Accountability in the Delivery of *A Vision for Change* – A Performance Assessment Framework for Mental Health Services

AMNESTY INTERNATIONAL

Indecon
INTERNATIONAL ECONOMIC CONSULTANTS

Acknowledgments and Disclaimer
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Throughout this report references are made to the Health Service Executive. The HSE has provided information on current performance indicators and we also understand that work is currently in train on the development of expanded performance assessment systems. We are grateful to the HSE for their assistance throughout the course of this exercise.

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Glossary of Terms and Abbreviations

AI	Amnesty International Ireland
AVfC	*A Vision for Change*
CAMHS	Child and Adolescent Mental Health Services
CMHT	Community Mental Health Team
CRPD	UN Convention on the Rights of Persons with Disabilities
DETE	Department of Enterprise, Trade and Employment
DMB	Difficult to Manage Behaviour
DoEHLG	Department of Environment, Heritage and Local Government
DoHC	Department of Health and Children
FMHS	Forensic Mental Health Service
GAMHS	General Adult Mental Health Services
HSE	Health Service Executive
HRB	Health Research Board
ICESCR	International Covenant on Economic, Social and Cultural Rights
KPI	Key Performance Indicator
LHM	Local Health Manager
Long Stay	Continuous hospitalisation for over one year
MHC	Mental Health Commission
MHCA	Mental Health Catchment Area
MHS	Mental Health Services
MHID	Mental Health Services for Adults with Intellectual Disability
MHSOP	Mental Health Services for Older People
NMD	National Minimum Data Set
PCCC	Primary, Community and Continuing Care (HSE Directorate)
UN	United Nations
WHO	World Health Organisation
WTE	Whole Time Equivalent

Foreword

Reform of Ireland's mental health services is at a critical junction. After decades of neglect the publication of *A Vision for Change* in 2006 promised renewed energy and drive to substantially improve the delivery of services.

But this change is still to be realised. Implementation has been painfully slow and there have not been effective checks in place to ensure change is progressing. The only way to successfully improve mental health services in Ireland is to address this gap.

This report clearly and simply sets out how implementation of the mental health services, as set out in *A Vision for Change*, can be effectively monitored.

Since the publication of *Planning for the Future* in 1984, Government policy has been clear that the best way to deliver mental health services is through comprehensive community-based mental health teams. But more than 25 years later and with a second policy echoing this priority, this is still far from reality for the thousands of people accessing services in Ireland today.

There remains an over-reliance on acute inpatient care, a lack of efficiency and accountability from the HSE on where and how money is being spent, community mental health teams remain critically under-staffed and at its current rate of progress, implementation of *A Vision for Change* remains severely behind schedule. This must change.

We acknowledge there has been some progress. We welcome in particular the Minister for Mental Health and Disability, John Moloney's, clear and renewed commitment to the full implementation of *A Vision for Change*. We also acknowledge the move towards greater accountability within the mental health system, as shown by the inclusion of information about mental health service performance in the HSE's monthly reports and the publication of the annual report into Child and Adolescent Mental Health Services. But it is still not enough.

Indecon has conducted a root and branch investigation into how mental health spending and performance is reported, and has provided practical solutions that will lead to greater efficiency in the mental health services. This means creating a service that is not only more economically efficient, but is also much better for the person accessing it.

This makes financial sense and also fulfils the State's responsibility to its people. Ireland has ratified the International Covenant on Economic, Social and Cultural Rights, and so has promised to deliver the highest possible standard of mental health for all people living within the State. But without accountability, this commitment to human rights and improving our mental health system remains just empty words.

If the Government were to adopt these recommendations it would be taking a huge step towards fulfilling its international obligations under human rights law.

A more transparent mental health service will benefit everyone. So we need to ensure there are measures that check how efficiently the money is being spent. We also need to monitor the service being delivered, in terms of the actual facilities and staffing allocation. Crucially, we also need to measure the quality of the service and the outcomes for the people who use it. This report makes provisional recommendations on measuring outcomes, which will need further development in partnership with those accessing the service.

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

The recommendations included in this report have taken into account the findings from Indecon's first report, international recommendations by the World Health Organisation and UN, international good practice examples in addition to the Department of Finance guidelines on measuring performance, the HSE's implementation plan for *A Vision for Change* and information provided by the HSE. They build on existing reporting systems so that changes can be kept to a minimum. We are confident they will work.

