The Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services

Evaluation report prepared under the Value for Money and Policy Review Initiative

21 December 2008
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<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>(the) Department</td>
<td>Department of Health and Children</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>HSE</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>PCCC</td>
<td>Primary Community Continuing Care</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>VFMP</td>
<td>Value for Money and Policy (Reviews)</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>WTE</td>
<td>Whole Time Equivalent</td>
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Executive Summary

The Evaluation

This report is an evaluation, conducted in accordance with the guidance for Value for Money and Policy (VFMP) Reviews, of the efficiency and effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services in Ireland. The evaluation focused on the current provision of service to long stay residents within mental health services and explores the way forward for the development of services within a Value for Money and Policy framework.

The terms of reference for the evaluation were as follows:

• Identify the objectives of the provision of Long Stay Residential Care.
• 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.
• 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.
• Identify the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care.
• 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.
• 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.

Evaluation Conclusions

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. The strategy presented in ‘A Vision for Change’ presents an opportunity to rebalance resource allocation to take better account of need in a cost neutral manner. While some cost savings may be

1 Department of Finance, 2006
2 The 2006 budget for Long Stay services was €485 million of which €249 million relates to services included within the scope of this review. The difference primarily relates to the provision of Acute in-patient care, which was outside the scope of this review.
generated, these would be absorbed or reinvested in the further development of community based support. Accordingly, the overall conclusion of the report is that full implementation of ‘A Vision for Change’ offers the prospect of enhanced effectiveness and impact of service in the longer term, in line with current international good practice, with little additional budget or resource allocation.

**Service Objectives**

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 alter 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.

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.

**Service Effectiveness and Efficiency**

Long stay residential mental health services cater for a diverse group of users ranging from the “graduates” of the old asylum system to new long stay users. This review identifies long stay users as those individuals who have been resident for over one year and one day. There are similar patterns for both in-patient and community residences, with a significant group of individuals being new long stay users. The predominately male client group are generally aged over 45 years, with a significant number being over 65 years of age. The service on census night returned 87% occupancy levels, with 75% of clients being identified as appropriately placed. Of those individuals who are inappropriately placed on in-patient units, over 59% would be more appropriately placed in the community and 32% of those inappropriately placed in community residences require lower support or independent accommodation.

The majority of service user activities are of a social nature, with fewer individuals engaged in therapeutic activities. The lack of a consistent understanding of, or approach to, rehabilitation is evident, with less than 25% of individuals in high support community residence and only 6.7% of individuals on identified rehabilitation units, participating in rehabilitation training. Of equal significance is the small difference between the numbers of individuals in paid employment who reside in high and low support community residences.

Community based services account for the majority of long stay admissions, however there continues to be a small number of long stay admissions to acute in-patient units (1.76% of long stay admissions over a five year period).
The majority of discharges from long stay residential services are to lower levels of supported accommodation. However, there is a relatively small throughput of service users with only a total of 5,159 discharges nationally over a five year period.

There is scope for significantly increasing the proportion of service costs that are recovered in residence charges.

**Service Resources**

Significant financial resources are allocated to mental health on an annual basis. Based on the returns for this review, in 2006 30% of the national Mental Health budget was spent on the provision of long stay residential mental health services; this equates to €249 million.

There are however, wide regional variations in the distribution of funding across mental health catchment areas, with variations of between €40 per capita in Meath and €506 per capita in Mayo (Walsh 2007). The difference in funding is primarily a function of the quantum of service provided (Meath 18 long stay beds, Mayo 107).

The most significant portion of costs are staff based, with 88% or €219 million of total costs directly attributed to staffing. There are significant differences in the staffing levels across mental health catchment areas. Wide regional variances occur in the WTE availability and the skill mix deployment, even in similar care environments, leading to significant differences in the cost per bed per day. High support community residences and long stay in-patient units account for the majority of staffing costs. Non-pay costs vary significantly between regions and need to be more closely monitored.

Non pay costs account for 12% or €30 million of the overall long stay costs.

There are 143 extra contractual placements outside the HSE, funded by mental health catchment areas. These are the single most significant non pay cost, accounting for €6.3 million or 2.72% of all long stay costs and 21.02% of non pay costs.

The review highlights concern regarding the quality of the infrastructure, with over 88% of all community residences having limited disabled accessibility. Comparison of existing bed numbers against recommendations in ‘A Vision For Change’ (2006) suggests there is over provision in bed capacity. However, of the current 2,790 beds, only 335 are in units which are disability accessible and therefore fit for purpose.

It has been extremely difficult to gather data in respect of costs across the service, as there is limited financial information available on a per unit or per bed basis. This review illustrates that the majority of units do not have an identified budget to meet running costs.

Both the variations in funding and access to staffing are, in some measure, explained by the historic location of old in-patient hospitals. Current services cluster in the same areas as the old psychiatric hospitals.

The full implementation of ‘A Vision for Change’ (2006) in relation to individuals who require long stay residential care and/or rehabilitation in a specialist service, would identify that a reduction in actual long stay bed numbers would result in significant savings, on an annual basis, in the residential aspect of long stay care. It is important, however, to recognise that both capital and human resources Chart 12
freed up would be required to ensure the establishment of the necessary specialist community teams such as assertive outreach, rehabilitation and home base treatment teams, as well as generic mental health teams.

**Future Funding and Alternative Approaches**

The justification for the continued allocation of public monies to the mental health services is rooted in strong economic and social arguments. From an economic perspective, the amounts spent on mental health services are modest in comparison to the relatively high proportion of adults (27%) who may experience some form of mental health problem in any one year, the significance of mental health within the total burden of ill health (20%) and the economic cost of mental illness measured in terms of gross national product (3-4%).

The continued validity of the objectives of mental health services is established through consideration of the key strategic elements of ‘A Vision for Change’ (2006). The general approach adopted is directly following the prevailing strategy supported by the WHO and the EU. The objectives are consistent with the EU objectives. From a Value for Money perspective, the strategy offers further improvements in cost effectiveness.

Due consideration of alternative approaches was taken in the development of ‘A Vision for Change’ (2006). By reference to specific practices in the USA and the UK, it is confirmed that the overall Irish approach reflects international good practice. The operation of the mental health services within the wider EU context provides an opportunity to keep abreast of current thinking for the further improvement of services.

**Performance Indicators**

A small core set of performance indicators are proposed for the long term residential care mental health services to support the implementation of ‘A Vision for Change’ and monitor, in value for money terms, the effectiveness of outcomes and the efficiency of the use of allocated resources.

The mental health services will need to collect performance information for its performance indicators, through both its management information systems and by periodic survey. Systems for the collection of performance information need to be further developed.

The Value for Money performance indicators are a small subset of a wider framework of indicators needed to provide for the information needs of stakeholders.
Key Findings/Conclusions:

A number of findings/conclusions outlined in this chapter (Executive Summary) are set out in more detail at the end of the various chapters, (refer pages 26, 30, 49, 62 and 69).

Key findings may be summarised as follows:

- **Resource Allocation** – The Report identified wide variations in resource allocation, levels of service provision and different staffing ratios across similar type residential units. A high level table of administrative areas and Central Mental Hospital resource allocations is set out hereunder.

<table>
<thead>
<tr>
<th>HSE Region</th>
<th>Population</th>
<th>Total Cost €</th>
<th>Total WTE Staff</th>
<th>Total Beds</th>
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<tr>
<td>Dublin Mid Leinster</td>
<td>1,216,848</td>
<td>€31,508,914.84</td>
<td>526.99</td>
<td>845</td>
</tr>
<tr>
<td>Dublin North East</td>
<td>928,619</td>
<td>€41,423,652.89</td>
<td>674.41</td>
<td>793</td>
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<td>South</td>
<td>1,081,968</td>
<td>€83,995,684.21</td>
<td>1,290.95</td>
<td>1513</td>
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<tr>
<td>West</td>
<td>1,021,413</td>
<td>€73,728,579.45</td>
<td>1,215.33</td>
<td>1501</td>
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<tr>
<td>Central Mental Hospital</td>
<td></td>
<td>€18,676,000.00</td>
<td></td>
<td>57</td>
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<tr>
<td>Nationally</td>
<td>4,248,848</td>
<td>€249,332,831.39</td>
<td>3,707.68</td>
<td>4709</td>
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</table>

- **A Vision for Change** – Full implementation of ‘A Vision for Change’ will enhance service effectiveness in the long term, at little additional cost and offers opportunity to re-balance resource allocations in line with service needs.

- **Placements** – A significant minority of clients were deemed to be inappropriately placed, many of whom could have their needs met in lower supported settings and at lower cost. External placements accounted for the biggest non-pay costs.

- **Residence Charges** – There is significant scope for recovering a higher proportion of the service costs.

- **Rehabilitation Training** – Participation levels are low across all residence types.

- **Performance Management** – Performance Indicators need to be developed, supported by collection of performance information.

- **Infrastructure** – Existing residential capacity, benchmarked against ‘A Vision for Change’ recommendations, suggest surplus in placements. Use of Low and Medium support environments could be discontinued. Concerns highlighted at quality of
infrastructure with majority of Community Residences deemed to have limited disabled accessibility.

**Key Recommendations**

A number of recommendations are made in chapter 7 of the main report, in response to the key findings outlined above. (Refer pages 70-73) The recommendations include the following:

- **Action Plan** – The development of a medium term Action Plan to be based on Report’s findings, with measurable targets and identified resources.

- **Strategic plan** – Strategic plans for mental health services should be supported by hierarchy of objectives, linking overall objectives, results and actions.

- **Resources** - Devolvement of financial budgets to local services should occur, so that the efficiency of service provision can be monitored. Staff distribution and accommodation capacity should be reviewed to ensure allocations are based on service needs. Sufficient resources should be allocated for implementation of ‘A Vision for Change’ based on a cost benefit analysis.

- **Infrastructure** – The improvement of accessibility to community residences should be prioritised.

- **Placements** – The changing profile of the service user population should be continuously monitored, to inform future strategic plans. Targets to be set and monitored to provide appropriate placements for clients and a comprehensive re-housing programme should be undertaken.

- **Residence Charges** – A policy review should be undertaken, to optimise the recovery of charges on a fair basis.

- **Rehabilitation Training** – Service should continue to refine its effectiveness objectives, based on strategies to support the ability of clients to return to independent living.

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 18\(^{th}\) 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 19\(^{th}\) 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:

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\(^{3}\) 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, 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 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.

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

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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\(^\text{11}\) 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.

<table>
<thead>
<tr>
<th></th>
<th>€Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing, Care and Household Staff</td>
<td>217</td>
</tr>
<tr>
<td>Other (including HSE and Non HSE Staff)</td>
<td>2</td>
</tr>
<tr>
<td>Total Pay Costs</td>
<td>219</td>
</tr>
<tr>
<td>Total Non Pay Costs</td>
<td>30</td>
</tr>
<tr>
<td>Total Cost of Service</td>
<td>249(^\text{12})</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Community Bed Numbers</th>
<th>Total In-patient Beds</th>
<th>WTE – Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Support</td>
<td>1,613</td>
<td>1,439</td>
</tr>
<tr>
<td>Medium Support</td>
<td>547</td>
<td>181</td>
</tr>
<tr>
<td>Low Support</td>
<td>630</td>
<td>299</td>
</tr>
<tr>
<td>Total In-patient Beds</td>
<td>1,919</td>
<td>18.18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total WTE Nursing, Care and Household Staff</th>
<th>WTE – Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurse Manager 3</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Nurse Manager 2</td>
<td>468</td>
</tr>
<tr>
<td>Clinical Nurse Manager 1</td>
<td>138</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2,066</td>
</tr>
<tr>
<td>Healthcare Assistant</td>
<td>374</td>
</tr>
<tr>
<td>Household Domestic</td>
<td>657</td>
</tr>
<tr>
<td>Total WTE Nursing, Care and Household Staff</td>
<td>3,707</td>
</tr>
<tr>
<td>WTE – Other</td>
<td>18.18</td>
</tr>
<tr>
<td>Consultant Psychiatrist</td>
<td>5.51</td>
</tr>
<tr>
<td>NCHD</td>
<td>5.63</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>7.04</td>
</tr>
</tbody>
</table>

\(^{11}\) 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

Strategy scope

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).

