Mental Health Policy in Ireland 1984-2004: theory, overview and future directions

Brendan D Kelly

Ir J Psych Med 2004; 21(2): 61-68

Recent years have seen renewed emphasis on the importance of mental health policy as a key component of health and social policy at both national and international levels.[1] In 2001 the European Commission produced a public health framework for mental health in the EU.[2] In the same year, the World Health Organisation devoted its annual health report to mental health and called on countries to formulate, update and implement mental health policies.[3] The EU and WHO initiatives both recognised that the challenges facing mental health policy makers are increasingly transnational in scope, related to issues such as rapid demographic change, increased transnational migration, the protection of human rights and the implementation of a growing number of international laws, directives and protocols in relation to mental health care.

Significant progress has been made in the development of Irish mental health services over the past 40 years. Nevertheless, many challenges remain. The aims of this paper are to outline:

- Prevailing theoretical perspectives on mental health policy
- Mental health policy in Ireland since the last major policy revision in 1984
- Relevant economic and demographic changes in Ireland since 1984
- Relevant clinical, legislative and policy developments in relation to mental health
- Future directions for mental health policy.

Electronic literature searches were performed using Psyclit (American Psychological Association, 1887-2003), Medline (United States National Library of Medicine, 1985 – 2003), with broad search terms related to mental health policy. Additional books and papers were identified by tracking back through references and consulting with colleagues. Policy documents and selected literature on Irish psychiatric services were reviewed and related to recent literature on mental health policy.

Theoretical perspectives on mental health policy

Mental health policy comprises a set of principles and strategic plans aimed at reducing the burden of mental illness. A broad range of service components are required for the effective implementation of policy.[1] These can be divided into national components, supportive infrastructure components and service components.

Brendan D Kelly , MD MRCPsych, Senior Registrar in Psychiatry, National Forensic Psychiatry Service, Central Mental Hospital, Dundrum, Dublin 14, Ireland.

SUBMITTED: JUNE 18, 2003. ACCEPTED: MARCH 15, 2004.

Effective policy requires all of these components to function in a coherent, co-ordinated fashion to promote the delivery of high quality mental health care that is effective, equitable and acceptable. There is a wide range of stakeholders in the provision of such services, including service-users, carers, service-providers, public (governmental) bodies, voluntary (nongovernmental) organisations (NGOs), the media and various professional bodies. The formulation of a mental health strategy needs to take appropriate account of the interests, preferences and legitimate needs of key stake-holders throughout the process of policy development and implementation. Rogers and Pilgrim[5] emphasise the importance of a range of perspectives in the consideration of health policy, including:

- The economic perspective, examining the relevance of both micro-economic and macro-economic factors
- The political science perspective, which forms a bridge between economic and sociological analyses
- The sociological perspective, which can be used to explore and explain differences of ideology and emphasis in different forms of policy analysis
- The epidemiological and public health perspective, which provides data on the prevalence and incidence of mental illness and measures likely to help address these
- The perspective of comparative sociology, which engages with varied models of health care and health policy drawn from different countries, in order to better inform strategy development in mental health care.[5]

Turning to the process of policy development itself, Bryson[6] has outlined several steps in public service strategy development which may be usefully applied to the development of mental health policy.[7] These include:

- Clarifying organisational roles and mandates
- Identifying the mission (eg. reducing morbidity and mortality, addressing stigma)
- Performing a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats)
- Defining key strategic issues, including both the consequences of action and those of inaction[7]
- Appropriate strategy, linking key actions to key objectives
- Adopting a strategic plan
- Implementing the strategic plan
- Evaluating the strategy.

As with all public policies, mental health policy is always developed in a particular social and political context, and will invariably be linked to other aspects of national health policy. In recent years, national health policies have started to take increasing account of a wide range of directives, recommendations and protocols issued by transnational organisations such as the United Nations,[8] the WHO,[3] the European

Commission[2] and the Institute of Medicine in Washington.[9]

In 1991, for example, the United Nations published its Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care .[8] These principles state that all persons are entitled to receive the best quality mental health care available and that care should be based on internationally accepted ethical standards. Despite problems with implementation,[10] these principles can usefully inform national mental health policy development and legislative reform in UN member states.

More recently, the WHO's World Health Report for 2001: Mental Health: New Understanding, New Hope contained 10 key recommendations aimed at improving the quality of mental health care around the world.[3] Recommendations included the provision of treatment in primary care settings, enhanced availability of psychotropic medication, improved educational initiatives, increased community involvement in mental health structures, the development of national mental health policies and increased research into mental health. Again, these guidelines, combined with local and national priorities in health care, can be used to inform the development of mental health services and strategies in both developed and developing countries around the world.

Mental health policy in Ireland

The Republic of Ireland has a population of approximately 3.9 million,[11] which is expected to increase to 4.4 million by 2015.[12] Ireland's health-care system is largely taxation-funded and is based on a mixture of public and private care.[13] While there is universal coverage for public hospital services, over 40% of the population buy private health insurance to cover the costs of private hospital care.[14]

Mental health care is provided through a network of community psychiatric teams, supported by dedicated psychiatric hospitals and inpatient psychiatric units located in general hospitals. In 2001 there were 24,446 admissions to Irish psychiatric hospitals or inpatient units, yielding a rate of 907 admissions per 100,000 population in that year.[15] In line with previous years, re-admissions accounted for 70% of all admissions.

Mental health policy in Ireland is currently based on a strategy document entitled 'The Psychiatric Services - Planning For The Future' published by the Irish Department of Health in 1984.[4] This policy directed that psychiatric services should be comprehensive and community-oriented, aimed at delivering care that is continuous, coordinated and multi-disciplinary. The population was divided into sectors, each comprising 25,000 to 30,000 individuals. Psychiatric care was to be delivered by consultant-led multi-disciplinary teams in each sector. The authors recommended that a dedicated crisis team be developed in each sector and that additional specialised services be developed to cover more than one sector. Day hospitals were directed to provide intensive treatment equivalent to that available in an inpatient setting for acutely ill patients.