It is essential that mechanisms be put in place to hold the HSE to account for its performance. Therefore legislation that places a statutory obligation on the HSE to provide community mental health teams, and to ensure transparent planning and reporting on the funding and delivery of mental health services by the HSE, is absolutely key. We believe such a move will breath life into Government policy that has only been adopted in a piecemeal fashion over the past 25 years.

Amnesty International Ireland endorses the recommendations in this report and calls on the Government and the HSE to implement them as a matter of priority in order to ensure accountability in the delivery of *A Vision for Change*. We also hope the NGO sector finds these recommendations useful in their campaigning.

We are thankful to Indecon, in particular William Batt, for producing this report. Indecon's expertise in mental health financing and performance measurement is a valuable addition to the sector.

Colm O'Gorman
Executive Director
Amnesty International Ireland

May 2010

Executive Summary

Introduction and Background

Currently there are limited mechanisms in Ireland for tracking mental health expenditure or its effectiveness. Yet accountability is a fundamental principle of human rights. Individuals need to be able to determine whether their government is fulfilling its obligation under human rights to progressively realise their right to the highest attainable standard of mental health. This report outlines the requirements to ensure accountability in the delivery of the Government's mental health policy, *A Vision for Change*, and develops a performance assessment framework for mental health services in Ireland. The report was commissioned by Amnesty International Ireland (AI) and prepared by Indecon International Economic Consultants.

This report takes place within the context of AI's work on the right to the highest attainable standard of mental health and Indecon's previous review of government spending on mental health services and progress on implementation of *A Vision for Change*, completed in September 2009.

AI's mental health campaign uses the human rights framework to demand action from Government. It campaigns for a social approach in response to mental health that is focused on people's rights, in particular, the right to live a full life in the community. One of AI's main campaign objectives is for the Government to introduce legislation that improves accountability and underpins the provision of appropriate, comprehensive and community-based mental health services.

The data and information gaps highlighted by Indecon's 2009 review form the basis for this report. The key findings of the previous review are summarised below.

Key Findings from Indecon 2009 Review

- A lack of available detailed data/information that would be required to facilitate the ongoing monitoring of funding, expenditure and human resource allocation across the mental health services and the assessment of progress on the implementation of *A Vision for Change;*
- Significant skill shortages in the development of community-based mental health services and deficiencies in staffing of community-based mental health teams at regional and catchment area levels;
- An over-reliance on traditional acute and long-stay inpatient beds within the mental health services compared with the recommendations of *A Vision for Change* that is unlikely to be consistent with achieving the best value for money;
- If the recent and current rate of progress on the main mental health service areas identified in *A Vision for Change* is maintained, the HSE will not achieve the recommended levels of resourcing of the mental health services within the timeframe envisaged by its Implementation Plan; and
- The report concluded that the setting of performance indicators and supporting data would be essential in order to ensure accountability and monitor the level of progress.

Source: Indecon, *Review of Government Spending on Mental Health and Assessment of Progress on Implementation of* A Vision for Change. Submitted to Amnesty International Ireland (1st September 2009).

A number of the recommendations from the first review are also relevant to this report. The key recommendations from the Indecon 2009 review for AI are summarised below.

Recommendations from Indecon 2009 Review

- New performance indicators and supporting up-to-date data should be developed and published so the progress of implementation of *A Vision for Change* can be monitored. It also recommended that performance indicators and related targets reflect best practice internationally. Data should include more detailed and higher frequency data on funding and expenditures by service area and on a regional basis, in addition to more detailed data on human resources by skill mix at regional and catchment area level;
- The targets for implementation of *A Vision for Change* should be reconfigured to realistic levels and a new set of annual targets formulated which take account of the current position and of the constraints in public expenditure;
- In order to ensure the most effective use of scarce public expenditure and to improve value for money, an increased focus is required on reducing the overall dependency in mental health services on acute and long-stay inpatient beds, and community residences, and to continue to increase the provision and usage of community-based services and teams;
- In order to further enhance value for money and effectiveness, there must be progress in relation to appropriate staffing and specialist supports services in community-based mental health teams;
- A reconfiguration of human resources in mental health services is required to ensure that resources are allocated on an equitable and efficient basis, both in terms of the functional and geographical distribution of these resources;
- Changes in resource allocations will be required to successfully support the required reconfiguration of existing resources in mental health services and the attainment of the required overall level and composition of resources in line with *A Vision for Change;*
- Planned capital investments must be made to ensure that required levels of community-based facilities are addressed across the mental health services;
- An increased overall national allocation of human staffing resources is required in the Health and Social Care and Other Patient and Client Care personnel categories;
- The geographical allocation of mental health service resources should be closely aligned with regional and local catchment area-level population levels and should also take account of local deprivation patterns; and
- Particular focus should be given to addressing the human resource shortfalls compared to recommended levels that exist in community-based mental health teams providing Child and Adolescent and Adult Intellectual Disability mental health services as well as mental health services for older people.