<table>
<thead>
<tr>
<th>HSE Dublin North East</th>
<th>HSE Dublin Mid Leinster</th>
<th>HSE South</th>
<th>HSE West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louth Meath</td>
<td>Dublin South (Former Area 3)</td>
<td>Carlow Kilkenny</td>
<td>Limerick</td>
</tr>
<tr>
<td>Dublin North West (Former Area 6)</td>
<td>Dublin South East (Former Area 2)</td>
<td>Kerry</td>
<td>Roscommon</td>
</tr>
<tr>
<td>Cavan Monaghan</td>
<td>Dublin South West (Former Areas 4 and 5)</td>
<td>North Cork</td>
<td>Galway East</td>
</tr>
<tr>
<td>Dublin North (Former Area 7)</td>
<td>South County Dublin (Former Area 1)</td>
<td>South Lee</td>
<td>Galway West</td>
</tr>
<tr>
<td>North County Dublin (Former Area 8)</td>
<td>Kildare and West Wicklow (former Area 9)</td>
<td>North Lee</td>
<td>Sligo Leitrim</td>
</tr>
<tr>
<td>East Wicklow (Former Area 10)</td>
<td>South Tipperary</td>
<td>Donegal</td>
<td></td>
</tr>
<tr>
<td>Laois Offaly</td>
<td>Waterford</td>
<td>Clare</td>
<td></td>
</tr>
<tr>
<td>Longford Westmeath</td>
<td>Wexford</td>
<td>Mayo</td>
<td></td>
</tr>
<tr>
<td>West Cork</td>
<td>North Tipperary**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** 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.
Table 1-3: Evaluation Criteria

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Evaluation Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Service Objectives</td>
<td>Identify the objectives of the provision of Long Stay Residential Care</td>
</tr>
<tr>
<td>3</td>
<td>Service Effectiveness</td>
<td>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</td>
</tr>
<tr>
<td>3</td>
<td>Service Effectiveness</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>Service Resources</td>
<td>Identify the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care.</td>
</tr>
<tr>
<td>5</td>
<td>Future Funding and Alternative Approaches</td>
<td>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.</td>
</tr>
<tr>
<td>6</td>
<td>Key Performance Indicators</td>
<td>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.</td>
</tr>
</tbody>
</table>

**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 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

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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\(^\text{15}\) 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\(^\text{16}\) 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\(^\text{17}\). (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 21,72018 “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:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measurable target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffed Residences</td>
<td>Three 10-bedded units per 100,000 population</td>
</tr>
<tr>
<td>Continuing Care Challenging Behaviour</td>
<td>300,000: 30 beds</td>
</tr>
<tr>
<td>Intensive Care Rehabilitation Care Units</td>
<td>1,000,000: 30 beds</td>
</tr>
<tr>
<td>High support intensive care residence</td>
<td>1,000,000: 20 beds</td>
</tr>
</tbody>
</table>

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 (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.

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”;

“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. 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)

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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**

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.
4. Service Resources

Introduction

4.1 This Chapter identifies the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care. The reference year is 2006. A bottom up approach was applied to establishing the resources consumed in the provision of the mental health services. The Chapter is divided into three sections. It begins by examining budgetary issues, and then considers resources in terms of staff and non-staff costs and the provision of accommodation (bed capacity) for the delivery of services.

Mental Health Service Budgets and Expenditure

International levels of funding

4.2 In 2005, the most recent WHO figures for countries that returned statistics, show Ireland is placed joint sixth in a league table with 7% of the overall health budget allocated to mental health (Chart 29). When making international comparisons, caution must be exercised. The overall health spend in Ireland includes social care packages that in other countries may be allocated to social welfare or other budgets. Similarly prescription charges and psychological services that are delivered by primary care services are not included in the mental health budgets. “A Vision for Change” (2006) records that mental health expenditure was equivalent to 8.4% of the overall health budget.

![Mental Health Budget as % of Health Budget](chart28.png)
4.3 “Corporate” overhead costs such as superannuation, high level administrative and clinical staff costs cannot be applied with any degree of accuracy as they are not broken down to unit level. Further research identified a breakdown of the mental health figures in the 2006 Book of Estimates, as follows:

<table>
<thead>
<tr>
<th>Mental Health Budget</th>
<th>€Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Stay</td>
<td>485\footnote{22}</td>
</tr>
<tr>
<td>Community</td>
<td>228</td>
</tr>
<tr>
<td>Old Age Psychiatry</td>
<td>8</td>
</tr>
<tr>
<td>Counselling</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>97</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>€834</strong></td>
</tr>
</tbody>
</table>

\footnote{22} Including the Central Mental Hospital and Acute inpatient costs

*Table 4-1: Analysis of the mental health services budget*
4.4 The category of long stay includes acute units which have traditionally been located in psychiatric hospitals alongside long stay wards. The terms of reference of this review excluded acute in-patients units and did not focus on the cost of acute in-patient care. The provision of Acute Care is estimated to cost approximately €238 million. This is based on applying the average cost per bed for long stay in-patient units to acute in-patient beds. Acute Unit pay levels are significantly higher than those within long stay in-patient units due to higher staffing levels, more significant input for medical teams and allied health professionals as well as associated non pay costs. Therefore, this review examines expenditure amounting to €249 million, which is included within the overall figure of €485 million set out in Table 4-1.

Long Term Residential Care Budgets

4.5 Historically, financial data in the mental health field has not been recorded and reported in a manner that facilitates performance comparisons across services. There is a lack of a consistent approach to record keeping, making it more difficult to compare like with like, even in some instances within the same service. In response to a survey question, the majority of areas reported that individual units do not have a clear budget allocation (Charts 32 and 33). The availability of comparable financial information is essential to enable mental health managers to explore alternative treatment approaches in an effective coordinated way.

4.6 In order to accurately measure cost effectiveness and to plan future services it is important to be able to identify the cost of each level of care. The introduction of unit specific budgets and reporting systems would initially require additional investment in adapting appropriate accounting systems to enable complete and accurate recording of expenditure. The longer term benefits should significantly repay the initial investment in terms of providing the ability to identify services and units which are performing well and target improvements in services and units that fall below national standards. This should contribute to an overall improvement in the cost effectiveness and service delivery of long stay residential mental health services.

4.7 As a check to ensure a degree of accuracy, the project team requested one catchment area to estimate its long stay residential mental health budget for 2006. This catchment area reported that approximately 21.5% was allocated to long stay mental health services. The VFM Review report identified a 20% spend on long stay mental health services within the catchment area, demonstrating only a small variance from the service’s own estimate.

4.8 The reference figure of €249 million used in this evaluation is a reflection of the cost of residential care rather than agreed budgets. No observations can be made on the capability of individual services to operate within fixed budgets in the absence of properly allocated budgets to these service levels.

4.9 The evaluation identifies a frontline cost of €249 million, which is 31.4% of the national mental health budget. This expenditure comprises pay and non-pay costs for the provision of the Long Stay Residential Mental Health Service. Despite the move away from institutional care since 1966, a significant percentage of mental health resources continues to be consumed by long stay residential care. The evaluation established that of their respective mental health budgets, the South spends the largest portion, 47.09% or €83.8 million, and the West spends 30.72% or €73.7 million, whereas Dublin North East spends 21.51% or €41.4 million and Dublin Mid- Leinster spends 21.43% or €31.5 million (Chart 30 and 31).
4.10 Mental health organisations are service organisations that provide human services and as a consequence, it is necessary to have a sizeable labour force. Pay costs constitute the largest share of the total expenditure for mental health services, with almost 88% of the identified budget allocated to pay costs (Chart 38). Due to the fact that the majority of long stay residential care is provided in Community based residences, non-pay costs are lower than in hospital based services, as the significant non-pay costs found in hospital environments do not apply in community residences. This results in a higher pay/non-pay division, than the usual 80%/20% division.

Pay Costs

4.11 Based on time records provided by service providers in the questionnaire, it is estimated that there are currently 3,725 whole time equivalent (WTE) staff members (based on a 39 hour week) working for long stay residential mental health services. The amounts reported for pay costs shown in Charts 39 to 41 were calculated based on analysis of the data collected for the evaluation. The analysis is described in Appendix 4. The information in Chart 39 shows the estimated pay costs per HSE administrative area.
Whole Time Equivalent (WTE) staff per bed

4.12 The level of staffing reflects historical posts associated with the old mental health institutions. "Planning for the Future" identified a breakdown of staff per old health board region in 1984 which continues to be referred to, in resource allocation today.

4.13 There is a wide variation in the levels of staff available in the four administrative areas (Chart 42) and a smaller variation in terms of skill mix between the administrative areas (Chart 43). High support community residence and long stay in-patient units have the greater number of WTEs, with the largest percentage of these staff being registered nurses. Regionally there is a variation in the allocation of WTE per bed. With the exception of the Secure/High Dependency beds which includes, for example, secure service in St. Brendan’s Hospital, this variation cannot be explained other than by the historical distribution of resources. There is

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23 Of the €18.6 million identified for Central Mental Hospital, the expenditure of only €4 million is specifically identified as staffing in long stay residential care.
limited use of research based assessment tools, with staff ratios having little or no relation to service user dependency.

4.14 The discrepancy in the relationship of staff ratios to the dependency of individuals who use the service, is most clearly evident in the WTE per bed ratios in community residences. The needs of individuals in each type of residence should not vary widely and the staffing resources to meet those needs should be uniform. In practice, wide variations exist across all areas ranging from 0.37 to 1.72 WTE per bed in high support community residences, with similar variations in both medium and low support (Maps 1 to 3, Pages 37, 38 and 39).

4.15 A similar pattern is evident in in-patient units, with a range of from 0.37 and 1.90 WTE per bed. (Map 4 – Page 40). Management grades i.e. Clinical Nurse Manager (CNM) 1 and above comprises over 16% of all WTES, with some areas employing no unqualified care staff. Staffing levels should predominately reflect the dependency of individuals who use the service. However, other factors such as location, access to support and risk should also be reflected in staffing numbers. Staffing levels which reflect service user dependency, ensure resources are allocated based on need and allow for appropriate deployment of staff.

4.16 Activities undertaken by staff should reflect their qualifications and expertise. Utilising qualified nursing staff in non-nursing roles offers little or no therapeutic benefit to the individuals using the service and is a significant waste of staff resources. Within the long stay residential mental health services, there is potential for considerable savings across the service by re-balancing the skill mix and greater utilisation of non-registered health care staff within the sector. Particular focus on skill mix should be paid to medium and low support accommodation.
Map 4.1: WTE per bed – High support

[Image of a map showing WTE per bed in different regions of Ireland, with shading indicating high support levels.]
Map 4-4: WTE per bed – In-patient long stay

WTE Per Bed - Inpatient Long Stay

Map Produced by:
PCCG Projects Office, Holland Rd, Limerick
Under licence HSE/309001

Data Sources:
Health Service Executive
Central Statistics Office

- 40 -
Map 4-5: Cost per bed per day – High support
Map 4-6: Cost per bed per day – Medium support
Map 4-7: Cost per bed per day – Low support
Map 4-8: Cost per bed per day – Long stay In-patient
Pay cost per bed per day

4.17 There is a significant catchment area variation in the staffing costs per bed per day, both in community and in in-patient units. (Maps 4 – 8. Pages 41 – 44)

4.18 A particular focus needs to be applied to the more independent individuals, i.e. those living in medium (rostered staff costs ranging from €0.00 to €143 per day) and low support (from €0.00 to €82 per day) accommodations. In some catchment areas, medium and low support units do not have regular rostered staff as defined in the guidance notes accompanying the survey, resulting in the €0.00 costing. In-patient Units show similar variations in staff cost from the national average.