Specifically, the authors recommended the provision of:

- 0.75 day places per 1,000 population
- 0.5 inpatient beds per 1,000 population for short-stay (up to 3 months) and medium-stay (up to one year) patients
- 0.5 beds per 1,000 population for 'new long-stay' patients
- 60 places in community residential accommodation per 100,000 population (increasing to 100 places per 100,000 population in areas with a backlog of existing long-stay patients).

The policy also addressed a number of specialised areas within psychiatry, including the provision of liaison services, rehabilitation programmes, the psychiatry of learning disability, services for elderly people, forensic services and mental health research. The authors recommended the establishment of one child guidance team per 200,000 population, and the development of community-based interventions for alcohol-related problems, aimed at prevention rather than treatment.

In the 20 years since the publication of The Psychiatric Services - Planning For The Future ,[4] Irish society has undergone a period of rapid social change, especially in terms of economics, demographics and legislation. These social changes have substantial implications for the day-to-day practice of psychiatry in Ireland.

Economic and demographic changes since the 1980s

Over the past 20 years the Irish economy has been transformed. In 1987 unemployment was at 16.9% - the highest since WWII. By 1999 this had fallen to 6%.[16] Long-term unemployment also fell dramatically, representing less than 3% of the workforce by 1999. These favourable employment trends occurred in the context of rapid economic growth, especially during the 1990s. Between 1993 and 1997 the average annual growth rate exceeded 8%, more than twice that of any other country in the Organisation for Economic Cooperation and Development area.[17]

The dramatic transformation of the Irish economy is attributable to a number of factors including specific government policies, international economic trends and demographic changes. Substantial government investment in education in the 1970s laid the foundation for a highly-skilled workforce which entered the job market in the 1990s. The introduction of low export taxes in the 1980s helped consolidate Ireland's position as an attractive location for multinational investment, particularly in the information technology and pharmaceutical sectors. These factors, along with other developments at both national and international levels, contributed significantly to reduced levels of unemployment, increased rates of growth, and substantial changes to the structures of both the Irish economy and Irish society over the past 20 years.

The full implications of the demographic and economic changes in Ireland are yet to be determined. A consideration of the full implications of such changes is beyond the scope of this paper, so suffice it to say that there is little evidence that recent changes have fundamentally improved social equality in Ireland or contributed to the economic betterment of socially disadvantaged groups in Irish society as a whole.[18] In terms of mental health services, some of the most relevant demographic changes relate to the process of 'globalisation' and subsequent alterations to traditional patterns of migration, and the rapid increase in the proportion of the population over the age of 65.

Owing to the introduction of low export taxes in the 1980s and Ireland's increasing attractiveness to multinational investors, Ireland was particularly well-positioned to benefit from the effects of 'globalisation' which opened up additional opportunities for economic growth in selected parts of the

world.[18] The literal meaning of globalisation, however, is 'crossing borders' and the effects of globalisation extend well beyond the realm of economics.[20] These effects relate to the development of international political organisations, the spread of information technology, increased rates of international travel and increased rates of trans-national migration.[21] One of the greatest challenges that globalisation presents to Irish mental health services stems from the increased rates of migration into Ireland since the mid-1990s.

Ireland has a long history of outward migration, especially following the Great Famine of the 1840s. This trend toward outward migration continued for the greater part of the 20th century: in 1988-1989 alone, 70,600 people, or approximately 2% of the population, left the country.[22] The economic success of the 1990s saw significant changes to this trend. Between 1995 and 2000, approximately 250,000 persons migrated into Ireland, of whom 50% were Irish people attracted back home by economic growth. The aggregate figure for immigrants over this five-year period represents an astonishing 7% of the population. The figure of 7% would be the equivalent of almost four million people migrating into France over the same time period.[22]

Migration has significant effects on both physical and mental health.[23,2425] In the UK, Irish, Caribbean and Pakistani men have substantially increased rates of suicidal thoughts and deliberate self-harm,[26] while Egyptian and Asian immigrants have higher rates of bulimia and anorexia nervosa.[27] In Oslo, post-traumatic stress disorder affects 46.6% of refugees.[28] Schizophrenia is up to six times more common in African-Caribbeans living in the UK compared to the native population[29] and four times more common among migrants to the Netherlands compared to the native population.[30]

In Ireland, there is a paucity of epidemiological information about the effects of migration, especially in relation to health. Existing mental health policy was formulated prior to the advent of significant inward migration and, as a result, services are poorly equipped to deal with this phenomenon.[31] There is a particular need for long-term service-planning in light of evidence that the effects of migration on mental health may well extend into the second generation of migrants.[32]

Migration is not the only demographic change likely to increase demand for psychiatric services in the coming decades. In common with many countries in western Europe, Ireland is experiencing a rapid increase in the proportion of the population over the age of 65-years.[33] In 1996 people aged 65 years or over made up 11.4% of the total population; by 2031 this will have risen to 18%. This will produce a substantial rise in the dependency ratio, which is the number of older people (65 years and over) as a proportion of the working-age population (15 to 64 years). In 2001 the dependency ratio in Ireland was 16.6%; by 2031 this will have risen to 28.2%.[33] This phenomenon is clearly not limited to Ireland: in 2000 the median age of citizens in the EU was 38 years; by 2020 this will have risen to 43 years.[12]

These demographic changes will produce a sharp rise in demand for psychiatric, medical and social services.[34] The cost of providing long-term care in the UK to older people with cognitive impairment is likely to increase from £4.6 billion in 1998 to nearly £11 billion in 2031.[35] This represents an increase from 0.61% to 0.70% of GDP. These projections are based on a set of assumptions about unit costs, including an annual 1% rise in the cost of social and health care. If the model is altered to assume a 2% rise in costs, then the costs of long-term care to this group could rise to 0.9% of GDP by 2031.[35]

In Ireland, it has been suggested that there are particular discrepancies between policy and practice in relation to care for elderly people, especially with regard to early assessment/screening for dementia, management of behavioural complications and treatment of concomitant medical and surgical problems.[34] Depression is also relatively common among elderly people, with estimates of a prevalence of up to 23% in the community.[36,37] In addition, O'Neill et al[38] also reported that depressive symptoms were the most common reason for psychiatric consultation among medical inpatients in a general hospital in Dublin, emphasising the strong association between physical and mental illness and the complexity of health care needs in this population.