Source: Indecon, *Review of Government Spending on Mental Health and Assessment of Progress on Implementation of* A Vision for Change. Submitted to Amnesty International Ireland (1st September 2009).

This present report was commissioned in order to develop many of the recommendations from the initial review. This report considers both financial accountability for and performance assessment of mental health services in Ireland.

The objectives of the present exercise were as follows:

- *Financial accountability*: To review existing financial information systems and develop a preliminary set of Key Performance Indicators (KPIs). This will help ensure accountability in the funding of, and expenditure on, mental health services in line with the policy set out in *A Vision for Change*. The report considers financial accountability between the Department of Health and Children and the HSE, as well as how to make budget and expenditure information available to other stakeholders
- *Performance assessment* of development of mental health services in line with goals set out in *A Vision for Change*. This report considers KPIs that will facilitate monitoring and incentivise development in relation to:
  - *Facilities* – KPIs that monitor the facilities recommended in *A Vision for Change*, including those necessary to support community-based teams and specialist services;
  - *Human/Staffing Resources and Deployment* – KPIs to reflect the development of community-based mental health services in line with *A Vision for Change*;
  - *Quality of Mental Health Service Provision* – KPIs to reflect the provision of recovery-oriented, holistic/complete and least restrictive locally provided mental health services; and
  - *Mental Health Outcomes* – a preliminary set of KPIs to support ongoing monitoring of outcomes for service users from mental health service intervention.

The term Key Performance Indicator is defined in the box below.

Key Performance Indicator - Definition

A Key Performance Indicator (KPI) is a high-level measure that shows whether and how well a programme is achieving its objectives. KPIs are typically used in external reporting, such as in a strategy statement or performance review report. An effectively designed KPI will usually be associated with an appropriate pre-specified target.

Source: *Indecon*

Approach to the Performance Assessment Framework

The development of the performance assessment framework set out in this report was informed by a review of international best practice approaches. It was also guided by the following inputs:

- The findings of Indecon's 2009 review completed for AI (summarised above) - particularly in relation to identified deficiencies in data collection and existing monitoring systems in each of the mental health services areas of focus;
- The World Health Organisation (WHO) guidance and UN human rights principles and the elements of the right to mental health;
- The findings in relation to international experience and best practice in the development and application of mental health information and performance assessment frameworks. This includes the guidance on mental health planning and performance assessment developed by the WHO (see further below);
- National guidelines on development and application of performance indicators set out by the Department of Finance;
- Developments since publication of *A Vision for Change* and the HSE's Implementation Plan (released in 2009);
- Consultations with HSE including with Martin Rogan, Dr. Ian Daly and Dr. Brendan Doody; and
- The work undertaken to date by AI in relation to how legislation could drive the provision of comprehensive and community-based services as recommended in *A Vision for Change*.

Review of International Best Practice Approaches

The development of comprehensive performance assessment frameworks for mental health is, in general, at a relatively early stage internationally, although progress in some jurisdictions has been more advanced than in others.

While it is important to caution against the indiscriminate application of external approaches to the Irish context, lessons can be learned from both the experiences of, and approaches adopted by, different organisations and governments.

The policy and guidance of the UN human rights framework and the WHO have informed the development of the proposed framework for performance assessment in funding and delivery of mental health services in Ireland set out in this report. This includes the need to ensure that performance assessment can serve to demonstrate how services are fulfilling human rights. The right to health is protected under Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which Ireland ratified in 1989. Article 12 ICESCR states:

> "States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of ... and mental health."