Indirect costs

4.19 Where the information was supplied, indirect staff costs such as regular sessional work by either Health Service or external agencies was applied in the overall analysis. Support administrative services e.g. director of nursing, administrators, administration staff, clinical director costs etc are not included in this analysis, as detailed cost coding is not carried out in the Irish mental health services.

4.20 High Support Community Residences and Long Stay In-Patient Wards account for almost 82% of pay costs. Registered nurse, (excluding management grades) account for 64.7% and nurse management grades account for 15.19%.

Non Pay Costs

4.21 The majority of units do not operate as individual cost centers, with costs being paid from a central budget. In the analysis which follows, central overheads i.e. electricity are presented based on the average figures per bed per area using figures returned in the survey. Comparisons to a National cost per bed per day are based on a national average cost. Stand alone charges such as rent, travel, clozaril, and funded placements were not averaged on a per bed rate but applied as total charges to each area. On this basis, non-pay costs account for over €30 million applied across all service types, representing 12.2% nationally of the overall long stay costs returned. The regional variations in non-pay costs are shown in Charts 44 and 46.

4.22 Over 55% of all non pay costs relate to in-patient facilities, which hold only 41% of all long stay beds.

4.23 Non service charges such as rent, transport, clozaril treatment, and the funding of specialist placements account for over 30% of all non staff costs. The largest portion of these costs relate to 143 funded placements, four of which are outside Irish jurisdiction. The placements arise as local services are not in a position to meet the needs of individual service users. The annual cost of these placements to the Mental Health Services is over €6.3 Million or 2.72% of the national budget. Only 8 Mental Health Catchment areas returned as having this type of funded placement.

4.24 The breakdown of the remaining non pay costs is shown below, with catering, maintenance and pharmacy being the three largest amounts (Chart 45).
4.25 Where financial data was not available, services frequently identified the HSE as a separate entity, having financial responsibility for these costs. This psychological split can be used to allow services to abdicate responsibility for financial management and has resulted in little or no monitoring of costs. In one exceptional case, catering returns for a twelve bed high support community residence were €6,955, while the catering expenditures for a six bed medium support community residence were €15,900.

Accessibility for the Provision of Services

4.26 The statistics reported in this review reflect the situation at 10 October 2007. Some services may have closed or redefined the use of units since then.

4.27 The majority of long stay beds nationally fall into two categories, High Support Community Residence and Long Stay In-patient beds. The geographical spread of beds demonstrates particular areas of concern. There are 32.13% of national beds located in the South and 31.88% in the West, a total of 64.01%, for 46% of the population. For the remaining beds, 17.94% are in Dublin Mid Leinster and 16.84% in Dublin North East. The remaining 1.21% of identified long stay beds are in the Central Mental Hospital.
4.28 The South has almost half of all in-patient beds at 49%, followed by the West with 20%. Dublin Mid Leinster has 14.12% and Dublin North East has 13.06% of the total number of in-patient beds. The remaining 2.7% are in the Central Mental Hospital.

4.29 Within the new structures established with the inception of the HSE there remains cross Local Health Office arrangements such as experienced in North and South Tipperary. Further examples may be found in East Galway, Louth Meath, etc with individuals who use the service, having an address in one mental health catchment area while accessing services in another, with no additional funding being attached. In a recent review of services provided by St Brendan’s Hospital it was highlighted that the use of services within St Brendan’s by service users outside the direct catchment area did not attract funding and in fact post discharge St Brendan’s was in a situation of funding placements for service users from a number of different catchment areas. This directly impacted on their ability to maintain services and led to discussions re the closure of specific units.

4.30 Different arrangements exist when the HSE purchases care from private service providers, such as St. John of God, or St. Patrick’s, with mental health catchment areas purchasing a bed and then providing post discharge care and support within their own service.

4.31 The inequity in the geographical spread of services, in particular community based services, is further reflected in the number of people on waiting lists for community placements and is a reflection of the allocation of revenue discussed earlier in this report and should inform how future budgetary allocations are made. The HSE South and West have significantly lower waiting lists than HSE Dublin North East and Dublin Mid-Leinster.

4.32 When considering the effectiveness and efficiency of long stay mental health services in the country, it is necessary to take cognisance of published research Harkness et al (2004) that highlights the effects of building features and locations on outcomes for individuals.

4.33 Due to the poor recording of financial data previously discussed in this report, it has been difficult to ascertain an exact cost of maintenance (The findings of this Review identify that an average of 18% of non-pay costs can be attributed to maintenance). It is clear from research that poor building repair leads to increased resident instability and a subsequent increase in overall costs. Harkness et al (2004) conclude that individuals with mental health problems living in newer and properly maintained buildings were found to have reduced mental health care costs and less residential instability. “Buildings with a richer set of amenity features, neighbourhoods with no outward signs of physical deterioration, and neighbourhoods with newer housing stock are also associated with reduced mental health care costs”.

4.34 On a per bed comparison with the recommendations in the ‘A Vision for Change’ (2006) document, it would seem that there are sufficient units designated as high support, with sufficient capacity to meet the requirements of Staffed Community Residence (3X10 Beds per 100,000). ‘A Vision for Change’ (2006) recommends a total of 1,239 high support beds nationally compared with the existing 1,613, or 30 beds per 100,000 populations. There are significant regional variations which do not reflect the recommendations for bed numbers based on catchment population identified in “A Vision for Change” (2006). However further consideration must be given as to the suitability of the current stock of buildings for use as therapeutic environments for individuals who use the service.
4.35 Harkness et al (2004) identify that older buildings are noted to have a direct negative impact on both cost to the service and service user outcomes. In particular, these buildings will not meet current standards in regards to insulation etc. leading to higher than normal non pay costs. While not all services were in a position to return the date of construction, of those returned, the breakdown is as follows: more than 80% of the current stock of buildings predate 1990 and 64% predate 1980. 13% of the current building stock predates World War 2 and 5% were built before 1900 (Charts 49 to 51).

4.36 Of the remaining traditional psychiatric hospitals which continue to house individuals who use the service, 15 were built pre 1900 with the remaining 4 being built between 1900 and 1950. The age of the buildings is reflected in the accessibility within them. Of the current stock, only 11.7% are considered by service providers to be disability accessible. Of the remaining 88%, over 66% can not be converted at a reasonable cost, according to the survey of service providers.

4.37 Over 80% of buildings are located over two or more floors, with less than 12% having access to second or third floors via lifts or stair lifts. This becomes an increasing problem with the ageing population of individuals who are currently using the services.

4.38 Where the result of the environmental survey identified premises which are no longer fit for purpose, these premises should be re-designated for office use, or to relocate non residential care services currently in leased or rented accommodation. Alternatively, unsuitable premises may be sold and the income generated re-invested in the development of mental health services. Income realised from the sale of properties could be used to address the deficits in services in Dublin Mid-Leinster and Dublin North East. It is important to note that the re-designation or sale of any property that currently offers accommodation is contingent on the appropriate alternative services being in place.
Conclusions

4.39 Significant financial resources are allocated to mental health on an annual basis. Based on the returns for this review, 30% of the national Mental Health budget is spent on the provision of long stay residential mental health services, this equates to €249 million.

4.40 The most significant portion of these costs are staff based, with 87% or €219 million of total costs directly attributed to staffing. There are significant differences in staffing levels across mental health catchment areas. Wide regional variances occur in the WTE availability and the skill mix deployment, even in similar care environments, leading to significant differences in the cost per bed per day and in the length of waiting lists. High support community residences and long stay in-patient units account for the majority of staffing costs. Non-pay costs vary significantly between regions and need to be more closely monitored.

4.41 The review highlights concern regarding the quality of the infrastructure available, with over 88% of all community residences having limited disabled accessibility. Comparison of existing bed numbers against recommendations in ‘A Vision for Change’ (2006) suggests there is over provision in bed capacity. However, of the current 2,790 beds only 335 are in units which are disability accessible and therefore fit for purpose.
Map 4-9: Total Community beds per 100,000 population

Total Community Beds (Per 100K)

Map Produced by:
PDCC Projects Office,
Hollard Rd,
Limerick
Under licence HSE0079601

Data Sources:
Health Service Executive
Ordnance Survey Ireland
Central Statistics Office
Map 4-10: Total long stay In-patient beds per 100,000 population
Map 4-11: Mental Health Locations
5. Future Funding and Alternative Approaches

Irish mental health services may be “continually faced with a series of great opportunities brilliantly disguised as insoluble problems” (John W. Gardner).

5.1 This Chapter is concerned with three parts of the Evaluation Terms of Reference:

Evaluate the degree to which the objectives of the provision of Long Stay Residential Care warrant the continued allocation of public funding.

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’; other relevant Government and EU policies and strategies and currently available evidence based practice.

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

Justification for the continued allocation of public monies

5.2 The starting point for the consideration of the continued justification for the allocation of public monies to mental health services provision is to consider the current situation. There are wide regional variations between the four administrative areas with further variations within the administrative areas between mental health catchment areas. This implies that some redistribution of the organisation of service provision is needed. This redistribution needs to be meaningful in the context of reflecting ‘A Vision for Change’ (2006) so that resources are targeted in support of the new service model. The future model as identified in “A Vision for Change” (2006) is based on a population focused service.

<table>
<thead>
<tr>
<th>HSE Region</th>
<th>Population</th>
<th>Total Cost €</th>
<th>Total WTE Staff</th>
<th>Per Capita Expenditure on Long stay Residential Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dublin Mid Leinster</td>
<td>1,216,848</td>
<td>€31,508,914.84</td>
<td>526.99</td>
<td>€ 25.89</td>
</tr>
<tr>
<td>Dublin North East</td>
<td>928,619</td>
<td>€41,423,652.89</td>
<td>674.41</td>
<td>€ 44.60</td>
</tr>
<tr>
<td>South</td>
<td>1,081,968</td>
<td>€83,995,684.21</td>
<td>1,290.95</td>
<td>€ 77.63</td>
</tr>
<tr>
<td>West</td>
<td>1,021,413</td>
<td>€73,728,579.45</td>
<td>1,215.33</td>
<td>€ 72.18</td>
</tr>
<tr>
<td>Central Mental Hospital</td>
<td></td>
<td>€18,676,000.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nationally</td>
<td>4,248,848</td>
<td>€249,332,831.39</td>
<td>3,707.68</td>
<td>€ 58.68</td>
</tr>
</tbody>
</table>

*Table 5-1: Snapshot of regional variations in resource allocations*
5.3 The WHO estimates that mental health disorders accounted for about 12 - 15% of total disability in the world in 2000, twice that of all forms of cancer, and higher than cardiovascular diseases. In its Green Paper on “Improving the mental health of the population: Towards a strategy on mental health for the European Union” the EU Health and Consumer Protection Directorate General identifies that more than 27% of the adult population of Europeans experience a form of mental health problem in any one year. This would equate to 872,319 of the adult population of Ireland based on the 2006 Census figures. The General Directorate further notes that more people die annually in Europe of suicide than road traffic accidents, homicide and HIV/AIDS combined.

5.4 Liimatainen & Gabriel, (2000) suggest that the cost of mental ill health within the EU is at least 3–4% of gross national product. McDaid et al (2005) further identify that between 60% and 80% of the total economic impact/consequences of major mental health disorders occur outside the health sector, being due to lost employment, absenteeism, poor performance within the workplace and premature retirement. The above factors are the basic economic and social rationale for the continued provision of funding for effective mental health services.

Current Validity of objectives

5.5 Mental health has a major impact on social wellbeing in a country. Mental disorders generally start at a young age. Almost 40% of all first admissions over a five year period were under the age of 34 (Daly and Walsh 2002-2006). This combined with a relatively low mortality rate makes mental health almost unique in its impact over an individual’s lifetime.