Alcohol misuse is another mental health problem that is receiving increasing attention in the elderly population. Greene et al[39] studied self-reported alcohol consumption among 518 non-institutionalised community dwelling elderly people and found that excess alcohol consumption was associated with male gender and widowed status. Clearly, there is an important role for mental health policies and social care policies that address the psychological, psychiatric and social needs of this population.[40] It is similarly important that mental health policy for elderly people is seen in the context of overall policy development, and takes adequate account of other developments in mental health services, such as recent reforms of mental health legislation.

Clinical, legislative and policy developments since 1984

Service provision

Planning For The Future set out both a general philosophy of mental health care and a series of recommendations in relation to levels of service provision.[4] In general terms, the policy directed that psychiatric services should be comprehensive and community-oriented, aimed at delivering care that is continuous, coordinated and multi-disciplinary. The authors recommended that a dedicated crisis team be developed in each sector and that additional specialised services be developed to cover more than one sector.

Almost 20 years later, in its 2002 Annual Report, the Mental Health Commission pointed out that the principles outlined in Planning For The Future were still relevant to psychiatric care in Ireland, and that while all of its recommendations had not yet been implemented, Planning For The Future had succeeded in bringing significant improvements to Irish psychiatric services, particularly in relation to de-institutionalisation.[41] Nonetheless, considerable challenges remain. As discussed above, for example, particular concern has been expressed about services for elderly people with mental illness.[34]

Overall, it is difficult to perform direct comparisons between the planning guidelines outlined in Planning For The Future[4] and the levels of service provision some 20 years later, owing to the confounding effects of changing diagnostic practices, changing therapeutic approaches and changes in the structure of health services over that time. Nonetheless, certain comparisons are of some interest. For example, Planning For The Future[4] recommends the provision of 0.75

psychiatric day places per 1000 population and, by 2001, there were 0.42 day hospital places and 0.93 day centre places per 1000 population.[15] There is, however, considerable variation in the provision of both day hospital and day centre places across Ireland, with some health boards providing service levels well below the figures presented here.[15] Planning For The Future [4] also recommended the provision of 100 places in community residential accommodation per 100,000 population in areas with an existing backlog of long-stay patients; in 2001, there were 114.2 places per 100,000 population in low, medium and high support community residences.[15] There is considerable variation in provision across different health board areas, with the highest rate of places recorded in the North Western Health Board at 199.2 per 100,000 population.[15] These comparisons between planning recommendations in 1984 and service provision in 2001 are interesting, but, as cautioned above, the possible effects of multiple confounders are difficult to estimate and must be borne in mind.

Since Planning For The Future [4] was published, the reduction in psychiatric inpatient numbers has been particularly notable, though the adequacy of community-based alternatives has been a cause of concern for many, including the Mental Health Commission, who point to the relatively high rates of involuntary admission in Ireland, as compared to other countries.[41] Various other concerns have also been repeatedly expressed in relation to service provision over past years,[42,43] especially in relation to the development of services for adolescents with mental illness,[44] elderly people,[34] the forensic population,[45,46] migrants with mental illness,[31] and the homeless mentally ill.[47,48]

Looking at studies from forensic psychiatry, for example, there is strong evidence that general psychiatric services are under-resourced in the areas of greatest predicted need and that this, in turn, is associated with increased use of forensic psychiatry services.[45] In addition, there is strong evidence of gross over-representation of Irish Travellers amongst forensic psychiatric admissions.[45] Clearly, the provisions outlined in Planning For The Future [4] would require significant updating to address forensic psychiatric need in Ireland today, especially in terms of community forensic psychiatry services.

In summary, then, the 20 years since the publication of Planning For The Future [4] have seen significant progress in the development of Irish mental health services, but many challenges remain. While the process of de-institutionalisation has progressed considerably, there is still considerable concern about the adequacy of community based services for adults with mental illness and the development of specialist services to meet the needs of particular groups such as children, adolescents, elderly people, the learning disabled and the forensic population.[41]

Mental health legislation

2001 to 2003 have seen some of the most significant advances in Irish mental health legislation since 1945. In 2001 the Department of Health and Children introduced new mental health legislation in the form of The Mental Health Act 2001.[49] This act replaced the outdated Mental Treatment Act 1945 and aims to bring Irish legislation into line with European and international law.[50] The legislation focuses on two key aspects of mental health care: involuntary detention of persons with 'mental disorders' and mechanisms for assuring standards of mental health care.

The Act defines 'mental disorder' as "a state of mind of a person which affects a person's thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons".[49] Mental disorder is divided into three components: mental illness, severe dementia and significant intellectual disability.

Persons with a 'mental disorder' who are admitted to an 'approved centre' on an involuntary basis will have their detention automatically reviewed by a mental health tribunal within 21 days of admission. Each mental health tribunal will comprise a consultant psychiatrist, a practicing barrister or solicitor, and one other person, who is not a medical practitioner, a registered nurse or a practicing barrister or solicitor.

The tribunals will be appointed by a body called the Mental Health Commission which was established in 2001 to promote the maintenance of high standards and good practice in the delivery of mental health services. It comprises 13 representatives: one barrister or solicitor, three doctors (including two psychiatrists), two nurses, one social worker, one psychologist, one member of the general public, three representatives of voluntary bodies and one representative of the chief executives of the health boards. The Commission has a number of functions, including the appointment of mental health tribunals, administration of the requisite legal aid scheme, registration of 'approved centres' and the appointment of an Inspector of Mental Health Services.