The right to the highest attainable standard of physical and mental health has since been recognised in a number of other human rights treaties including, most recently, Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD), which Ireland has signed but not yet ratified.

The UN Committee on Economic, Social and Cultural Rights has identified four elements to the State's obligation to provide health services under the right to the highest attainable standard of health, namely:

- *Availability* in sufficient quantity of functioning public health and healthcare facilities, goods and services, as well as programmes;
- *Accessibility* of health facilities, goods and services to everyone without discrimination;
- *Acceptability* of health facilities, goods and services in terms of being respectful of medical ethics and being culturally appropriate; and
- *Quality* - health facilities, goods and services must be scientifically and medically appropriate and of good quality.[1]

Human rights law and standards do not demand that the State be overburdened financially. Instead the right to health imposes an obligation on States to ensure the satisfaction of, at the very least, core minimum essential levels of services required under the right to health.[2] This is an immediate obligation; failure to comply constitutes a breach of the State's international law obligations. It then requires that such core minimum services be improved and expanded over time in accordance with the principle of progressive realisation.

Indecon acknowledges the need to take account of the current severe constraints in the public finances, which are impacting across the health services. However, the principle of progressive realisation recognises the economic realities of individual States. Thus the human rights framework accepts that certain elements of the right to health will not become a reality overnight, but will take some time to realise, depending on the resources available to the State in question. This should not be misinterpreted as rendering the right to health meaningless.[3] Progressive realisation requires the State *to take steps* (which must be deliberate, concrete and targeted)[4] *to the maximum of its available resources* with a view to progressively realising the right to health over time. It thereby imposes an immediate obligation on States to move as *expeditiously and effectively* as possible towards that goal by using all appropriate means.[5]

Indecon believes that effective performance indicators will help prioritise resources and increase value for money, enabling the State to progressively improve services and thereby realise the right to health over time in accordance with its obligations under international human rights law.

Performance indicators can be used to measure various aspects of the mental health system, according to the WHO's guidance, including:

- Needs – including definition of service requirements of different groups within the population;
- Inputs – pertaining to the financial, human and other resources required to carry out the activities of the mental health services;
- Processes – the activities of the mental health services in transforming inputs into outputs;
- Outputs and Results – the outputs resulting from the combination of financial and human resources, and activities of mental health services, in terms of service provision and results achieved from the perspective of the service user while utilising the service; and
- Outcomes – the identifiable long-term benefits of mental health interventions for service users.

1 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14 (right to health) (2000) http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument.

2 Committee on Economic, Social and Cultural Rights General Comment 3 on the nature of States parties obligations under article 2(1) of the Covenant UN Doc E/1991/23(14/12/90), para 10.

3 ibid para 8.

4 ibid para 2.

5 ibid para 9.

This review also reflects the international best practice in defining performance measures within a number of 'domains', as follows[6]:

- Acceptability
- Accessibility
- Appropriateness
- Competence
- Continuity
- Effectiveness
- Efficiency
- Safety

Target setting
For indicators to be effective they should ideally be compared to performance targets or benchmarks. Targets represent commitments made in advance to achieve a stated level of performance. Targets may also have associated milestones, or intermediate targets, when objectives are expected to be achieved in a staged manner over a defined period. Indecon also accepts that such targets, including targets based on the recommended levels of service development and provision as set out in *A Vision for Change*, may need to be adjusted in line with overall expenditure budgets. However, effective targets and aligned performance indicators are needed to ensure value for money.

Proposed indicator set
In terms of types of indicators two broad types of indicators are considered in this report:

- *Transformation indicators* – designed to facilitate monitoring of achievement of mental health service reconfiguration and development goals set out in *A Vision for Change*; and
- *Ongoing performance indicators* – designed to facilitate the ongoing monitoring of performance and financial accountability in the mental health service.

The focus of this report is on assessment of performance in relation to the implementation of the recommendations of *A Vision for Change*. In particular, the report focusess on the development of indicators that would monitor the progress on *transformation* of the mental health service in line with the goals of this policy. Given the strategic focus of this framework, this report does not include consideration of detailed indicators to monitor day-to-day operational dimensions such as, for example, staff turnover, staff attendance and capacity utilisation, among other aspects. These operational characteristics are, however, important in the context of assisting mental health service management to efficiently and effectively deliver services and should be incorporated in ongoing performance assessment.

