1% increase from 2002
[9] 2006 census data
[10] Mental Health Commission 2006. Note: These are the four regions used for mental health services.

the aegis of steering committees which are representative of the Departments/Offices managing the programme areas being reviewed.

Scope of the Evaluation

1.10 The evaluation focused on long stay mental health service users whose placement costs were fully or partially met by the mental health services, including within the forensic services. It evaluates the current provision of service to long stay residents within mental health services in line with these Terms of Reference and explores the way forward for the development of services within a Value for Money and Policy framework.

Resources scope

1.11 Hospital based services include long stay wards, as well as individuals on acute admission wards who meet the definition of long stay. Community based services are divided into High, Medium and Low Support environments. A snapshot of the scale of 2006 expenditure covered by the evaluation and of the key resources involved in the provision of long stay residential mental health care on 10 October 2007[11] is summarised below (Table 1-1). The €249 million identified in this review focuses solely on the provision of long stay residential care; an estimated €238 million can be allocated to the provision of acute in-patient care which was excluded from the terms of reference of this review.

	€Million		
Nursing, Care and Household Staff	*217*		
Other (including HSE and Non HSE Staff)	*2*		
Total Pay Costs	**219**		
Total Non Pay Costs	**30**		
Total Cost of Service	**249**[12]		
Total Community Bed Numbers	**2,790**	**Total In-patient Beds**	**1,919**
High Support	1,613	In-patient Long stay	1,439
Medium Support	547	High/Dependency/Secure	181
Low Support	630	Rehabilitation	299
Total WTE Nursing, Care and Household Staff	**3,707**	**WTE – Other**	**18.18**
Clinical Nurse Manager 3	4	Consultant Psychiatrist	5.51
Clinical Nurse Manager 2	468	NCHD	5.63
Clinical Nurse Manager 1	138	Allied Health Professionals	7.04
Registered Nurse	2,066		
Healthcare Assistant	374		
Household Domestic	657		

WTE = Whole Time Equivalent staff numbers

Table 1-1: Resources Profile

Strategy scope

1.12 The current reference policy document '*A Vision for Change*' (2006) "details a comprehensive model of mental health service provision for Ireland" and "proposes a holistic view of mental illness and recommends an integrated multi-disciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems[13]". '*A Vision for Change*' (2006) focuses on the delivery of care in the most appropriate environment

[11] This review conducted a census of services on this date.
[12] This includes the costs of €18.6 Million associated with the Central Medical Hospital but excludes central overheads, superannuation. See also Footnote 2
[13] Department of Health and Children, 2006

to meet the needs of the clients/service users. It outlines the objectives of all care, including long stay mental health care, advocating the key concepts of a dignified, inclusive, and recovery based model of care for people with mental health problems. It recommends that steps be taken to bring about the closure of all mental hospitals and to re-invest the resources released by these closures in a community-based mental health service.

1.13 The HSE has initiated a service wide strategy to fully implement '*A Vision for Change*' (2006). This includes the establishment of a national implementation group, with representatives of all the key stakeholders and subsequent groups at administrative area level with representatives from all mental health catchment areas. In the future, the implementation plan for "*A Vision for Change*" (2006) may change to reflect any structural changes within the HSE.

Locations scope

1.14 As the implementation of *'A Vision for Change'* (2006) is the benchmark by which mental health services will be measured into the future, its recommendations are reflected throughout this evaluation. There are 31 mental health catchment areas divided across four administrative areas (Table 1-2), with the Central Mental Hospital (CMH) providing a national service that falls under the management structure for Primary Community Continuing Care (PCCC).

HSE Dublin North East	**HSE Dublin Mid Leinster**	**HSE South**	**HSE West**
Louth Meath	Dublin South (Former Area 3)	Carlow Kilkenny	Limerick
Dublin North West (Former Area 6)	Dublin South East (Former Area 2)	Kerry	Roscommon
Cavan Monaghan	Dublin South West (Former Areas 4 and 5)	North Cork	Galway East
Dublin North (Former Area 7)	South County Dublin (Former Area 1)	South Lee	Galway West
North County Dublin (Former Area 8)	Kildare and West Wicklow (former Area 9)	North Lee	Sligo Leitrim
	East Wicklow (Former Area 10)	South Tipperary	Donegal
	Laois Offaly	Waterford	Clare
	Longford Westmeath	Wexford	Mayo
		West Cork	North Tipperary**
Central Mental Hospital			
** North Tipperary is in HSE West Region but Long stay services are provided by South Tipperary in HSE South.			