Many aspects of the The Mental Health Act 2001 have been warmly welcomed: automatic review of involuntary status, explicit guarantees of patients' rights to information, and the establishment of the Mental Health Commission in order to maintain high standards in mental health services. It is hoped that these provisions will form the basis for the ongoing development of a mental health service that is effective, accessible and appropriate to Ireland's mental health needs. Mental health tribunals, in particular, have the potential to serve as powerful tools for the protection of human rights. Similar systems work quite well in other countries.[51] New Zealand, for example, has a system of mental health tribunals not unlike the incoming system in Ireland. In New Zealand, however, a judge is present at tribunal hearings to make final decisions, based on the contributions of patient, family, psychiatrist, nurses, social workers and other stake-holders.[52]

Certain aspects of The Mental Health Act 2001 provide cause for concern. Mental health tribunals, for example, will present a huge logistic challenge to the psychiatric service.[53] In 2001 there were 2,667 involuntary admissions to psychiatric hospitals or inpatient units.[15] If 60% of these people are still inpatients after 21 days, there will be 1,600 mental health tribunal hearings for these patients in any one year. If involuntary status is maintained for three months, further hearings will be necessary. This would lead to over 2,000 tribunal hearings a year, each requiring considerable resources in terms of clinical input, administration and legal aid.

Moreover, the definition of 'mental disorder' in The Mental Health Act does not accord with the definition of mental illness contained in a more recent piece of legislation, The Criminal Law (Insanity) Bill.[54] The Bill aims to address the needs of mentally-disordered offenders and to make provi-

sion for those considered either unfit to be tried or not guilty by reason of insanity to be referred to appropriate centres. The threshold for psychiatric admission outlined in the Criminal Law (Insanity) Bill appears much lower than that outlined in the Mental Health Act 2001. Moreover, the reforms suggested in the Bill will be essentially impossible to introduce without increasing the number of forensic psychiatry centres and psychiatric intensive care units throughout Ireland. Such developments formed an important component of the plans outlined almost 20 years ago in The Psychiatric Services - Planning For The Future. [4]

The Disability Bill 2001 is another legislative initiative with direct relevance to mental health policy.[55] This Bill, published in December 2001, had a number of stated aims, including:

- To make better provision for persons with disabilities in terms of accessibility to public buildings, public services and employment in the public service
- The establishment of a personal advocacy service to represent, help and support persons with disabilities in seeking assistance from statutory or voluntary bodies
- To give additional powers to the National Disability Authority (NDA) to monitor and promote compliance with the Act
- To develop regulations for genetic testing.

The Disability Bill 2001 stimulated considerable public debate,[56,57] with many commentators stating that the Bill failed to provide statutory rights for the disabled and should therefore be redrafted.[18] In 2002 the Bill was withdrawn and a new draft is due to be published by the Department of Justice, Equality and Law Reform shortly. In the run up to the revised Bill, People With Disabilities in Ireland, an advocacy group for the disabled, have emphasised their view that the Bill should include both positive rights that can be enforceable by individuals and duties to be placed on public and private bodies that provide services to the public with the aim of removing barriers to the full participation of people with disabilities.[58]

In summary, then, there are significant discontinuities both within Irish mental health legislation and between mental health legislation and mental health policy. It will be regrettable if the problematic aspects of recent legislation were to delay the implementation of the positive aspects, especially in relation to The Mental Health Act 2001. The Mental Health Commission is starting to implement certain aspects of the Act[41] and a new version of the Disability Bill is imminent. These initiatives need a pragmatic and dynamic mental health policy if they are to be implemented to their full potential.

General health policy

Over the past 20 years, sections on mental health were included in two general health policy documents, published as Shaping A Healthier Future: A Strategy For Effective Healthcare In The 1990s[59] and Quality And Fairness: A Health System For You.[60]

In Shaping A Healthier Future,[59] the Department of Health restated its commitment to implement the recommendations contained in The Psychiatric Services - Planning For The Future.[4] The Department also proposed initiatives in relation to suicide research, national alcohol policies and new Mental Health Legislation. Several of these initiatives were followed through: the Report of the National Task Force on Suicide [61] was published in 1998 ; the Interim Report of the Strategic Task Force on Alcohol [62] was published in 1998; and in 2001 the Mental Health Act 2001[49] was brought into law, though it has yet to be fully implemented.[41,50]

Table 1: Summary of the Audit of Structures and Functions in the Health System (The Prospectus Report)[68]

The outcomes the Prospectus audit aimed to achieve were five-fold:

- To support the implementation of policies outlined in Quality and Fairness, and the delivery of national health care priorities
- An optimal combination of public sector responsibilities and service organisation
- Delivering value from investment in health care
- A more responsive health system of greater benefit to the consumer
- The creation of a high performing health system.

The audit proposed four major reforms:

- The creation of a national health executive to replace existing health boards and the Eastern Regional Health Authority (ERHA)
- The enhancement of processes and capabilities aimed at managing change and delivering value for money
- Increasing and simplifying governance and accountability in health services;
- Reorganising many services including, for example, a significant reduction in the number of stand-alone agencies.

In Quality And Fairness ,[60] the Department of Health and Children again restated its commitment to implement the recommendations contained in The Psychiatric Services - Planning For The Future .[4] The Department also outlined the aim that by 2008 all psychiatric patients would be admitted to acute psychiatric units based in general hospitals – an aim which some believe may not be achievable in the given timeframe at current levels of resourcing.[63] The Department also emphasised its commitments to implement The Mental Health Act 2001, to develop suicide prevention policies and to develop advocacy services for people with mental health problems.