Outcome indicators
Performance indicators that relate to needs, inputs and processes have been prioritised in this report. This is because of the particular need to ensure accountability and monitor the progress of implementation of *A Vision for Change*. However, the ultimate measure of achievement of both *A Vision for Change* and the right to the highest attainable standard of mental health is in the outcomes achieved by service users in terms of their ability to realise their abilities and participate in their communities. For this reason, a preliminary examination of outcome indicators and their application in the Irish mental health services is presented in Section 6.

76 Canadian Institute for Health Information and Statistics Canada (2000), *Canadian Health Information Roadmap Initiative Indicators framework.*

Recovery-based model of mental health intervention
The recovery-based model outlined in *A Vision for Change* will need to be reflected in mental health information systems and associated performance assessment frameworks. Under this model, interventions are designed both with a view to addressing the symptoms experienced by service users and with the objective of maximising the quality of life of individuals. This review takes account of the need to develop performance measures that incentivise the development of recovery-oriented mental health services.

Financial Accountability
It is not currently possible to ensure financial accountability for mental health service delivery in Ireland, as set out in *A Vision for Change*, because there are weaknesses in financial management systems.

This report considers the deficiencies highlighted by the previous Indecon review of existing financial information on the ongoing operation and development of the mental health services. It then addresses financial accountability by identifying the requirements in terms of a framework and system of key performance indicators. Implementation of this framework will help to incentivise good governance and financial management. It will also facilitate transparency and accountability in relation to both funding and expenditure on mental health services.

Indecon found that there are issues in relation to the availability of information in the public domain that prevent full transparency and accountability in the funding of and expenditure on mental health services.

These include the absence of:

- transparent information on the allocation of funding and ongoing budgeting in the mental health services;
- timely and detailed information on recurrent and capital funding commitments and expenditures in the mental health services by service area (including between inpatient/hospital services and community-based provision) and by sub-national/regional catchment area; and
- the particular absence of transparent detailed information regarding the allocation of development funding recommended under *A Vision for Change* and the expenditure of this funding on a year-to-year basis.

In relation to capital spend, a new multi-annual programme of investment was announced in Budget 2010. This was to be supported through the release of funding from the sale of mental health service assets. However, there is an absence of clarity surrounding how funding under this programme will be provided beyond the current financial year. Furthermore, though the Minister announced a number of new facilities including community nursing units, acute units and community mental health centres in Primary Care Centres, there is no detailed plan published that sets out all of the projects and costings that make up the €50 million budget for 2010.

Therefore Indecon recommends that appropriate budgeting and information systems be developed by the HSE so that KPIs can be measured. This would ensure full transparency and accountability for the planning, funding and effective and efficient delivery of the mental health services, which is crucial.

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

Proposed framework of Key Performance Indicators to support financial accountability
A proposed suite of KPIs to support ongoing accountability for the investment in mental health services is presented in the table below. The KPIs are presented alongside the objective of each indicator, the nature and setting of supporting indicator targets, and the frequency and method of collection of indicator data/information. Organisational responsibility for implementation of the proposed indicators and delivery of the related service components would rest with the HSE.

Summary of Proposed Key Performance Indicators to Support Ongoing Assessment of *Financial Accountability* in Funding of and Expenditure on Mental Health Services