5.6 Those with enduring mental illness, such as schizophrenia or other psychoses, which are the most debilitating and stigmatising, are more likely to become long stay users of the mental health services and to require long stay residential care. Over a five year period, research published by Daly and Walsh of all admissions to in-patient psychiatric care in Ireland identified that over 14% of first admissions and 29% of readmissions are due to a diagnosis of schizophrenia or other psychoses.

5.7 While it is clear that mental ill health has a significant impact on society, spending on mental health is consistently less than the other major care groups, with the exception of groups for Children, Families and Other. Two groups that would directly impact on the delivery of long stay residential mental health services - Older Persons and Disability - have a significantly greater portion of the PCCC budget. The PCCC Resource Distribution Overview (Walsh 2007), together with the data from this review, demonstrates a break down of the mental health component of PCCC budget is as set out in Chart 53.
Map 5-1: Per capita spending on long term mental health, as returned
5.8 The National Economic and Social Forum (2007) published a report on Mental Health and Social Inclusion and concluded that there is a consistent relationship between mental ill health and indicators of social exclusion. It argues that mental health is a key resource which contributes to the overall social human and economic capital of our society.

5.9 A briefing to the European Ministerial Conference in Helsinki on behalf of the WHO in 2005 identifies a twelve point action plan which includes:

- Mental Health Promotion
- Ensuring the centrality of mental health in public policies
- Tackling Stigma and discrimination
- Promoting activities sensitive to vulnerable life changes
- Preventing mental health problems and suicide
- Ensuring access to good primary care for people experiencing mental health problems
- Offering effective care in community based services
- Establishing partnership across services
- Creating a sufficient and competent workforce
- Establishing good mental health information
- Providing fair and adequate funding
- Evaluating the effectiveness of services and generate new evidence

5.10 Recent legislative changes such as the Human Rights Act 2003, and the Mental Health Act 2001, combined with the policy developments of ‘A Vision for Change’ (2006) puts in place a framework that addresses the European Action Plan. It identifies additional funding requirements as well as the remodelling and reallocating of existing resources for the full mental health services. It places Irish mental health services in a position to substantially change, in a positive way, the lives of individuals who use the service.

5.11 The WHO in 2003 recognised Community-based mental health services generally cost the same as the hospital-based services they replace. However, studies carried out in the UK, Italy and Norway have consistently found that outcomes for clients discharged to community care are better than in long stay in-patient units.

5.12 Over a five year follow up on a group of individuals who use the service, the TAPS study in the UK found that at the end of five years, two thirds of the individuals were still living in their original residences. Moving individuals to the community did not increase the service user death rate or suicide rate, and fewer than 1 in 100 individuals became homeless, and no individual from a staffed home was lost to follow-up. Over one third of the individuals were readmitted during the follow-up period, at the end of which 10% were in hospital. Overall, service user’s quality of life was greatly improved by the move to the community, but disabilities remained due to the nature of severe psychotic illness.

5.13 Mental health services must remain central to health policy in Ireland. The evaluation has established that the national commitments made in ‘A Vision for Change’ (2006), are designed to meet the highest international standards as identified by the WHO and European Union.

5.14 Resource allocation should map future requirements and services required to ensure available funding is used in a manner which meets the needs of the individuals who use the service. There is a consensus among all national models, in particular “A Vision for Change” (2006), and international models that individuals who use mental health service are best served
by a model described by the WHO (Thornicroft and Tansella 2003) as a balanced care model including both primary care mental health with specialist backup and mainstream mental health care which includes:

- Outpatient/ambulatory clinics
- Community mental health care teams (CMHTs)
- Case management
- Acute in-patient care
- Long-term community-based residential care
- Occupational and day care
- Coordination
- Specialised and differentiated mental health services
- Specialised outpatient/ambulatory clinics
- Specialised community mental health care teams (CMHTs)
- Assertive community treatment (ACT) teams
- Early intervention teams
- Alternatives to acute in-patient care
- Acute day hospitals
- Crisis houses
- Home treatment/crisis resolution teams
- Alternative types of long-stay community residential care
- 24-hour staffed residential care
- Day-staffed residential places
- Accommodation with lower levels of staff support
- Alternative forms of occupational rehabilitation

5.15 The demographics of individuals who use mental health service is changing, with a reduction in the number of graduates of traditional psychiatric care, but a substantial group of new long stay residents of five years or less. Where possible, future models of care should allow this group to achieve and maintain their independence. As noted in Chapter 2, individuals who use, or have used the service, are one of the key stakeholders in planning services moving forward.

5.16 The core philosophy of mental health services is to provide individualised care programmes for individuals and carers, based on identified need and implemented as much as possible in a non-institutional setting. While some services are delivered in long stay in-patient wards, the majority are in community residences, supported accommodation or the individual’s own home. A variety of models exist in Ireland some of which are explored below.

5.17 Cavan/Monaghan Mental Health Services provide a comprehensive integrated, community based service, responsive to the needs of individuals, families/carers and the community and that assists individuals to achieve their maximum potential. The structure through which services are delivered is based on specialist multi-disciplinary teams – two teams for those who are acutely or recurrently mentally ill (one per county), a team for individuals who use the service, with complex rehabilitation needs (both counties), and a team for psychiatry of later life (both counties). Through initiatives such as developing relationships with housing authorities etc. and the support of appropriate teams, the service is now moving to a new phase in delivery. Closing community residence as individuals move to independent
living, in many ways is a key objective of ‘A Vision for Change’ (2006) and which other services must strive to attain.

5.18 Many catchment areas in HSE South offer effective alternative models. In Wexford, community services are delivered in partnership with the local Mental Health Association, which provides the physical infrastructure and non pay costs, with mental health services providing staffing for the community residences. Similarly, in North and West Cork, Kerry, South and North Lee, only high support community accommodation is provided by Mental Health Services. Support to other individuals is either in their own home or in rented accommodation, whereby several individuals hold a tenancy agreement with either private landlords or in council accommodation.

**Alternative Approaches**

5.19 Long stay residential mental health services are delivered in a variety of ways, both nationally and internationally. This makes it extremely difficult to compare services even on a national level. The most common theme to any effective model is adequate funding, competent staffing and appropriate care being delivered in appropriate environments.

5.20 Some international models such as those suggested in the draft strategy from Carmarthenshire in 2007 are reflected in ‘A Vision for Change’ (2006) and suggest a range of support options for people with mental health problems which require innovative approaches. In Blackburn and Preston, mental health services, in conjunction with a private community based service (Supported Homes), provide a recovery focused, supported living arrangement and care packages for people with severe and enduring mental health needs. A floating Outreach Support Team, based on assessed need, is also provided. The focus is on promoting independence and aims to assist individuals who use the service to:

- Maintain a tenancy
- Develop life skills
- Gain coping mechanisms
- Manage their Medication
- Enrol in further education
- Gain meaningful employment
- Access community resources and enhanced social inclusion
- End the cycle of relapsing and returning to hospital

5.21 In the USA, the State of Tennessee developed a strategic plan to create housing options for people with mental illness and co-occurring disorders\(^\text{24}\). The aim of this plan was to “create and expand affordable, safe, permanent and quality housing options for people with mental illness and co-occurring disorders in Tennessee”. This was achieved through assertively and strategically partnering with local communities to educate, inform and expand affordable, safe, permanent and quality housing options for people with mental illness and co-occurring disorders. While a range of alternative accommodations similar to those identified are included, a key element of the Tennessee model is that of case management, whereby an individual has an identified case manager who coordinates all the care that individual receives.

\(^{24}\) Trotter at al. (2005)
5.22 In the UK, the Care Programme Approach adopts a similar philosophy, whereby a Care Plan Coordinator oversees all aspects of care delivery; include organising reviews of care, placements and team involvement.

5.23 The key to all successful models is the provision of a variety of housing options, which involves separating mental health treatment from housing requirements and supporting these options with a seamless integrated and fully staffed community based service.

**Conclusions**

5.24 The justification for the continued allocation of public monies to the mental health services is rooted in strong economic and social arguments. From an economic perspective, the amounts spent on mental health services are modest in comparison to the relatively high proportion of adults (27%) who may experience some form of mental health problem in any one year, the significance of mental health within the total burden of ill health (20%) and the economic cost of mental illness measured in terms of gross national product (3-4%).

5.25 The continued validity of the objectives of mental health services is established through consideration of the key strategic elements of ‘A Vision for Change’ (2006). The general approach adopted is directly following the prevailing strategy supported by the WHO and the EU. The objectives are consistent with the EU objectives. From a Value for Money perspective, the strategy offers further improvements in cost effectiveness.

5.26 Due consideration of alternative approaches was taken in the development of ‘A Vision for Change’ (2006). By reference to specific practices in the USA and the UK, it is confirmed that the overall Irish approach reflects international good practice. The operation of the mental health services within the wider EU context provides an opportunity to keep abreast of current thinking for the further improvement of services.
6. Key Performance Indicators

Introduction

6.1 This Chapter specifies potential future performance indicators that might be used to better monitor the performance of Long Stay Residential Care for Adults within Mental Health Services. The Project Team made a short literature review of relevant approaches to performance indicators for mental health services, with a specific emphasis on service effectiveness. This Chapter summarises a possible approach to indicators based on this review.

6.2 Only 22% of community residences and 30% of in-patient residences use key performance indicators to report on compliance with legislation and with up to date policies rather than outcomes for individuals who use, or have used, the service.

Stages in the development of Key Performance Indicators

6.3 The WHO (2005) describes Performance Indicators as ‘measures which:

(i) summarise information relevant to a particular phenomenon;
(ii) can be used to indicate a given situation; and
(iii) can therefore be used to measure change.

In the context of mental health care, indicators are measures that summarise information relevant to the mental health service and the population that it serves.’ The WHO recognises that while there is a historic focus on input and process indicators, it is generally difficult to build in outcome indicators.

6.4 When considering developing performance indicators, the WHO (2005) recommends four key stages:

What information do we need? (Needs assessment)

6.5 The WHO differentiated between the different information needs of key stakeholders. It is critical that any performance indicators developed should reflect and capture the appropriate information for each key stakeholder. Any framework must be discussed and finalised with all key stakeholders. A list of suggested stakeholders by the WHO is shown in Table 6-1. (Page 64).

6.6 For most direct stakeholders, the information needs are a mix of clinical and operational measures that concern them. The Value for Money perspective is most closely reflected by the information needs of the ‘planners, managers and policy-makers’ group. The information needs shown in Table 6-1 for this group indicate the demand side of the service in terms of the ‘needs of the population for services’ and the strategic and tactical response of the service providers (resources, processes and outcomes). The Value for Money agenda will consider the effectiveness of outcomes in terms of the extent to which the actual outcomes contribute to meeting the targets that were set and the efficiency of resource use in terms of the processes and resources.
Table 1. Mental health stakeholders and their information needs

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Information needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with mental disorders</td>
<td>&gt; Information on good quality, accessible, affordable care</td>
</tr>
<tr>
<td></td>
<td>&gt; Privacy</td>
</tr>
<tr>
<td></td>
<td>&gt; Confidentiality</td>
</tr>
<tr>
<td></td>
<td>&gt; Outcomes</td>
</tr>
<tr>
<td>Families of people with mental disorders</td>
<td>&gt; Information on appropriate care for family member</td>
</tr>
<tr>
<td></td>
<td>&gt; Information on course and likely outcome of family member's condition</td>
</tr>
<tr>
<td></td>
<td>&gt; Information on available support</td>
</tr>
<tr>
<td></td>
<td>&gt; Outcomes</td>
</tr>
<tr>
<td>Clinicians</td>
<td>&gt; Case records</td>
</tr>
<tr>
<td></td>
<td>&gt; Treatment guidelines</td>
</tr>
<tr>
<td></td>
<td>&gt; Referral routes</td>
</tr>
<tr>
<td></td>
<td>&gt; Available resources in adjacent services</td>
</tr>
<tr>
<td></td>
<td>&gt; Outcomes</td>
</tr>
<tr>
<td>Planners, managers and policy-makers</td>
<td>&gt; Current mental health policy and plans</td>
</tr>
<tr>
<td></td>
<td>&gt; Needs of the population for services</td>
</tr>
<tr>
<td></td>
<td>&gt; Resources (inputs) available to deliver the services</td>
</tr>
<tr>
<td></td>
<td>&gt; Process of care delivery</td>
</tr>
<tr>
<td></td>
<td>&gt; Outcomes</td>
</tr>
<tr>
<td>NGOs</td>
<td>&gt; Any of the above, depending on their focus</td>
</tr>
<tr>
<td></td>
<td>&gt; Areas of potential overlap or collaboration with the public sector</td>
</tr>
<tr>
<td></td>
<td>&gt; Current mental health policy and plans</td>
</tr>
</tbody>
</table>

Table 6-1: Mental Health Stakeholders and their Information Needs (WHO 2005)

What information do we have? (Situation analysis)

6.7 Currently a minority of services, within an Irish Mental Health context, collect any information in relation to measuring performance. Those that do by and large describe the key performance indicators as achieving compliance with legislative requirements such as those that govern health and safety etc. Few, if any, focus on outcomes for individuals who use the services or operating within fixed budgets.