Elsewhere in Shaping a Healthier Future , the Department of Health and Children outlined three general principles that were to underpin the Irish health service as a whole. These were equity, quality and accountability.[59] In Quality and Fairness a fourth principle was added: people-centredness.[60]

Since the publication of Shaping Healthier Future and Quality and Fairness there has been considerable interest in the extent to which these four principles, especially equity, have been applied within Irish mental health services. O'Neill et al,[45] for example, presented evidence that general psychiatric services are significantly under-resourced in areas of greatest predicted need, especially in the East, and that there is a five-fold difference in overall bed and hostel place allocation between Irish health areas. This point was also emphasised in the recent Annual Report of the Mental Health Commission .[41]

The implementation of at least some of the principles in Quality and Fairness [60] is likely to be enhanced following the establishment of the Mental Health Commission and the phased implementation of the The Mental Health Act 2001. The effectiveness of the incoming measures, however, is critically dependent on the provision of adequate resources for change and, in the case of mental health tribunals, on the development of a non-adversarial and therapeutically-sensitive context in which to conduct tribunal hearings.

Clearly, the provision of adequate resources is critical for the ongoing development of services and for the implemen-

Table 2: Summary of the Report of the Commission on Financial Management and Control Systems (The Brennan Report) [69]

The Commission identified four central problems with existing systems:

- There was no organisation with responsibility for managing the health system at a national level
- There were no incentives for decision-makers to manage costs effectively;
- There was inadequate evaluation of programmes and expenditure;
- There was insufficient investment in information systems and management development.

The Commission used four core principles to address these:

- Health should be managed as a national system
- Accountability should lie with those who commit expenditure
- Costs should be capable of being allocated to individual consumers
- Good financial control is not solely a financial function.

The Commission made 136 recommendations, including:

- Establishing a national Executive to manage services
- Designating general practitioners and consultants as the main units of financial accountability
- Rationalising existing health agencies
- Appointing future consultants to work exclusively in the public sector
- Introducing a practice budget for each general practitioner
- Enhancing the evaluation of clinical and cost effectiveness for publicly funded drug schemes.

Table 3: Summary of the Report of the National Task Force on Medical Staffing (The Hanly Report)[70]

The Task Force based its recommendations on three principles:

- Bringing the hours of non-consultant hospital doctors (NCHDs) into line with the guidelines in the European Working Hours Directive
- Introducing a consultant-provided health service
- Reform of structures for medical education and training.

'Key messages' of the Task Force to date include:

- The provision of high quality patient care is fundamental
- NCHD working hours must be brought into line with the guidelines in the European Working Hours Directive, but simple recruitment of more NCHDs is not the best way to achieve this
- There should be a move towards more consultant-provided services, requiring the appointment of more consultants
- Acute hospital services are best delivered by an integrated network of hospitals, currently serving about 350,000 population; primary care services should be a fully integrated part of this network
- Health professionals should work as part of multi-disciplinary teams delivering high quality care 24-hours per day
- NCHD numbers should be regulated at national level and each NCHD post should be subject to approval by a central authority
- Value for money.

tation of the four principles of health services outlined in Quality and Fairness .[60] A pragmatic, flexible mental health policy is an essential part of this process which could both strengthen the overall service infrastructure and enhance the provision of bio-psycho-social models of care most appropriate to the needs of those with mental illness.[64]

Mental health policy could also provide a stronger framework within which mental health services could benefit from various other policy developments and analyses, including the 1998 publication Guidelines on Good Practice and Quality Assurance In Mental Health S ervices [65] and the annual reports of the Inspector of Mental Hospitals.[66] There is also a number of other policy developments, while not directed solely at mental health, could nonetheless be used to enhance mental health services. In a recent document on health research, for example, the Department of Health and Children[67] outlined a commitment to establish a research and development function within the Irish health services and to boost its support for health research in general. It is to be hoped that such initiatives, including the introduction of 'health research scientists,' will be actively carried forward into mental health policy in the coming years.

Recent years have seen the publication of three important reports on the future of Irish health services. These are the Audit of Structures and Functions in the Health System ,[68] also known as The Prospectus Report; the report of the Commission on Financial Management and C ontrol Systems in the Health S ervice,[69] also known as The Brennan Report; and the Report of the National Task Force on Medical Staffing,[70] also known as The Hanly Report. The central points of these three reports are summarised in Tables 1,2 and 3.

The impact of these reports on health service provision has yet to be determined. They have generated widespread comment and debate in both national and medical media. In one week alone, medical newspapers published a multiplicity of articles addressing a wide range of reactions to the Hanly Report,[70] including:

- A report suggesting that the intake of medical students would need to be doubled to meet the manpower requirements of the Hanly Report[71]
- The comparability of the Hanly reform programme with that of the National Health Service (NHS) in England[72]
- A report that there was a discrepancy in the figures given by the Hanly Report and a certain health board for hospital attendances at one particular hospital[73]
- A claim that the Hanly Report represented a Dublin-based approach to a nationwide problem[74]
- A report that the benefits of the Hanly Report should be clear to all who seek improved services[75]
- A report relaying the concern of the Irish Hospital Consultants Association that the Interim Board of the Health Service Executive did not include any representative involved in drafting the Hanly Report.[76]

Since the publication of the Hanly Report,[70] two particular areas appear to have become consistent sources of concern:

- There has been particular public and professional concern about the implications of the Hanly Report for local hospitals that currently provide services for smaller Irish towns and remote rural areas[77]
- Doctors have also expressed particular concern about the likely implications of the Hanly Report for the working hours and conditions of consultants, non-consultant hospital doctors and GPs working in the health service. The introduction of the European Working Hours Directive for NCHDs and the development of a consultant-provided health service will require substantial re-balancing of staff structures, allied to a fundamental reconsideration of training and career structures for doctors in all parts of the Irish health service, including psychiatric services.[70]

These are just two areas among many that need to be

resolved through the implementation of not only the Hanly Report, but also the Brennan Report, the Prospectus Report and the overall health strategy outlined in Quality and Fairness.[60] It is imperative that the development of an integrated, health-focused approach to these reforms takes adequate account of the particular needs of mental health services.