Table 1-2: Locations of Service

Evaluation Criteria

1.15 The Terms of Reference establish the evaluation criteria which are the specific evaluation questions/issues that the evaluation seeks to address. These questions, and the report chapter where they are considered, are set out in Table 1-3.

Chapter	Title	Evaluation Terms of Reference
2	Service Objectives	Identify the objectives of the provision of Long Stay Residential Care
3	Service Effectiveness	Examine the extent to which, and the effectiveness with which, those objectives have been achieved in terms of overall quality and costs and the necessity for continuation
3	Service Effectiveness	Identify the level and trend of outputs, associated with the provision of Long Stay Residential Care and thus comment on the efficiency with which it has achieved its objectives.
4	Service Resources	Identify the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care.
5	Future Funding and Alternative Approaches	Examine the current validity of those objectives in light of the current changes in health service provision and their compatibility with the overall strategy of the Department of Health and Children, the Mental Health Act 2001, '*A Vision for Change'* (2006); other relevant Government and EU policies and strategies and currently available evidence based practice. Evaluate the degree to which the objectives of the provision of Long Stay Residential Care warrant the continued allocation of public funding. Examine and evaluate likely alternatives to the provision of Long Stay Residential Care in achieving these objectives on a more efficient and/or effective basis, e.g. through international comparison and making use of all potential synergies with other services.
6	Key Performance Indicators	Specify potential future performance indicators that might be used to better monitor the performance of Long Stay Residential Care for Adults within Mental Health Services.

Table 1-3: Evaluation Criteria

Evaluation Approach

1.16 A full description of the methodological steps is set out in Appendix 2. The main activities of the evaluation are summarised below. A National VFMP Steering Committee was established and under this committee, a specific evaluation steering group was formed to carry out this evaluation (Appendix 1). The evaluation was managed by a project team who reported to the steering group. The evaluation was conducted in accordance with a plan detailing the scope of the evaluation that was developed by the project team and agreed by the steering group.

1.17 A national audit of both residential mental health services (in-patient and community) and the individuals who use them and who meet the criteria of the evaluation was conducted in October 2007. A written questionnaire[14] was developed in consultation with operational Mental Health Services, the Vision for Change Implementation Group and the National Mental Health Steering Group. It was divided into three parts covering Low, Medium and High Support Accommodation; Long Term Residents in In-Patient Facilities; and Long Term Residents funded in Non-HSE Facilities.

1.18 The questionnaire on Long Term Residents funded in Non-HSE Facilities captured details of contracted placements and discharge trends due to ward/unit or facility closures over

[14] The results of the questionnaire are reported in the charts used in this report.

a five year period (2002-2006). It was circulated between 27th September 2007 and 1st October 2007 with a service user census date of 10th October 2007 and a return date of 15th of November 2007. A response rate of 100% was achieved by the end of February 2008.

1.19 A small project team[15] conducted extensive background literature reviews to establish likely alternatives to current provision, examined relevant reports and strategy documents and analysed income and expenditure. Secondary data sources were supplemented by consultation with the Department of Health and Children (the Department), Local Health Managers, Administrators and Service Area Managers. International comparators were obtained through liaison with experts from New Zealand and the USA. A statistical analysis company[16] was employed to produce a summary of all data captured from each question within each questionnaire in tabular format. The review was independently assessed and validated by an external consultant[17]. (See Appendix 5: Independent Assessor's Report)

Deviations from the Department of Finance Guidelines for VFMP Reviews

1.20 This is the first VFMP review that has been attempted for aspects of the provision of mental health services. In approaching the review, the steering group was aware of the limitations (see below) that existed in data availability and in the establishment of measurable results driven targets for the activities covered by this evaluation. Accordingly, the review report has been written in the style of a descriptive evaluation. This approach examines the recent improvements in strategy and assesses the data collected from the census and questionnaire for the purpose of reaching conclusions and providing recommendations that will propose suitable baselines for future consideration of VFM performance issues. The descriptive approach also supports recommendations for the improvement of systems.