6.8 This evaluation is contributing to the agenda for improving the availability of performance information by highlighting the gaps in financial (budget and actual expenditure) allocation within the mental health services and the reconciliation to statutory based information. It also shows the baseline information that is available as a starting point to conduct a Value for Money analysis of the service.

How can we get the information we need? (Implementation)

6.9 Developing appropriate indicators requires a high degree of judgment and input from all potential key stakeholders. In order to keep the list of indicators simple and straightforward, the following questions may usefully be asked (Bodart & Shrestha, 2000):
• Validity: Does the indicator measure what it is supposed to measure?
• Reliability: Does the indicator provide a consistent measure?
• Cost (proportionality): Is the indicator worth the resources required to measure it?
• Relevance: What useful decisions can be made from the indicator?
• Specificity: Does the indicator actually capture changes that occur in the situation under study?
• Sensitivity: Does the change shown by the indicator represent a true change in the situation?
• Balance: Do we have a set of indicators that measure different components of the mental health service?
• Data capture: How, when and where would the necessary data be captured?

6.10 As the HSE in general, and the Mental Health Services in particular, further develop a strategic objectives-driven approach, the performance indicators selected to reflect Value for Money need to be embedded into its management system by a close alignment to objective setting at different levels from overall objective to expected results to activities. Further refinement of activity measures and performance indicators for both the HSE Corporate Plan and the HSE Annual National Service Plan will take place under the auspices of the recently established Joint HSE/Department Performance Information Group.

6.11 The use of the census in this evaluation gives some indication of what can be achieved in terms of data collection and analysis without an elaborate and expensive monitoring system. Some census or sampling based data is always needed to make a comprehensive study of outcomes in terms of effectiveness and impact. The routine monitoring of resources and activities through reliable management information systems is also needed to provide a consistent information set over several years for the purpose of considering relevant aspects of the efficiency of service provision.

*How well are information systems working? (Evaluation)*

6.12 This step considers the extent to which the information systems assists managers and clinicians in their decision-making and actions; and the extent to which it helps the planning process

**Performance measurement domains**

6.13 The selection of suitable performance indicators should be organized around specific Value for Money and Policy criteria. Hallwright (2006) has identified nine domains of the national mental health performance framework within which the criteria can be organised. The domains cover both national strategic planning priorities and the desired positive outcomes for service users. The nine domains can be divided between the two Value for Money criteria of effectiveness and efficiency to provide a convenient framework on which to build a robust set of performance indicators. This is shown in Table 6-2. (Page 66).
### Performance criteria/ attribute | Explanation
--- | ---
**Effectiveness**
Effective Care: | Intervention or action achieves desired outcome.
Responsiveness: | Service provides respect for persons and is consumer orientated – respect for dignity, confidential, participate in choices, prompt, quality of amenities, access to social support networks, and choice of provider.
Accessibility: | Ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background.
Sustainability: | System or organisation’s capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring).
**Efficiency**
Appropriateness: | Care/intervention/action provided is relevant to the service user’s needs and based on established standards.
Efficiency: | Achieving desired results with most cost effective use of resources.
Continuity: | Ability to provide uninterrupted coordinated care or service across programmes, practitioners, organisations and levels of time.
Capability: | An individual or service’s capacity to provide a health service based on skills and knowledge.
Safety: | Potential risks of an intervention or the environment are identified and avoided or minimised.

Table 6-2 Effectiveness and efficiency performance criteria (based on Hallwright, 2007)

**Performance indicator set**

6.14 For the further identification of a small basic set of performance indicators that are relevant to both the WHO stakeholder perspective (resource, process, outcome) and to the Value for Money agenda (effectiveness, efficiency), reference was made to a model from Gauteng province, South Africa that uses a small set of Inputs, Process and Outcomes indicators, as follows:

<table>
<thead>
<tr>
<th>Input indicators</th>
<th>Process indicators</th>
<th>Outcome indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>used to measure standards related to adequate staff numbers, adequate bed numbers and the availability of medications.</td>
<td>used to measure standards related to the optimal utilisation of residential facilities.</td>
<td>used to measure standards related to the positive impact of interventions, for example:</td>
</tr>
<tr>
<td>• Budgets</td>
<td>• bed occupancy rates;</td>
<td>• clinician assessments of outcome at discharge from long stay services;</td>
</tr>
<tr>
<td>• the ratio of beds to population;</td>
<td>• length of consultation times in outpatient settings;</td>
<td>• satisfaction of people with mental disorders;</td>
</tr>
<tr>
<td>• the ratio of staff to beds per unit type;</td>
<td>• readmission rates to acute services</td>
<td>• satisfaction of family members or other carers.</td>
</tr>
<tr>
<td>• WTEs per 100,000 population</td>
<td>• family involvement in care of the people with mental disorders;</td>
<td></td>
</tr>
<tr>
<td>• Staff Cost per bed per day per unit type</td>
<td>• service support for families.</td>
<td></td>
</tr>
</tbody>
</table>

Table 6-3: Input – process – output indicators
6.15 The Project Team considers that this small set would be a convenient starting point to commence constructing a set of performance targets that could be progressively monitored as ‘A Vision for Change’ is implemented. Table 6-4 expands this set into a more formal structure, identifying the relevant information and timeframes for data collection.

### Timeframe for the measurement of indicators

6.16 It is important to identify the times during an annual cycle when key performance indicators are collected and processed. Data collection will depend on how frequently data can feasibly be collected and the rate at which change is likely to be observed in the aspect being measured (WHO 2005).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Type of Information</th>
<th>Method of Collection</th>
<th>Frequency of collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
<td><strong>Efficiency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget</td>
<td>Has each unit an identified budget against which all costs are allocated</td>
<td>Financial Control</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Does Unit operate within agreed budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is the average cost per bed per day, how does this reflect a national average</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are records and statistics of budgets and costs maintained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds per 100K Population</td>
<td></td>
<td>Survey</td>
<td>Annual</td>
</tr>
<tr>
<td>Staffing</td>
<td>Are staffing levels based on a dependency ratio model</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number/Type of Staffing and Rostered hours</td>
<td>Survey</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Do staffing levels reflect an appropriate skill mix based on needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Capable</strong></td>
<td></td>
<td>Survey</td>
<td>Annual</td>
</tr>
<tr>
<td>Skills and knowledge</td>
<td>What is the level of staff training</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are evidence based models used</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td><strong>Effective Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td>From where, how many, reason for</td>
<td>Routine day</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>to day data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Stay bed occupancy Rate</td>
<td></td>
<td>Routine day</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>to day data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite Bed Occupancy Rate</td>
<td>Number of occupied bed nights</td>
<td>Routine day</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of individuals using services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length stay</td>
<td></td>
<td>Routine day</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>to day data</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accessible Services</strong></td>
<td><strong>Demographic Profile of Individuals who use the service</strong></td>
<td>Routine annual data</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Age,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Type of Information</td>
<td>Method of Collection</td>
<td>Frequency of Collection</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Appropriate Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral System</td>
<td>Logical and Efficient</td>
<td>Survey</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Is there an evidence based assessment using a tool such as Camberwell prior to placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Profile</td>
<td>ICD 10 Data</td>
<td>Routine Annual Data</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Continuous Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to provide</td>
<td>Are there regular reviews, frequency, duration and</td>
<td>Routine Daily data</td>
<td>Monthly</td>
</tr>
<tr>
<td>uninterrupted coordinated</td>
<td>attendeees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care or service across</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>programmes, practitioners,</td>
<td>Have service user’s access to primary care services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>organisations and levels</td>
<td>GPs etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have service users fair and equal access to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>secondary and tertiary services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service provide</td>
<td>Level of activities of service users: attendance at Day</td>
<td>Routine day to day data</td>
<td>Monthly</td>
</tr>
<tr>
<td>meaningful activities for</td>
<td>Centres, participation in social and therapeutic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>individuals who use the</td>
<td>activities attendance at sheltered workshops, participation in paid employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency of residents meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service provides</td>
<td>Purpose of meeting, therapeutic, social, household</td>
<td>Annual</td>
<td>Survey</td>
</tr>
<tr>
<td>respect for persons and</td>
<td>management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>is consumer orientated</td>
<td>Are consumer satisfaction levels monitored and what are the outcomes of this monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are family and carers actively encouraged to be</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>involved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are advocacy or voluntary groups involved and what is the level of this involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharges</td>
<td>Number of Discharges</td>
<td>Routine day to day data</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>When discharged do service users move to more or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>less independent accommodation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is the readmission rate to acute services from</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>long stay residential units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe</td>
<td>Are services disability accessible</td>
<td>Annual</td>
<td>Survey</td>
</tr>
<tr>
<td></td>
<td>Are evidence based risk assessments utilised</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do the services meet the requirements laid out in the National Risk Register for mental health service environments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 6-4: Performance indicators – time and frequency of collection*
Challenges in implementing the performance indicator framework

6.17 The WHO (2003) identifies that a “fundamental problem with defining such indicators is the lack of consensus about these goals and the consequent lack of definition as to what constitutes good performance. The various stakeholders in a mental health system, i.e. people with mental disorders, family members, advocates, providers, funders and policy-makers, often have different performance requirements.”

6.18 Accurate capturing of data allows services to plan and organise the delivery of care in the most effective and efficient way. For staff working within the services it allows them to measure the benefits of their interventions with individuals who use the service. Considerable work is currently being undertaken and a working group was established in 2006 with representatives of the Mental Health Commission and the Health Research Board to work on ‘A Mental Health Minimum Data Set’.

6.19 By improving the quality of care, services will increase the likelihood of positive outcomes of care for individuals who use the services. “The ultimate goals of quality improvement are to respect the rights of people with mental disorders, to ensure that they are provided with the best available evidence-based care, to increase self-reliance and to improve the quality of life.” (WHO 2003) Performance indicators are however only, one of the assessment tools that can be used.

6.20 While an IT system would enhance data collection and collation, in its absence the information can be collected manually. However, it will be necessary for services to develop the necessary systems and to change work practices to ensure the accurate recording of the relevant information.

Conclusions

6.21 A small core set of performance indicators are proposed for the long term residential care mental health services to support the implementation of ‘A Vision for Change’ and monitor in value for money terms of the effectiveness of outcomes and the efficiency of the use of allocated resources.

6.22 The mental health services will need to collect performance information for its performance indicators through both its management information systems and by periodic survey. Systems for the collection of performance information need to be further developed and maintained.

6.23 The Value for Money performance indicators are a small subset of a wider framework of indicators needed to provide for the information needs of stakeholders.
7. Conclusions and Recommendations

7.1. This Chapter is divided into two sections. In the first section, the conclusions from the earlier chapters are assembled in a table in order to make recommendations that are relevant to the Value for Money and Policy agenda for the Mental Health Services. The second section consists of a wider and more detailed set of recommended actions covering strategic and operational issues for the Long Term Residential Care services. This is also set out under the Chapter headings used for the report.