The recent Annual Report of the Mental Health Commis - sion looked specifically at the challenges currently facing Irish mental health services and highlighted measures planned to address some of the central issues in the coming years.[41] The Commission emphasised that there is a five-fold variation in funding between health board areas and recommended that delivery of services should take greater account of changes in population structure and various socio-economic factors that can significantly affect health, including levels of deprivation. The Commission's report explicitly addressed a number of specific areas of concern, such as rates of involuntary admission, the psychiatry of learning disability and the issue of stigma. The Commission also set a target of mid-2004 for the commencement of Part 2 of the Mental Health Act 2001, which deals with reforms to the process of involuntary admission of persons to approved centres and the protection of the rights of individuals who require involuntary admission and treatment of mental illness.

All of the reforms recommended in these reports require adequate resourcing if they are to be implemented on an effective and equitable basis across Irish mental health services. Financial resources form a key component of the package of resources needed to implement change. In 2002, public spending on health in Ireland amounted to €8.3 billion, which is almost a quarter of Government's day-to-day spending.[78] As the Mental Health Commission has pointed out, mental health services have access to just 7% of the national health budget, despite the fact that 20%-30% of all health disability is related to mental health problems.[41] Enhanced financial resources would be best complemented by the development of a renewed and updated policy on the provision of mental health services, which would also serve to identify additional monetary and non-monetary resource requirements. In 2003 the Government established an expert group to prepare a new policy on mental health and to examine a range of issues including the role of medication and measures to reduce stigma.[79] It is hoped that these measures will assist in the building of a mental health service which is efficient, acceptable and equitably distributed.

Conclusions

Significant progress has been made in the development of Irish mental health services in past decades. However, as the Mental Health Commission has pointed out,[41] while the recommendations outlined in Planning For The Future [4] have lead to considerable improvement in services (particularly in relation to de-institutionalisation), not all of its recommendations have been implemented yet. Significant challenges remain which could be addressed, in substantial part, by:

- The development of evidence-based mental health policy
- The development of appropriate specialist services within the mental health system
- The deepening of partnerships with social care providers
- Enhanced recognition of an international dimension to mental health care.

Evidence-based policy

Evidence-based medicine is the explicit, conscientious and judicious use of current best evidence to make decisions related to the care of individual patients.[80] Systematic evidence is combined with individual clinical experience to inform the clinical decision-making process, in partnership with the patient. In recent years, evidence-based medicine has become a critical component of medical curricula at both undergraduate and postgraduate levels. The principles of evidence-based medicine are currently changing the day-to-day practice of clinical medicine and, increasingly, clinical psychiatry. In terms of mental health policy, there is a strong need for evidence examining health-care outcomes associated with particular models of service-provision – a valuable process which has already started in many countries, including Ireland.[81] Epidemiological evidence is particularly important for the development of policy and for the rational planning of mental health services.[1, 81] Current priorities for epidemiological study in Ireland and elsewhere include the effects of migration on population structure, the impact of the 'greying population' on health care need, and the likely effects of declining birth rates on the incidence and prevalence of illness in the future.[83]

Specialist services

Certain groups of patients require specialist services to meet their needs. For example, The Irish College of Psychiatrists has recommended the provision of one out-patient multidisciplinary adolescent team per 100,000 population and one in-patient team per 300,000 population.[44] The development of such specialist teams was approved in The Psy chiatric Services – Planning For The Future .[4] There is now a clear need for the further development of a number of specialist services within psychiatry. Services aimed at early intervention in psychosis, for example, provide the opportunity for rapid assessment, early treatment and important secondary preventive measures.[84] Dedicated teams are already in place in a number of countries and there is a compelling need to foster the development of such initiatives in Ireland. There is also an urgent need to develop and maintain a comprehensive service for elderly people, designed to address the range of mental health problems that occur in the population, including, in particular, depression and cognitive impairment.

Partnership

In 1957 the UK Royal Commission on the Law Relating to Mental Illness and Mental Deficiency[85] addressed the need for partnership in community care, stating: "No patient shall be retained as a hospital in-patient when he has reached the stage at which he could return home if he had a reasonably good home to go to. At that stage the provision of residential care becomes the responsibility of the local authority."[85]

In general terms, this partnership between local authorities and mental health services has failed to develop sufficiently to meet the needs of the mentally ill.[47,48] Studies in both Ireland and the UK have reported serious mental illness in over one third of the homeless population.[86,87] Addressing the needs of the homeless mentally ill requires intensive co-operation between medical and social service providers. This is a partnership that needs to be emphasised at the levels of both national and international policy. There is a similar need for an explicit renewal and building of partnerships in relation to

issues such as suicide, mental illness in migrant groups and the provision of care to the elderly people with depression or cognitive impairment. The effectiveness of such partnerships can be enhanced through additional initiatives aimed at reducing stigma and building advocacy structures.

The international dimension

An increasing number of transnational bodies are issuing protocols, guidelines, directives and recommendations which can be used, to varying degrees, to inform national mental health policies and shape legislative reform. Certain issues, such as stigma, lend themselves particularly well to a 'globalised' approach that recognises both national and international dimensions to a particular problem.[21] Migration is another intrinsically 'globalised' issue and one which merits both national and transnational approaches. Overall, the process of 'globalisation' is a complex one which presents both challenges and opportunities to health care providers.[19-21,88] The development of flexible, evidence-based mental health policies that take account of this international dimension is a critical step in meeting these challenges and in delivering models of care that are effective, efficient, equitable and acceptable to our patients.