	Indicator No. and Description	KPI Objective	Indicator Target Setting and Timeframe	Indicator Data Frequency and Method of Collection
	Financial Input Indicators			
1	*Recurrent Expenditure* on MHS - € million and % breakdown by Hospital/Inpatient and Community-based MHS and by MHCA*	Improve transparency in and accountability for expenditure of allocated recurrent funding by service area and geographically	Level and breakdown of recurrent expenditure to align with optimal configuration based on population need and resource requirements	Annual via DoHC and HSE mental health budget planning and expenditure controls
2	*Capital Expenditure* on MHS - € million and breakdown by Hospital/Inpatient and Community-based MHS developments	Improved transparency in and accountability for expenditure of allocated capital funding	Multi-annual programme of capital expenditure by service and catchment area to target requirements implied by AVfC (adjusted to reflect current population and costs)	As above
3	*AVfC Development Funding* - € million and % breakdown by Service Area** and MHCA*	Improved transparency in and accountability for allocation of Development Funding for implementation of *A Vision for Change*	Multi-annual targets by Service Area/Care Plan and Catchment Area consistent with AVfC (adjusted to reflect current population and costs)	As above
4	*AVfC Development Expenditure* - € million and % breakdown by Service Area** and MHCA*	Improved transparency in and accountability for expenditure of allocated AVfC Development Funding	Annual expenditure to match allocated funding by service area and catchment area	Monthly and Annual data via HSE
	Efficiency Indicator			
5	Average Recurrent Cost per Inpatient Bed per Day by MHCA*	Improved systems of financial control to ensure efficiency and value-for-money of expenditures on long-stay bed provision	Target to reduce average cost to align with best practice benchmarks internationally	Annual via HSE expenditure monitoring and returns

*Service area refers to area of community-based MHS, i.e. General Adult, Child & Adolescent, Older People, Rehabilitation, Intellectual Disability and Forensic and other Specialist Services.
**Mental Health Catchment area (MHCA) refers to super-catchment areas
Source: Indecon

Mental Health Services Facilities

A summary of proposed KPIs designed to support the assessment of progress on delivery of required mental health services facilities is presented in the table below. Each indicator recommended below should be monitored by the HSE on an annual basis.

Summary of Proposed Key Performance Indicators – *Mental Health Services Facilities*

	Indicator No. and Description	KPI objective	Indicator Target Setting*
	General Adult MHS		
1	No. of Long-Stay General Adult Inpatient Beds by MHCA	Reduction in dependence on long-stay inpatient units in line with recommendations of AvfC	Eliminate dependence on long-stay inpatient beds within pre-defined timescale and reconfigure to AVfC targets set out in indicators (2) to (5) below
2	No. of Staffed Community Residences by MHCA	Provision of facilities for patients moving from long-stay and other inpatient units	3 units of 10 places per 100,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible facilities*	*Maximise proportion of disability accessible units*
3	No. of Continuing Care Challenging Behaviour Units	As for (2) above	One 30-bed unit per 300,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible facilities*	*Maximise proportion of disability accessible units*
4	Intensive Care Rehabilitation Units	As for (2) above, including for people with enduring illness DMB	One 30-bed unit per 1,000,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible facilities*	*Maximise proportion of disability accessible units*
5	High Support Intensive Care Residences	As for (2) above	One 20-bed unit per 1,000,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible facilities*	*Maximise proportion of disability accessible units*
6	No. of Community Mental Health Centres by MHCA	Provision of ifacilities required to support operation of CMHTs at local level as recommended by AVfC	Develop total of 338 centres nationally and ensure geographic division in line with MHCA catchment populations
7	No. of Crisis Houses for Adult Services by MHCA	Monitoring of provision of facilities to support least restrictive, accessible local treatment	Develop 14 facilities nationally located close to local CMHTs
	Child & Adolescent MHS		
8	No. of CAMHS Acute Inpatient Beds by MHCA	Address requirements of AVfC in relation to CAMHS inpatient capacity	Deliver 100 inpatient beds nationally for all aged 0-18 years in five units of 20 beds
9	No. of Community Mental Health Centres for CAMHS by MHCA	Address requirements of AVfC in relation to delivery of community-based CAMHS	Deliver 84 centres (based on 1 centre per team per 50,000 population)
10	No. of CAMHS Forensic CMHT Units	Address requirements of AVfC in relation to provision of specialist MHS	Provide 1 unit with appropriate regional distribution
11	No. of CAMHS Day Hospitals by MHCA	Address requirements of AVfC in relation to CAMHS day hospital facilities	Deliver 14 day hospitals (1 day hospital per catchment of 300,000 total population)
	Specialist Services		
12	No. of Adult Forensic CMHT Units	Address requirements of AVfC in relation to provision of specialist MHS	Provide 4 units with appropriate regional distribution
13	No. of Intellectual Disability CMHT Units	Address requirements of AVfC in relation to provision of specialist MHS	Provide 2 units per 300,000 population

**Note: Based on AVfC recommend coverage ratios*
Source: Indecon

Human Resources in Mental Health Services

If mental health services are to develop in line with the goals of *A Vision for Change*, ongoing monitoring will be necessary to ensure there are appropriate levels of skilled human resources. As part of this review Indecon developed a number of focused KPIs, based on international approaches and identification of the requirements in relation to human resource/staffing recommended in *A Vision for Change*. A summary of proposed KPIs is presented in the table below. As in the case of the financial accountability indicators, responsibility for implementation of the proposed human resource indicators would rest with the HSE.