VFMP Conclusions and Recommendations Table

<table>
<thead>
<tr>
<th>Conclusions</th>
<th>Recommendations</th>
<th>Action by:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Objectives</strong></td>
<td>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 alter 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.</td>
<td>A medium term action plan, based on the findings of this report should be drawn up and presented to the management of the Mental Health Services for consideration. The action plan should have measurable targets and should identify the resources needed for implementation.</td>
</tr>
<tr>
<td></td>
<td>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,</td>
<td>The medium term strategic plans for the mental health services should be supported by a hierarchy of objectives linking overall objectives, results and actions and identifying time bound output and results indicators to monitor the progress of implementation.</td>
</tr>
</tbody>
</table>

25 It is noted the Management Structure may change in 2009 but a strong national lead is essential
activities and financial resources.

### Service Resources

Significant financial resources are allocated to mental health on an annual basis. Based on the returns for this review, 30% of the national Mental Health budget is spent on the provision of long stay residential mental health services, this equates to €249 million.

<table>
<thead>
<tr>
<th>The financial allocation should be devolved to services so that the efficiency of service provision can be monitored.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A review of staff distribution should be made, combined with a review of accommodation capacity to ensure an appropriate staff allocation based on service needs.</td>
</tr>
<tr>
<td>Sufficient resources should be allocated for the implementation of ‘A Vision for Change’ based on a cost benefit analysis, so that the potential cost savings can be realised over the medium term.</td>
</tr>
<tr>
<td>The improvement of accessibility to community residences should be prioritised in order to meet the obligations for equal access to services.</td>
</tr>
</tbody>
</table>

The most significant portion of these costs are staff based, with 87% or €218 million of total costs directly attributed to staffing. There are significant differences in the utilisation of staffing across mental health catchment areas. Wide regional variances occur in the WTE availability and the skill mix deployment, even in similar care environments, leading to significant differences in the cost per bed per day. High support community residences and long stay in-patient units account for the majority of staffing costs.

<table>
<thead>
<tr>
<th>While some cost savings may be generated, these would be absorbed or reinvested in the further development of community based support. Accordingly, the overall conclusion of the report is that full implementation of ‘A Vision for Change’ offers the prospect of enhanced effectiveness and impact of service in the longer term, in line with current international good practice, with little additional budget or resource allocation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The changing profile of the service user population should be continuously monitored to inform future strategic plans for the mental health services.</td>
</tr>
</tbody>
</table>

### Service Effectiveness and Efficiency

Long stay residential mental health services continue to cater for a diverse group of users ranging from the “graduates” of the old asylum system to the new long stay, those who have been resident for less than five years. The predominately male client group fall into an age bracket of over 45 years.
with a significant number over 65 years of age.

The service on census night returned 87% occupancy levels, with 75% of clients being identified as appropriately placed. Of those individuals who are inappropriately placed on in-patient units over 59% would be more appropriately placed in the community and 32% of those inappropriately placed in community residences require lower support or independent accommodation.

Community based services account for the majority of long stay admissions, however there continues to be a small number of long stay admissions to acute in-patient units (1.76% of long stay admissions over a five year period).

The majority of service user activities are of a social nature, with fewer individuals engaged in therapeutic activities. The lack of a consistent understanding of, or approach to, rehabilitation is evident, with less than 25% of individuals in high support community residence and only 6.7% of individuals on identified rehabilitation units, participating in rehabilitation training. Of equal significance is the small difference between the numbers of individuals in paid employment who reside in high and low support community residences.

The majority of discharges from long stay residential services are to lower levels of supported accommodation. However, there is a relatively small through flow of services users with only a total of 5,159 discharges nationally over a five year period.

There is scope for significantly increasing the proportion of service costs that are recovered in residence charges.

Future funding and Alternative Approaches

The justification for the continued allocation of public monies to the mental health services is rooted in strong economic and social arguments. From an economic perspective, the amounts spent on mental health services are modest in comparison to the relatively high proportion of adults (27%) who may experience some form of mental health problem in any one
year, the significance of mental health within the total burden of ill health (20%) and the economic cost of mental health measured in terms of gross national product (3-4%).

The continued validity of the objectives of mental health services is established through consideration of the key strategic elements of ‘A Vision for Change’ (2006). The general approach adopted is directly following the prevailing strategy supported by the WHO and the EU. The objectives are consistent with the EU objectives. From a Value for Money perspective, the strategy offers further improvements in cost effectiveness.

Due consideration of alternative approaches was taken in the development of ‘A Vision for Change’ (2006). By reference to specific practices in the USA and the UK, it is confirmed that the overall Irish approach reflects international good practice. The operation of the mental health services within the wider EU context provides an opportunity to keep abreast of current thinking for the further improvement of services.

Performance Indicators

A small core set of performance indicators are proposed for the long term residential care mental health services to support the implementation of ‘A Vision for Change’ and monitor in value for money terms the effectiveness of outcomes and the efficiency of the use of allocated resources.

Senior management should adopt the proposed performance indicators set out in this report. Performance reports based on these indicators should be introduced with effect from 2009.

The mental health services will need to collect performance information for its performance indicators through both its management information systems and by periodic survey. Systems for the collection of performance information need to be further developed and maintained.

The proposed performance indicators should be made known to the working teams responsible for the development of management information systems in the mental health services.

The Value for Money performance indicators are a small subset of a wider framework of indicators needed to provide for the information needs of stakeholders.

The performance indicators should be used to inform a continuous dialogue between the mental health services and its primary stakeholders.
Actions needed to implement ‘A Vision for Change’

7.2. In this Section, a more detailed set of actions is presented to reinforce the implementation of ‘A Vision for Change’.

Service Objectives

Full implementation of ‘A Vision for Change’ (2006) must be pursued as a matter of urgency across all regions in respect of people with long stay mental health problems. The introduction of fully staffed community teams will allow service to move forward and be delivered in a more effective way for service users and achieve a more cost effective residential service.

Residential mental health services must ensure that cultural and religious needs of all individuals who use the services can be addressed.

A complete review of individuals’ experiences, who use the service, should be carried out on a national level across all long stay residential units. The findings of this review should inform future planning and development of services. This review should ideally be undertaken by a group, representative of those who use the service.

Non HSE agencies should lead in meeting the housing needs of individuals with mental health problems, within mainstream housing.

Future service developments should take place in locations which reflect the needs of service users.

Service Resources

In order to fully cost services, and measure their efficiency and cost effectiveness, budgets must be devolved to unit level.

Where historic services are provided from one Local Health Office area to another, it is essential that clear financial arrangements are put in place to support clients in their journey through mental health services. To ensure fair and equal distribution of funding, extra contractual arrangements need to be put in place to ensure equal distribution of burden.

In order for mental health services to deliver the quality care aspired to in policy documents, it is essential that a complete environmental review of current stock be undertaken.

Dispose of, or re-designate, the use of those buildings no longer fit for purpose and replace as necessary.

Funding released through the sale of these properties should be ring-fenced within the Exchequer, to support the development of Mental Health Services and the implementation of ‘A Vision for Change’ (2006).

Capital funding must be made available to address the deficits in service in Dublin Mid-Leinster and Dublin North East. This can be achieved either by the replacement or refurbishment of existing facilities or by additional facilities where necessary.
Staffing levels must be determined by the use of an accepted service user dependency rating system, to ensure the most efficient and effective deployment of staff.

A complete audit to identify staff activity, as well as monitoring any changes in activity (both positive and negative) and the reasons for any significant variations that are observed amongst the different providers of similar services should be carried out as a matter of urgency.

Annual Key Performance indicators should capture the unit’s ability to operate within fixed and agreed budgets.

Service effectiveness and efficiency

Placement of clients should reflect the role, purpose and function of each unit and the appropriateness of the environment to their needs.

In-appropriately placed long service users on acute in-patient units should be prioritised for placement within the community based services.

It is clear that there continues to be a need for the HSE to provide long stay residential mental health services into the future. In the absence of the necessary community based supports and an appropriate housing strategy, the onus is currently on the HSE to provide accommodation. However, there should be clarification between HSE responsibility to provide appropriate treatment and the housing needs of service users.

The concept of rehabilitation and recovery needs to be fully implemented in practical and measurable ways.

Training and employment agencies, in consultation with both service providers and service users, should seek to develop appropriate supported employment for people with severe mental health problems.

Future Funding and Alternative Approaches

An equitable distribution of mental health service funding must be achieved, in order to allow regions with serious deficits in service to achieve national standards. This however should not be to the detriment of existing services.

Any new resources should be allocated through an agreed national model which takes account of burden population (deprivation weighting) and base funding.

Appropriate funding for mental health service must remain central to all health funding. Mental health funding should be ring fenced within the PCCC care group structure.

A restructurin of service provision, can be achieved when the appropriate services, i.e. fair access to permanent housing, employment etc. are in place. This restructuring will free funds currently tied up in capital stock, such as low and medium support accommodation and release the staffing resources allocated to them for use in implementing the teams identified in “A Vision of Change” (2006).

The various stakeholders in mental health care often have different performance requirements. Consequently it is difficult to prove the effectiveness of long stay residential mental health care
in terms of outcomes for individuals who use the service. These outcomes are based on improving quality of life, which is however a subjective assessment.

The introduction of a case management system, which would see service users having an identified worker responsible for co-planning all aspects of their care, would both enhance the quality of care an individual receives and allow more effective planning and delivery of services.

*Performance Indicators*

Performance indicators should include both service management systems (facility-level and system-level data) and service user record systems (episode-level and case-level data).

The content and design of performance indicators should take into consideration the views and contributions of all key stakeholders.
Appendices
Appendix 1: Members of the National Steering Group

David Gaskin  Chair, Local Health Manager Meath & Lead Local Health Manager Mental Health Services, HSE Dublin North East
Declan Mangan  Project Leader & Assistant Director of Nursing – Louth/Meath Mental Health Services, HSE Dublin North East
Martin Rogan  HSE Assistant National Director - Mental Health Services
John Redican  CEO, Irish Advocacy Network
Stephen Mulvany  HSE Assistant National Director – Finance

*Replaced by:* Joe Sheeky, HSE Assistant National Director – Finance

Ena Lavelle  Consultant Psychiatrist (Rehabilitation), St Ita’s Hospital, Portrane.
Dora Hennessy  Principal Officer, Department of Health and Children, with Responsibility for Mental Health
Conor Kerlin  Principal Officer, Performance Evaluation Unit, Department of Health and Children

*Replaced by:* Tracey Conroy, Principal Officer, Performance Evaluation Unit, Department of Health and Children

Eddie O Reilly  Assistant Principal Officer, Finance Unit, Department of Health & Children

*Replaced by:* Nuala O’Reilly, Assistant Principal Officer, Finance Unit, Department of Health & Children.

David Byrne  Assistant Principal Officer, Performance Evaluation Unit, Department of Health and Children

*Replaced by:* Tony Flynn, Assistant Principal Officer, Performance Evaluation Unit, Department of Health and Children

Patricia Purtill  Principal Officer, Sectoral Policy Division, Department of Finance
Breda Rafter  Assistant Principal Officer, Department of Finance
Barry O’Brien  Assistant Principal Officer, Department of Finance

Project Group: Service Objectives

Declan Mangan: Project Leader & Assistant Director of Nursing Louth Meath Mental Health Service
John Redican: CEO, Irish Advocacy Network
Martin Rogan: HSE Assistant National Director - Mental Health
Ena Lavelle: Consultant Psychiatrist (Rehabilitation), St Ita’s Hospital, Portrane

Project Office

Declan Mangan: Project Leader & Assistant Director of Nursing Louth Meath Mental Health Service
Doreen Doran: Administrator

Maps Produced by

Dr. Deirdre Mullins, Senior Research and Information Officer, Project Office – PCCC, Health Service Executive, Holland Road, Plassey Technological Park, Limerick
Appendix 2: Methodology

The review was managed by a project team who reported to the HSE’s National VFMP Steering Committee. A document detailing the scope of the project was developed by the project team and agreed by the steering group.