Declaration of interest: None

References

1. Jenkins R. Supporting governments to adapt mental health policies. World Psychiatry 2003; 2: 14-19.
2. Lavikainen J, Lahtinen E, Lahtinen V. Public Health Approach On Mental Health in Europe. Helsinki: Stakes, Helsinki, 2001.
3. WHO. The World Health Report 2001. Mental Health: New Understanding, New Hope. WHO. Geneva, 2001.
4. Department of Health. The Psychiatric Services - Planning For The Future. The Stationery Office, Dublin, 1984.
5. Rogers A, Pilgrim D. Mental Health Policy in Britain (2nd ed.). Palgrave, Hampshire, 2001.
6. Bryson JM. Strategic Planning for Public and Non-Profit Organisations. Jossey-Bass, San Francisco, 1995.
7. Jenkins R, McCulloch, Friedli L, Parker C. Developing A National Mental Health Policy (Maudsley Monographs 43). Psychology Press, United Kingdom, 2002.
8. United Nations. Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. United Nations, Secretariat Centre For Human Rights, New York, 1991.
9. Institute of Medicine. Neurological, Psychiatric And Developmental Disorders: Meeting The Challenge In The Developing World. National Academy Press, Washington, 2001.
10. Harding TW. Human rights law in the field of mental health: a critical review. Acta Psychiatr Scand (Supp), 2000; 399: 24-30.
11 Central Statistics Office. Statistical Yearbook of Ireland. The Stationery Office, Dublin, 2003.
12. Economist. Europe in Figures. The Economist, London, 2001.
13. Organisation for Economic Cooperation and Development. OECD Economic Surveys 1996-97 Ireland 1997. Organisation for Economic Cooperation and Development, Paris, 1997.
14. O'Sullivan T, Butler M. Current Issues In Irish Health Management: A Comparative Review. The Institute of Public Administration, Dublin, 2002.
15. Daly A, Walsh D. Activities of Irish Psychiatric Services 2001. The Health Research Board, Dublin, 2002.
16. Department of Finance. National Development Plan. The Stationery Office, Dublin, 1999.
17. O'Connell P. Astonishing Success: Economic Growth And The Labour Market In Ireland (International Labour Organisation Employment And Training Paper No. 44). International Labour Organisation, Geneva, 1999.
18 O'Toole F. After The Ball. Tasc, Dublin, 2003.
19. Economist. Globalisation. Economist/Profile, London, 2001.
20. Stiglitz J. Globalization and its discontents. Penguin, London, 2002.
21. Kelly BD. Globalisation and psychiatry. Adv Psychiatr Tr 2003; 9: 464-474.
22. MacÉinrí P. Immigration into Ireland: Trends, Policy, Responses, Outlook. Irish Centre For Migration Studies, Cork, 2001. (available at www.migration.ucc.ie).
23. Gleize L, Laudon F, Sun LY et al (2000) Cancer registry of French Polynesia: results for the 1990-1995 period among native and immigrant population. Eur J Epid 2000; 16: 661-667.
24. Singh GK, Siahpush M. All-cause and cause-specific mortality of immigrants and native born in the United States. Am J Pub Health 2001; 91: 392-399.
25. Gavin B, Kelly BD, Lane A et al. The Mental Health of Migrants. Ir Med J 2001; 94: 229-230.
26. Nazroo J. Ethnicity And Mental Health. PSI, London, 1997.
27. Bhugra D, Jones P. Migration and Mental Illness. Advances in Psychiatric Treatment 2001; 7, 216-223.
28. Lavik NJ, Hauff E, Skrondal A et al. Mental disorder among refugees and the impact of persecution and exile: some findings from an out-patient population. Br J Psychiatry 1996; 169: 726-732.
29. Harrison G. Searching for the causes of schizophrenia: the role of migration studies. Schizophr Bull 1990; 16: 663-671.
30. Selten JP, Slaets JP, Kahn RS. Schizophrenia in Surinamese and Dutch Antillean immigrants to The Netherlands: evidence of an increased incidence. Psychol Med 1997; 27: 807-811.
31. Feeney L, Kelly BD, Whitty P et al (2002) Mental illness in migrants: diagnostic and therapeutic challenges. Ir J Psychol Med 2002; 19; 29-31.
32. Hutchinson G, Takei N, Bhugra D et al. Increased rate of psychosis among African-Caribbeans in Britain is not due to an excess of pregnancy and birth complications. Br J Psychiatry 1997; 171: 145-147.
33. Department of Health and Children. Long-stay Activity Statistics. The Stationery Office, Dublin, 2001.
34. Swanwick G, Lawlor B. Services For Dementia Sufferers And Their Carers: Implications For Future Development. In: The Irish Health System In The 21st Century (eds A.L. Leahy & M.M. Wiley). Oak Tree Press, Dublin, 1998.
35. Comas-Herrera, A., Wittenberg, R., Pickard, L., et al. Cognitive impairment in older people: its implications for future demand for services and costs. PSSRU Discussion Paper 1728. Personal Social Sciences Research Unit, London School of Economics, London, 2003.
36. Weissman MM, Leaf DJ, Tischler GL et al. Affective Disorders in Five United States Communities. Psychol Med 1988; 18: 141-153.
37. Johnson J, Weissman M, Klerman GL. Service utilization and social morbidity associated with depressive symptoms in the community. J Am Med Assoc 1992; 267: 1478-1483.
38. O'Neill C, O'Connell H, Lawlor B. Psychiatric consultation to elderly medical inpatients in a general hospital. Ir J Psych Med 2003; 20: 80-83.
39. Greene E, Bruce I, Cunningham C, Coakley D, Lawlor B. Self-reported alcohol consumption in the Irish community dwelling elderly. Ir J Psych Med 2003; 20: 77-79
40. Department of Health and Children. The Years Ahead: A Policy For The Elderly (Report Of The Working Party On Services For The Elderly). The Stationery Office, Dublin, 1998.
41. Mental Health Commission. Annual Report 2002. The Mental Health Commission, Dublin, 2003.
42. Keogh F, Roche A, Walsh D. "We Have No Beds…": An Enquiry Into The Availability and Use of Acute Psychiatric Beds In the Eastern Health Board Region. The Health Research Board, 1999.