1.21 Expenditure is recorded in most services as total expenditure for the services. There are limited or no systems in place to give a detailed breakdown of expenditure to specific unit level. This lack of a detailed approach to financial data management at unit level forced the evaluation to take a bottom up approach and the evaluation focus is based on a cost analysis. The fact that costs are not broken down means those "corporate" costs such as superannuation, high level administrative and clinical costs cannot be applied to a unit level. This issue is discussed further in Chapter 3.

1.22 It was also difficult to consider the effectiveness of long stay residential mental health care (Chapter 4) in terms of measurable outcomes for individuals who use the service, as trends were not firmly established. Effectiveness is best measured by a combination of the outcomes, structures and systems that are in place to deliver it. Notwithstanding the above, a 100% return rate from the census, allied to cross checking of averages used, relief rates and pay scales applied, ensures sufficiently reliable data quality to support the findings of the report. While steps were taken to both improve and verify the accuracy of the data collected, the findings of the evaluation are limited by the level of information available. The lack of a single consistent approach to financial data management across mental health services has made it difficult to compare like with like. At times, it was necessary to use averages based on returns from areas where more detailed records were held and apply these to form a national picture.

[15] Led by Mr Declan Mangan.
[16] Insight Statistical Consultants
[17] Mr Michael Griffin, Petrus Consulting Limited

Summary

In 2006, the expenditure on long term residential care in the mental health services was in the region of €249 million. This first evaluation of these services reveals considerable regional variations in the provision of services from the different perspectives of financial allocations, staff allocation, non-pay expenditure, locations and accessibility of services. All long stay care units, both in the community and in-patient facilities, fell within the scope of this review.

2. Service Objectives

> *When service users always receive exactly the care they need at the appropriate time, healthcare will have achieved its ultimate altruistic goal - the holistic, humanistic and seamless integrated health care delivery system. (Taylor and Pinczuk, 2005)*

2.1. This Chapter is concerned with identifying and examining the objectives of the provision of Long Stay Residential Care.

Historical policy developments

2.2. The key objective of all mental health care is to enable people to achieve their optimum level of mental health, specifically by providing appropriate treatment to any individual with a healthcare need in an appropriate environment. Brennan (2008) identifies that "in the 1950s there were 21,720[18] "mentally ill" persons resident in institutions in the Republic of Ireland. An analysis of available data in the 1950s for 84 countries places Ireland first with 710 psychiatric beds per 100,000 of population, second highest was the USSR with a rate of 618 beds per 100,000 population." Developments in treatment options since that time have enabled a change in focus for mental health service users, offering alternatives to hospital based care.

2.3. A key objective of all subsequent policy documents has continued to be a reduction of in-patient bed numbers. The Commission of Enquiry on Mental Illness recommended a reduction in the number of in-patient beds. The number of beds had been reduced from 18,084 in 1958 to 3,389 in 2006. 'A Vision for Change' emphasises closing psychiatric hospitals and providing care in the community.

2.4. The current policy document, '*A Vision for Change*' (2006), was developed in consultation between all of the key stakeholders, and offers a blue print for mental health services over the next 10 years. *'A Vision for Change'* (2006) is the accepted strategy based on the recommendations of the expert group and will be the driving force in mental health care policy and delivery into the future. The report of the Independent Monitoring Group in 2008 identifies that while some recommendations have been prioritised for implementation, there is little progress towards the full implementation of the majority of the recommendations of *'A Vision for Change'*. It is anticipated that by the end of 2008 a comprehensive implementation plan will be available.