A national audit of both residential mental health services (In-patient and community) and the individuals who use them, who meet the criteria of the project, was conducted in October 2007. A written questionnaire was developed in consultation with operational Mental Health Services, The Vision for Change Implementation Group and the National Mental Health Steering Group. Following feedback from a working group consisting of the managers of three mental health services (administrative and nursing representatives), the project team and subsequent national meetings, the questionnaires were modified prior to their circulation. The final survey was launched with three questionnaires on Low, Medium and High Support Accommodation; Long Term Residents in In-Patient Facilities; and Long Term Residents funded in Non HSE Facilities.

The questionnaires captured a broad range of information detailing:

- service provision, including management structures, unit/ward details, residence age, type, location and ownership,
- capacity, both long stay and respite,
- occupancy details including current vacancies and admission and discharge trends over a 5 year period (2002-2006),
- service user/resident activities, expenditure, including non staff and staff expenditure (utilising figures from the financial year ending 31st December 2006),
- resident charges,
- quality measurements.

The Questionnaire on Long Term Residents Funded in Non HSE Facilities captured details of contracted placements, discharge trends due to ward/unit or facility closures over a five year period (2002-2006). The purpose of this data was to explain spikes in admissions to community residences when, or if, they occurred. Prior to the circulation of the questionnaire, a letter was sent to all Local Health Managers and the National Offices of Staff Representative Groups, informing them of the survey and its purpose. The questionnaires were 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. The project team in conjunction with the National Steering Group set a target of 100% return. 100% of returns were received by the end of February 2008.

A sub-group of the national steering group was established to review the objectives of Long Stay Mental Health Care. This group comprised of:

Declan Mangan, Project Leader
John Redican, Advocacy Ireland
Martin Rogan, Assistant National Director Mental Health
Dr Ena Lavelle, Consultant Psychiatrist (Rehabilitation) St Ita’s Hospital, Portrane

A small project team was led by Declan Mangan, and based in David Gaskin’s office in Kells, Co. Meath. David is Lead LHM Mental Health Services for Dublin North East, and Chair of
the Value for Money Steering Group. The project team 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, Local Health Managers, Administrators and Service Area Managers. International comparators were obtained through liaison with:

Fran Silvestri, Director, International Initiative for Mental Health Leadership, New Zealand.
Bob Glover, Executive Director, National Association of State Mental Health Program Directors (NASMHPD), USA
David W. Miller, Project Director, NASMHPD, USA.
A statistical analysis company, ‘Insight Statistical Consultants’ were employed to input the data and produce a summary of all data captured from each question within each questionnaire in tabular format. David Harmon of Insight oversaw this aspect of the project. The review was independently assessed and validated by Michael Griffin, of Petrus Consulting Limited.

Data quality

The results of the survey are very much dependant on the quality of the data supplied by Mental Health Service Areas. Every effort was made by the project team to both improve and verify the accuracy of the data. The steps taken include:

- A series of meetings, two per HSE Region, was held with mental health administrators and/or representatives of nursing management prior to circulating the survey questionnaires. All mental health catchment areas were represented at these meetings.
- Guidance notes based on issues raised at these meetings accompanied the questionnaires.
- Throughout the census month (October 2007) a helpline and dedicated email support was available with FAQs and their answers were circulated to all mental health managers on a daily basis.

Where anomalies were discovered in returned questionnaires, these queries were referred back for validation to the services concerned. Further meetings were then organised with these services to clarify the anomalies prior to commencing data analysis.

In April 2008, Insight Statistical Consultancy produced a summary sheet for each mental health catchment area. This was circulated to each Local Health Manager for verification.

Limitations

The findings of the project 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.

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 consistent approach to financial data management forced the project to take a bottom up approach and the 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 can not be applied to a unit level.

It is also difficult to prove the effectiveness of long stay residential mental health care in terms of outcomes for individuals who use the service. This effectiveness is best measured by a combination of outcomes and more particularly, the structure and systems that are in place to deliver it. Notwithstanding the above, a 100% return rate 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.
Appendix 3: A Vision for Change

The current policy document ‘A Vision for Change’ (2006) was developed by an Expert Group on Mental Health Policy established in 2003 by the Minister of State for Mental Health. The Group engaged in a wide consultation process, with all stakeholders playing an active part in its deliberations. Published in January 2006 and accepted by Government as National Policy for Mental Health the Expert Group’s report ‘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 multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems.”

Moving forward into the 21st century, ‘A Vision for Change’ (2006) focuses on the delivery of care in the most appropriate environment 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 (chapter 1), inclusive (chapter 4) and recovery (chapter 12) 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.

The recommendations from the expert group in ‘A Vision for Change’ (2006) are:

Involvement of service users and their carers should be a feature of every aspect of service development and delivery.

Mental health promotion should be available for all age groups, to enhance protective factors and decrease risk factors for developing mental health problems.

Well-trained, fully staffed, community-based, multidisciplinary CMHTs (Community Mental Health Teams) should be put in place for all mental health services. These teams should provide mental health services across the individual’s lifespan.

To provide an effective community-based service, CMHTs should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families.

A recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Care plans should reflect the service user’s particular needs, goals and potential and should address community factors that may impede or support recovery.

Links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalised.

The mental health services should be organised nationally in catchment areas for populations of between 250,000 and 400,000. In realigning catchment boundaries, consideration should be made of the current social and demographic composition of the population, and to geographical and other administrative boundaries.

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26 Department of Health and Children, 2006
Organisation and management of local catchment mental health services should be co-ordinated locally through Mental Health Catchment Area Management teams, and nationally by a Mental Health Service Directorate working directly within the Health Service Executive.

Service provision should be prioritised and developed where there is greatest need. This should be done equitably and across all service user groups.

Services should be evaluated with meaningful performance indicators annually to assess the added value the service is contributing to the mental health of the local catchment area population.

A plan to bring about the closure of all mental hospitals should be drawn up and implemented. The resources released by these closures should be protected for re-investment in the mental health service.

Mental health information systems should be developed locally. These systems should provide the national minimum mental health data set to a central mental health information system. Broadly-based mental health service research should be undertaken and funded.

Planning and funding of education and training for mental health professionals should be centralised in the new structures to be established by the Health Services Executive.

A multi-professional manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this policy. This plan should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers.

An implementation review committee should be established to oversee the implementation of this policy.

Substantial extra funding is required to finance this new Mental Health Policy. A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.

A Vision for Change (2006) should be accepted and implemented as a complete plan.
Appendix 4: Estimation of Pay Costs

In order to determine the amount of pay costs, an analysis was made of all staff in post in the HSE Dublin North East Region, to establish the average point on the pay scale for each grade of staff (in excess of 1,200 staff were included in the analysis). This average was then applied nationally. All pay was calculated on the basis of an 11.14 hour shift, due to the variety of shift patterns and local arrangements. The formula to calculate pay cost included basic pay calculated on the hourly rate of appropriate pay scale, Sunday, night and Saturday premiums, and premium pay.

An additional 18% (relief costs) was included to capture annual leave and sickness costs, based on an analysis of actual nursing costs for Louth Meath Mental Health Services for 2007. This was broken down to, 12% was applied for relief cover required for annual leave based on the assumption that staff have six weeks annual leave; 4% to cover sick leave on the assumption of two weeks sick per employee each year; and 2% for other leave, including public holiday relief and maternity leave. Finally, 10.7% was added for employer PRSI contributions.

Salary scales for 1st June 2007 were applied to all grades.
Assessment Report to the

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

From

Petrus Consulting Ltd

Value for Money and Policy Review of
The Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services

17th December 2008
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1. Introduction

1.1 Background

This draft report presents an independent Quality Assessment of the Value for Money and Policy Review (VFMPR) of the Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services. The review was prepared internally within the HSE with external assistance and presented for assessment on the 3rd December 2008. The file submitted for assessment was named “Mental Health report 081204 with Maps”.

This report is presented by Petrus Consulting Limited, an independent management consulting firm and a member of the panel of independent experts appointed by the Department of Finance for the purposes of the VFMPR process.

1.2 Value for Money and Policy Review Process

Government Departments and Offices are required to undertake VFMPRs of expenditure under their responsibility which analyse in a systematic way what is being achieved by Government spending and to provide a basis on which more informed decisions can be made on priorities within and between programmes. The VFMPR process is overseen by the Central Steering Committee (CSC) on Programme Evaluation, chaired by the Secretary General of the Department of Finance.

1.3 VFMPR Terms of Reference

The Terms of Reference for the review were based on a standard template applying to all public sector value for money reviews with minor modifications. Specifically the review sought to:

1. Identify the objectives of the provision of Long Stay Residential Care
2. 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.
3. Identify the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care.
4. 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.

5. Evaluate the degree to which the objectives of the provision of Long Stay Residential Care warrant the continued allocation of public funding.

6. 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.

7. 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.

It appears that the redrafting of the report has omitted in error the following: “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. This is addressed below.

1.4 Scope of the review

The evaluation focussed 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. Expenditure in 2006 on a bottom up basis is estimated to have amounted to €249 million with pay costs amounting to €219 million and non pay amounting to €30 million. The report explains that the difference between the amount allocated in 2006 to Long Stay services amounting to €485 million and the €249 relates to long stay patients in Acute settings.

1.5 Structure of Quality Assessment Report

The remainder of the Quality Assessment report is structured as follows:

- Section 2 describes the requirements of the Quality Assessment process;
- Section 3 presents the principal findings and conclusions of the assessor, in keeping with the criteria required for the Quality Assessment; and
- The report itself is also attached as an appendix with further observations on editing and formatting changes for consideration.
2. Requirements of Quality Assessment

2.1 General Requirements

The Value for Money and Policy Review Guidance Manual stipulates that all completed review reports must be quality assessed before completion. The Department of Finance established a Panel of Independent Evaluation Experts for this purpose in 2003.

2.2 Specific Requirements of Assessor

The quality assessment is carried out using the following criteria approved by the CSC:

Are the Terms of Reference appropriate to the Value for Money and Policy Review Initiative?

1. Does the evaluation report comprehensively address the terms of reference?

2. Is the overall analytical approach adequate and are the methodologies utilised robust?

3. Does the report address potential future performance indicators that might be used to better monitor the performance of the programme?

4. Are the conclusions and recommendations of the evaluation supported by the analysis carried out?

5. Comment on the structure, presentation and clarity of the report.

In the assessment process, the quality assessor is required to prepare an initial draft of the assessment report and to forward it to the Department/Office concerned. The Department/Office may initiate additional contact with the quality assessor at this stage if there are matters that require further clarification. The Department/Office then has the opportunity to amend the report in light of the comments made.
3. Findings and Conclusions

3.1 Introduction

This section presents the conclusions and recommendations of the assessment. It begins with the overall conclusions, followed in turn by the assessor’s conclusions in relation to each of the criteria agreed for quality assessments – namely the appropriateness of the Terms of Reference, whether the Report has comprehensively addressed these, the adequacy of the analytical approach and methodologies, whether the Report addresses future performance indicators, whether conclusions and recommendations are supported by the analysis carried out, and a comment on the Report structure, presentation and clarity.

3.2 Overall Conclusions

Apart from the exclusion of one of the standard terms of reference which is discussed later the terms of reference are appropriate for the purposes of a value for money and policy review assessment.

The presentation of the Executive Summary can be improved by ensuring consistency with later sections of the report and by clarifying the key messages from the report.

In one case the evaluation concludes that “While some cost savings may be generated, these would be absorbed or reinvested in the further development of community based support” appears to be contradicted by later text “On a strictly average cost per bed basis, the full implementation of ‘A Vision for Change’ (2006) in relation to individuals who require long stay residential care and/or rehabilitation in a specialist service, would result in significant savings on an annual basis.” This text is repeated in a number of places and the two apparently contradictory conclusions need to be reconciled.