43. Irish Psychiatric Association. The Stark Facts. The Irish Psychiatric Association, Dublin, 2003.
44. Irish College of Psychiatrists Position Statement On Psychiatric Services For Adolescents. Irish College of Psychiatrists, Dublin, 2002.
45. O'Neill C, Sinclair H, Kelly A et al. Interaction of forensic and general psychiatric services in Ireland: learning the lessons or repeating the mistakes? Ir J Psychol Med 2002; 19: 48-54.
46 Linehan S, Duffy D, O'Neill H, O'Neill C, Kennedy HG. Irish Travellers and forensic mental health. Ir J Psychol Med 2002 19: 76-79.
47. McKeon K. Mentally Ill And Homeless In Ireland: Facing The Reality, Finding Solutions. Disability Federation of Ireland. Dublin, 1999.
48. Amnesty International. Mental Illness: The Neglected Quarter. Amnesty International, Dublin, 2003.
49. Department of Health and Children. The Mental Health Act 2001. The Stationery Office, Dublin, 2001.
50. Mills S. Clinical Practice And The Law. Butterworths, Dublin 2002.
51. Turner TH. Why do so few patients appeal against detention under section 2 of the Mental Health Act? New Zealand's system has much to offer. BMJ 1995; 310: 1196-1197.
52. Kelly BD. The Mental Health Act 2001. Ir Med J 2001; 95: 151-152.
53. Royal College of Psychiatrists (Irish Division) Comments on the Mental Health Act 2001. Royal College of Psychiatrists (Irish Division), Dublin, 2001.
54. Department of Justice, Equality and Law Reform. The Criminal Law (Insanity) Bill. The Stationery Office, Dublin, 2002.
55. Department of Justice, Equality and Law Reform. The Disability Bill. The Stationery Office, Dublin, 2001.
56. Irish Times. Editorial: Disability Bill. December 22nd 2001.
57. Humphreys J. Calls to withdraw the Disability Bill rejected. Irish Times, 11th February 2002.
58. People With Disabilities in Ireland. Disabilities Bill must be rights-based and all-embracing. Cumhacht Newsletter. Vol. 1, No. 6; Autumn 2003.
59. Department of Health. Shaping A Healthier Future: A Strategy For Effective Healthcare In The 1990s. The Stationery Office, Dublin, 1987.
60. Department of Health and Children. Quality and Fairness: A Health System For You. The Stationery Office, Dublin, 2001.
61. Department of Health and Children. Report Of The National Task Force On Suicide. The Stationery Office, Dublin, 1998.
62. Department of Health and Children. Strategic Task Force on Alcohol: Interim Report. The Stationery Office, Dublin, 1998.
63. Cassidy B. Strategy Has Done Little For Psychiatry. Irish Medical Times, March 14th 2003.
64. Gabbard GO, Kay J. The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist? Am J Psychiatry 2001; 158: 1956-1963.
65. Department of Health and Children. Guidelines on Good Practice And Quality Assurance In Mental Health Services. The Stationery Office, Dublin, 1998.
66. Department of Health and Children. Report of the Inspector of Mental Hospitals For The Year Ending 31st December 2001. The Stationery Office, Dublin, 2002.
67. Department of Health and Children. Making Knowledge Work For Health. The Stationery Office, Dublin, 2001.
68. Prospectus. Audit of Structures and Functions in the Health System. The Stationery Office, Dublin, 2003.
69. Commission on Financial Management and Control Systems in the Health Service. Report of the Commission on Financial Management and Control Systems in the Health Service. The Stationery Office, Dublin, 2003.
70. National Task Force on Medical Staffing. Report of the National Task Force on Medical Staffing. The Stationery Office, Dublin, 2003.
71. Shannon J. Hanly will need doubling of students. Medicine Weekly, 3rd Deceber 2003.
72. West P. Hanly and NHS report and not incompatible. Irish Medical Times, 5th December 2003.
73. McGuinness I. Major discrepancy in Hanly. Irish Medical Times, 5th December 2003.
74. Ryan S. Hanly 'a Dublin 4 solution.' Irish Medical Times, 5th December 2003.
75. Hunter N. 'Benefits of Hanly must be sold more vigorously to the public.' Irish Medical News, 1st December, 2003.
76. Bergin D. IHCA concern at no Hanly input into Health Service Executive. Irish Medical News, 1st December 2003.
77. Medicine Weekly. Editorial: Hanly Heckles. Medicine Weekly, 3rd December 2003.
78. Wren, MA. Unhealthy State: Anatomy of a Sick Society. New Island, Dublin, 2003.
79. Beesley A. Group set up to prepare new policy on mental health. Irish Times, 5th August 2003.
80. Sackett DL, Rosenberg WMC, Muir Gray JA et al. Evidence based medicine: what it is and what it isn't. BMJ 1996; 312: 71-72.
81. McCauley M, Rooney S, Clarke C, Carey T, Owens J. Home-based treatment in Monaghan: the first two years. Ir J Psychol Med 2003; 20: 11-14.
82. Jenkins R. Making psychiatric epidemiology useful: the contribution of epidemiology to government policy. Acta Psychiatr Scand 2001; 103: 2-14.
83. Barry J. Developments In The Epdiemiology Of Disease In The Next Century. In: The Irish Health System In The 21st Century (eds A.L. Leahy & M.M. Wiley). Oak Tree Press, Dublin, 1998.
84. Clarke M, O'Callaghan E. Is earlier better? At the beginning of schizophrenia: timing and opportunities for early intervention. Psychiatr Clin North Am 2003; 16, 65-83.
85. Department of Health and Social Security. Royal Commission On The Law Relating To Mental Illness And Mental Deficiency. Cmnd 169. London: Her Majesty's Stationery Office, London, 1957.
86. George SL, Shanks NJ, Westlake L. Census of Single Homeless People in Sheffield. BMJ 1991; 302: 1387-1389.
87. Holohan TW, Holohan W. Health and Homelessness in Dublin. Ir Med J 2000; 93: 41-43.
88. Lewis G, Araya R. Globalization and mental health. In: Psychiatry in Society (eds. Sartorius N, Gaebel W, Lopez-Ibor JJ, Maj M) Wiley, Chichester, 2002.