Objectives of Long Stay Residential Mental Health

2.5. The key objectives of long stay residential mental health services, are set out in *'A Vision for Change'*, as follows:

- To provide alternatives to long-stay hospitalisation, and facilitate a reduction in in-patient bed numbers.
- To develop a policy of Social Inclusion and reduce the stigma of mental illness.
- To develop a rehabilitation/recovery model.
- To deliver appropriate cost effective and efficient services.

[18] 11,207 males and 10,513 females

- To provide accessible services in appropriate locations.

Examination of the Objectives

Provide an alternative to long-stay hospitalisation, and facilitate a reduction in in-patient bed numbers

2.6. The objective for alternative provision is supported by the following directly measurable targets:

Indicator	Measurable target
Staffed Residences	Three 10-bedded units per 100,000 population
Continuing Care Challenging Behaviour	300,000: 30 beds
Intensive Care Rehabilitation Care Units	1,000,000:30 beds
High support intensive care residence	1,000,000:20 beds

Table 2-1: Capacity targets in 'A Vision for Change'

2.7. The current structure of long stay care provision does not reflect the above targets set out in *'A Vision for Change'* (2006). Unless a radical overhaul of care in community residences is undertaken, there is a risk of achieving trans-institutionalisation rather than de-institutionalisation. A lesson learned from international experiences of mental health services is that any move towards a non-hospital based service, which enables individuals who use the service to achieve an optimum level of independence, is absolutely reliant on the availability of the appropriate support services. These would include Assertive Outreach, Rehabilitation and Home Based Treatment teams, working alongside generic community mental health teams and appropriate inpatient/residential services. '*A Vision for Change*' (2006) identifies key developments necessary to deliver a 21st century mental health service to those people who require long stay mental health care. For the success of any mental health strategy moving forward, it is of utmost importance that the recommendations in '*A Vision for Change*' (2006) are implemented fully. The implementation structure for '*A Vision for Change*'(2006) is detailed in appendix 3.

Develop a policy of Social Inclusion and reduce the stigma of mental illness.

2.8. A second objective of the provision of long stay mental health care is to promote social inclusion and eliminate the stigma of mental illness. The effects of stigma can be more debilitating than the illness itself. Stigma represents a significant public health concern, and is a major barrier to care seeking or ongoing treatment participation.

2.9. The ethnic and religious make up of the Irish population has changed significantly. The 2006 Census recorded that there were over 164,000 residents from other European Union[19] (EU) countries and a further 174,000 residents from non-EU countries in Ireland. A further 271,000 were from the United Kingdom (UK) and an additional 22,400 were from the Irish Travelling community. It is essential that the long stay residential mental health services are in a position to cater for the needs of an increasingly diverse population.

[19] Excluding the United Kingdom

2.10. The social inclusion objective includes involving individuals who use mental health services (key stakeholders) in meaningful ways. This involvement extends to residents committees and residents meetings. Residents' involvement means not only being consulted on the development of their individual Care Packages, but of equal importance, that individuals who use the services are involved at a strategic level in developing and expanding services. Charts 1 and 2 show that there are differences in the level of involvement in the areas surveyed, particularly for in-patient residents meetings. This data provides a useful baseline for tracking future achievement of this objective. A measurable target for residents' involvement should be set for the medium term.