There is a need to align the text in the executive summary with the conclusions at the end of each section and with the text presented in Section 7.

In the case of the justification for the continued allocation of funds to the provision of long stay residential care the report discusses the allocation of funds to the mental health services overall and not to the allocation of funds to long stay residential care.
The report fails to sufficiently highlight the need to reduce the number of residential beds as recommended in A Vision of Change, the progress which has been made in that regard in recent years and the likely impact of such closures.

The report addresses potential future performance indicators that would help to monitor better the effectiveness of the expenditure although here there needs to be a sharper focus on the specific indicators to be used given that two sets of different indicators are proposed.

A useful summary or conclusions and recommendations is presented. Some of the recommendations would benefit from being made more specific in terms of the allocation of responsibility.

The review needs a final thorough edit to reflect the changes identified in this assessment and arising from the comments received from the Departments of Health and Children and Finance. Many of these are reflected in the marked up copy of the report attached.

3.3 Review Terms of Reference

Comparison of Terms of Reference for this review to the Standard Terms of Reference

<table>
<thead>
<tr>
<th>Number</th>
<th>Standard Terms of Reference</th>
<th>ToR for this Review</th>
<th>Are the Terms of Reference for this Review Appropriate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify programme objectives</td>
<td>Identify the objectives of the provision of Long Stay Residential Care.</td>
<td>Complies</td>
</tr>
<tr>
<td>2</td>
<td>Examine the current validity of those objectives and their compatibility with the overall strategy of the Department</td>
<td>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.</td>
<td>Complies</td>
</tr>
<tr>
<td></td>
<td>Define the outputs associated with the programme and identify the level and trend of those outputs</td>
<td>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.</td>
<td>Complies</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>3</td>
<td>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.</td>
<td>Complies</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Identify the level and trend of costs and staffing resources associated with the programme and thus comment on the efficiency with which it has achieved its objectives</td>
<td>Complies</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Identify the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care.</td>
<td>Complies</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>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.</td>
<td>Complies</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Specify potential future performance indicators that might be used to better monitor the performance of Long Stay Residential Care for Adults within Mental Health.</td>
<td>Complies</td>
<td></td>
</tr>
</tbody>
</table>
Conclusion: The missing element from the Terms of reference needs to be replaced in the text where necessary. Apart from that, the terms of reference are appropriate for Value for Money and Policy Review purposes.
3.4 Does the Evaluation report comprehensively address the Terms of Reference?

The terms of reference are repeated below and against each we have provided our assessment.

<table>
<thead>
<tr>
<th>Number</th>
<th>Standard Terms of Reference</th>
<th>ToR for this Review</th>
<th>Assessment</th>
</tr>
</thead>
</table>
| 1      | Identify programme objectives | Identify the objectives of the provision of Long Stay Residential Care. | This is dealt with in Chapter 2. The objectives are clearly set out in 2.5 and examined in turn:  
  • 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 that mental ill health can bring about.  
  • To facilitate the use of a rehabilitation/recovery model.  
  • To deliver appropriate cost effective and efficient services.  
  • To provide accessible services in appropriate locations. |
| 2      | Examine the current validity of those objectives and their compatibility with the overall strategy of the Department | 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. | This is addressed in Chapter 5. The review concludes that the objectives remain valid. |
| 3      | Define the outputs associated with the programme and identify the level and trend of those outputs | 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. | Chapter 3 refers. As described in the methodology it was not possible to carry out an analysis covering trend data because the data was not available. The approach used was to use a descriptive approach from which future service provision decisions can be made. In this chapter and elsewhere extensive use was made of a comprehensive and detailed survey which underpins this descriptive approach. |
| 4 | Examine the extent to which the programme’s objectives have been achieved and comment on the effectiveness with which they have been achieved | TO BE RE-INSERTED Examine the extent to which the programme’s objectives have been achieved and comment on the effectiveness with which they have been achieved | As previously referred to trend data was not available. The report examines in Annex 2 to Chapter 3 the extent to which the objectives set out above in the context of “A Vision for Change” have been achieved. This annex is central to the content of the report and should be incorporates directly within the chapter. |
| 5 | Identifying the level and trend of costs and staffing resources associated with the programme and thus comment on the efficiency with which it has achieved its objectives | Identify the level and trend of costs and staffing resources associated with the provision of Long Stay Residential Care. | Chapter 4 refers. For reasons already stated trend analysis was not possible. Based on the census returns much valuable data was gathered and presented in the form of maps and charts highlighting the local area and regional variations in the staffing levels across the country. “Wide regional variances occur in the WTE availability and the skill mix deployment, even in similar care environments, leading to significant differences in the cost per bed per day”. |
| 6 | Evaluate the degree to which the objectives warrant the allocation of public funding on a current and ongoing basis, and examine the scope for alternative policy or organisational approaches to achieving these objectives on a more efficient and/or effective basis (e.g. through international comparison) | 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. | This is also dealt with in Chapter 5. The justification for the continued allocation of public funds relates to the allocation of funds to the mental health services overall and not to the allocation of funds to long stay residential care. However, elsewhere in the report there are references to examining the relationship between the role of mental health treatment and the provision of housing. In 5.23 the report states “The key to all successful models is the provision of a variety of housing options, which involves separating mental health treatment from housing requirements and supporting these options with a seamless integrated and fully staffed community based service”. The report also strongly advocates the implementation of the recommendations set out in “A Vision for Change”. In 7.2 it is stated that “Non HSE agencies should lead in meeting the housing needs of individuals with mental health problems, within mainstream housing”. |
In finalising the report it would be helpful to readers to make the conclusion in this area clearer and reflect them in the executive summary.

| 7 | Specify potential future performance indicators that might be used to better monitor the performance of the Scheme | 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 | Detailed performance indicators are proposed in chapter 6. There are two sets of indicators proposed in 6.14 and 6.16 and these two sets need to be more closely aligned and made more consistent. If necessary, the shorter list in 6.14 could be used as the basis. It should also be highlighted that additional work would be required to develop a final set of measures, indicators and targets. (This is done in 6.15 but needs to be made very clear in the exec summary.) |

Conclusion: Apart from the points raised above, in overall terms the terms of reference are covered.
3.5 **Is the overall analytical approach adequate and are the methodologies utilised robust?**

The methodology for the review was constrained because of the lack of data available at a unit level. For this reason a national census 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.

This extensive exercise gathered much useful information and is especially noteworthy because of the 100% response rate achieved. The very large amount of data gathered through the survey has been condensed and presented in graphical and map based formats, using external consultants, making it easy to recognise the wide disparities in many of the key resource inputs across the country.

Background literature reviews were carried out and interviews carried out with a wide range of stakeholders. An international perspective was provided by means of contacts with a number of international experts.

As the review points out, the lack of historical data meant that trend analysis was not possible and a descriptive approach was taken in order to inform future work in this area.

While the approach was limited by the lack of historical data referred to above, the census based approach provides much useful information on which to base decisions for the future of the service and which can inform future evaluations.

3.6 **Does the report address potential future performance indicators that might be used to better monitor the performance of the programme?**

Yes. See comments above

3.7 **Are the conclusions and recommendations of the evaluation supported by the analysis carried out?**

The conclusions and recommendations are supported by the analysis carried. There is also a need to more clearly state other findings of the report which identify that:

- there are too many beds provided directly by the HSE compared to the levels set out in A Vision for Change
- a large percentage of individuals are being provided with services in care settings that exceed their needs and
- significant additional costs are being incurred as a result.
In the process of final editing of the report, it would also be helpful if the responsibilities for implementation of recommendations could be more directly identified.

The recommendations set out as supporting the implementation of A Vision for Change need to be checked to ensure they are supported in the text in each case. Cross referencing each of the recommendations would ensure that the subject matter is assessed and supported in the body of the report.

3.8 Comment on the structure, presentation and clarity of the report and items for discussion

The report is a well structured document with much useful information on the extent and scope of activities and addresses the terms of reference in a logical and sequential manner. This draft is a significant improvement over earlier drafts and is now more readable for someone not directly involved in the area.

There is still some text editing, formatting, presentation and consistency checks or redrafting to be carried out and in the report attached to this assessment I have noted these areas where I believe the text could be improved or clarified.

Appendix 2 contains the terms of reference with bullet points that were not part of the terms of reference and these should be removed.

The terms of reference are set out in several places but in each case it appears that one item has been omitted in the redrafting process.

The full text of the report is attached as an Appendix to this report with further detailed comments.

END OF ASSESSMENT REPORT
Appendix 6: Bibliography


Brennan D 2004 A consideration of the social trajectory of psychiatric nursing in Ireland Journal of Psychiatric and Mental Health Nursing Volume 11 Issue 4, Pages 497 - 501

Carling, P. J., Randolph, F. L., Blanch, A. K., & Ridgway, P 1987 Rehabilitation research review: Housing and community integration for people with psychiatric disabilities National Rehabilitation Information Center Washington

Daly A., Walsh D., Dunne Y and Caprani L 2002 Activities of Irish Psychiatric Services Health Search Board Dublin

Daly A., Walsh D., Dunne Y and Caprani L 2003 Activities of Irish Psychiatric Services Health Search Board Dublin

Daly A., Walsh D., Dunne Y and Caprani L 2004 Activities of Irish Psychiatric Services Health Search Board Dublin

Daly A., Walsh D., Dunne Y and Caprani L 2005 Activities of Irish Psychiatric Services Health Search Board Dublin

Daly A., Walsh D., Dunne Y and Caprani L 2006 Activities of Irish Psychiatric Services Health Search Board Dublin


Department of Finance 2007 Value for Money and Policy Review Initiative Department of Finance Dublin

Department of Health 1966 Report of the Commission of Inquiry on Mental Illness Department of Health Dublin

Department of Health 1984 Planning for the Future Department of Health Dublin
Department of Health 1991 The Care Programme Approach Department of Health London

Department of Health and Children 2006 A Vision for Change The Stationary Office Dublin

Department of Health and Children 2001 Mental Health Act 2001 Department of Health and Children Dublin

Department of Health and Social Services 1975 Better Services for the Mentally Ill HMSO London

Department of Justice Equality and Law Reform 2003 Human Rights Act 2003 Department of Justice Equality and Law Reform Dublin

Department of Local Government 1950 Housing (Amendment) Act Department of Local Government Dublin


Hallwright S 2006 The Evaluation of Community Living Services Lattice Consulting Limited New Zealand


Liimatainen M.R. & Gabriel P. 2000 Mental Health in the Workplace International Labour Organisation Geneva:

McDaid D., Knapp M. & Curran C. 2005 Policy Brief Mental Health III Funding mental Health in Europe European Observatory on Health Systems and Policy

Mental Health Commission Quality Framework Mental Health Services in Ireland Mental Health Commission Dublin

National Economic and Social Forum 2007 *Mental Health and social Inclusion* National Economic and Social Forum Dublin


Taylor D & Pinczuk J. 2005 *Healthcare Financial Management for Nurse Managers: Merging the Heart with the Dollar*; Jones Bartlett


Torrey, E, Bigelow, D, & Sladen-Dew, N. 1993 Quality and cost of service for individuals with serious mental illnesses in British Columbia compared to the states. *Hospital & Community Psychiatry*, 44, 493-450

Treadstone D, Walsh D., Moran R. 2007 *Happy living Here A survey and Evaluation of community Residential Mental Health Services in Ireland* Health Research Board

Trotter Betts V., Williams M., Peterson C.M., Bradshaw C. & Wilson L Walsh V 2007 *Tennessee’s Creating Homes Initiative Presentation to National Association of State Mental Health Program Directors Summer 2005 Commissioners’ Meeting*

World Health Organisation 2003 *Investing in Mental Health* World Health Organisation Geneva

World Health Organisation 2003 *Quality improvement for mental health* (Mental Health Policy and Service Guidance Package) World Health Organisation Geneva,

World Health Oganisation 2005 *Mental Health Action Plan for Europe Facing Challenges, Building solutions*