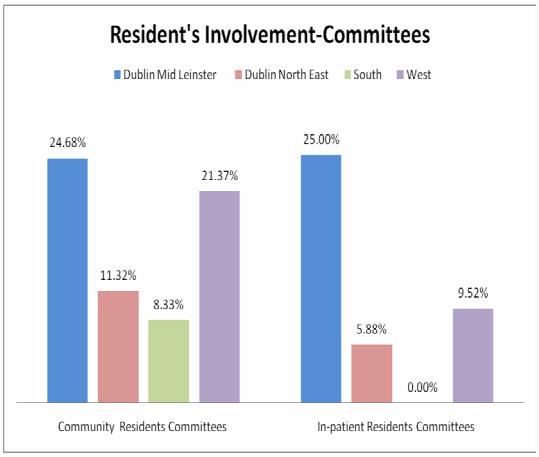

Chart 1

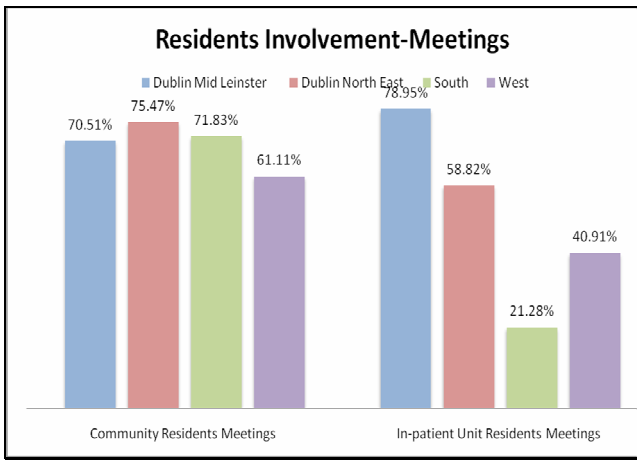

Chart 1A

2.11. In 2007, as part of a joint study, the Mental Health Commission and the Health Research Board published a survey entitled "Happy Living Here" which reflected the experiences of a number of individuals who use high support accommodation across a limited number of Mental Health Catchment Areas. This survey provides useful data to support this objective but a broader census of individuals who use the services would provide a better baseline to inform future planning of the development of services.

Facilitate the use of a rehabilitation/recovery model

2.12. Recovery has been introduced as a key objective of the provision of mental health services. Davidson et al (2005) have defined recovery in two ways:

> "amelioration of symptoms and other deficits associated with the disorder to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social, and vocational activities within what is considered a normal range"; and
>
> "overcoming the effects of being a mental patient—including poverty, substandard housing, isolation, unemployment, loss of valued social roles and identity, loss of sense of self and purpose in life, and iatrogenic effects of involuntary treatment and hospitalisation—in order to retain or resume some degree of control over their own lives".

2.13. '*A Vision of Change*' (2006) identifies recovery as "the belief that it is possible for all service users to achieve control over their lives, to recover their self esteem and move towards building a life where they experience a sense of belonging and participation". It goes on to state that commitment to the principle of recovery is critical to the specialist mental health rehabilitation services.

2.14. Mental health service providers need to be clear in the distinction between their expectations of what constitutes recovery and the level of recovery achievable by individuals who use the service. The future success of any model of long stay mental health care will be measured in terms of its achievements within a recovery model. The Mental Health Commission (2007) produced a resource pack focusing on "translating principles (of recovery) into practice". This pack offers "A Vision for A Recovery Model in Irish Mental Health Services".

2.15. The separation of health care and social care can lead to conflicts over funding and increased tensions between the demands for care for those with mild mental health problems and for those who are more severely mentally ill, as experienced in the UK model of care. Where there is a lack of appropriate community services such as rehabilitation teams and assertive outreach teams, or appropriate accommodation either in-patient or community the lives of chronically mentally ill service users have not improved much. This will invariably contribute to the revolving door syndrome common to all community based mental health service. The result is most resources are still allocated to institutional programs (Carling, Randolph, Blanch, & Ridgway, 1987).

Deliver appropriate cost effective and efficient services

2.16. The inclusion of an objective that specifically refers to the primary VFM issues of efficiency and cost effectiveness is recognition of the need to balance the pursuit of the desired social objectives within the limitations of the available resources. *'A Vision for Change'* recognises that effectiveness and efficiency needs to achieve a balance in service provision between the performance attributes of equity, accessibility, quality and cost effectiveness. This objective places a challenge for the organisation and management of the available resources to maximise the service outputs and results. At the time when *'A Vision for Change'* was produced, there was insufficient data to support the development of immediate measurable targets to support this objective. The provision of census data and the consideration of these issues in Chapter 3 and 4 of this report is intended to contribute to the effort to identify suitable measurable efficiency and cost effectiveness targets for the service.

Provide accessible services in appropriate locations

2.17. Confusion can exist in mental health services between appropriate accommodation and appropriate treatment centres, with the two apparently interchangeable. Support can be found for the argument that clients living in accommodation provided by healthcare providers have improved outcomes. However, an unforeseen outcome for service users is the effect of reducing the chances of an individual with a mental health problem being housed by their local authority, a right they have under the Housing (Amendment) Act 1950, as well as diverting financial benefits from clients[20]. Less than 5% of the current service user group are reported as receiving a rent allowance. This inequity in the benefit system can result in the increased reliance of individuals who have used mental health services, contributing to institutional behaviours. The exclusion of individuals with mental health problems from mainstream society can lead to the establishment of mental health ghettos, e.g. more than 50% of all community residences in one catchment area are located on the same street. '*A Vision for Change*' (2006)

[20] Clients accommodated in HSE owned buildings are not entitled to the same benefits they would have access to in private or council rented accommodation

argues that this lack of allowances diverts mental health funds away from providing mental health treatment and care.

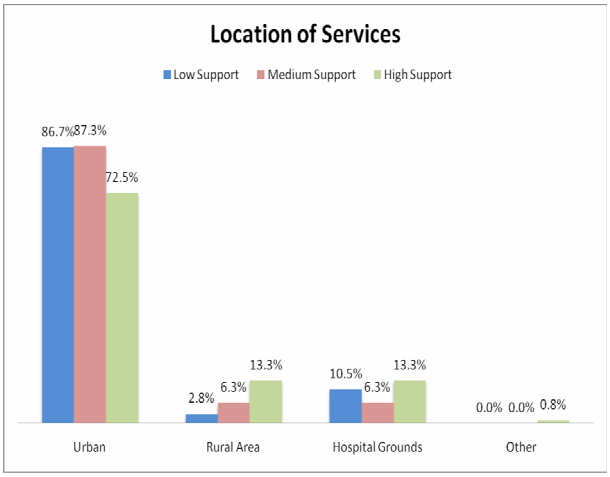

Chart 2

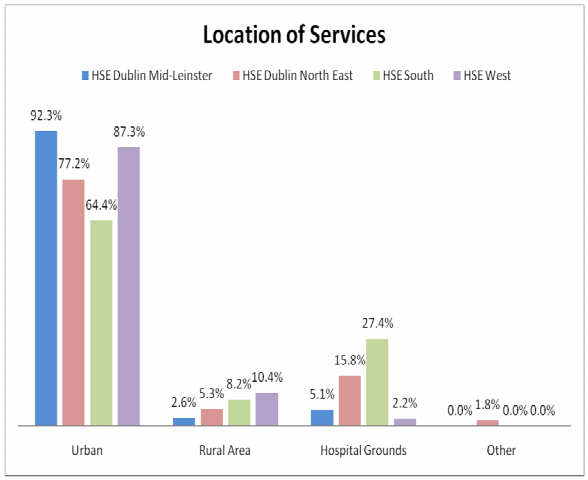

Chart 3

2.18. In Ireland, 81.9% of the current community provision is located in urban areas (Charts 3 and 4).

Conclusions

2.19. The impact of previous reports, such as the Commission of Enquiry on Mental Illness (1966) and Planning for the Future (1984), is evident in the way in which long stay services are currently delivered, with an increase in community based services from 1984 onwards. The launch of '*A Vision for Change*' (2006) puts Irish mental health services in the situation of not only being in a position to continue this situation, but also places an onus on all tiers of health care delivery to get it right. It is clear that the strategy laid out in '*A Vision for Change*' in relation to the provision of long stay residential mental health services, will not only deliver an efficient and cost effective service but will also to some degree, address the imbalance in current services and funding arrangements because proposed service levels are population based.

2.20. There is a clear, up-to-date set of objectives for the mental health services that reflect developments in treatment, legislation and policy over a number of years and which are in line with current international views of good practice. A key objective (in terms of accommodation provision) is supported by a measurable target but the remaining objectives, including a Value for Money objective for efficiency and effectiveness, do not have measurable targets. The objectives are set at a high level and are not supported by appropriate structures or joined-up through identification of linked results, activities and financial resources.