Summary of Proposed Key Performance Indicators – *Mental Health Service Human Resources*

	Indicator No. and Description	KPI Objective	Indicator Target Setting*	Indicator Data Frequency and Method of Collection
	Development of Community-based MHS			
1	Overall national ratio of staff in Community Mental Health Teams to total no. of MHS staff	Monitoring of progress in reducing current over-staffing of adult inpatient services and reconfiguring resources to increase staffing of CMHTs across MHS	National ratio to target 39% of MHS staff employed in CMHTs	Annual data based on Mental Health Commission census of CMHT staffing
2	No. of Child & Adolescent CMHTs with full multi-disciplinary staffing by MHCA	Monitoring of progress in development of CMHTs in line with recommendations of *A Vision for Change*	84 fully staffed multi-disciplinary teams with 1,092 staff WTE nationally	As above
3	Adults with Intellectual Disability CMHTs with full multi-disciplinary staffing by MHCA	As above	28 fully staffed multi-disciplinary teams with 424 staff WTEs nationally	As above
4	MHS for Older People CMHTs with full multi-disciplinary staffing by MHCA	As above	42 fully staffed multi-disciplinary teams with 508 staff WTEs nationally	As above
5	General Adult CMHTs with full multi-disciplinary staffing by MHCA	As above	84 fully staffed multi-disciplinary teams with 1,770 staff WTEs nationally	As above
6	Rehabilitation Services CMHTs with full multi-disciplinary staffing by MHCA	As above	41 fully staffed multi-disciplinary teams with 902 staff WTEs nationally	As above
7	Specialist CMHTs with full multi-disciplinary staffing by MHCA**	As above	44 fully staffed multidisciplinary teams across 9 specialist MHS categories employing total of 810 staff WTEs nationally	As above
	MHS Staff Training			
8	No. of MHS professional staff trained in recovery principles	Incentivising application of recovery-model of mental health care to Irish MHS	Target 100% of MHS patient-contact staff to have received basic training in recovery principles	As above

* Based on AVfC recommended ratios of team provision and staffing relative to current (2006) population levels
** See Annex 2 for further details on indicators for human resources in specialist services
Source: *Indecon*

Scope and Quality of Mental Health Service Provision

Indecon has also developed a short list of potential KPIs to support ongoing assessment of the scope and quality of mental health service provision. The scope of service provision refers to the extent and range of services provided at national and local levels. Quality of service is distinguished from outcome (which is considered in Section 6) on the basis that the former relates to the immediate results for the service user in terms of access to recovery-oriented, holistic and least restrictive, locally provided services. These indicators are presented below.

Proposed Key Preformance Indicators – *Indicators of Scope and Quality of Mental Health Service Provision*

	Indicator No. and Description	KPI Objective	Indicator Target Setting	Indicator Data Frequency and Method of Collection
1	First-time admission rate per 100,000 population	Incentivise shift in service provision to least restrictive community care settings	Reduce ratio to align with best practice benchmarks internationally with pre-defined timescale	(Data already collected by HSE and reported annually by HRB)
2	% of service users in receipt of an individual care and recovery plan	Incentivise application of a 'recovery' approach to MHS provision in line with MHC Quality Framework Standard 1.1	Target to have all MHS service users to be in receipt of individual treatment programme within a pre-defined timescale	Annual data via NMD/WISDOM database
3	% of acute inpatient admissions referred via local CMHT crisis service	Incentivise provision of least-restrictive, accessible, local MHS and reduce likelihood of patients being inappropriately admitted to acute facilities	Target to increase % of referred admissions and usage of community services as primary referral point over a pre-defined timescale	Annual data via NMD/WISDOM database
4	No of GP referrals to adult CMHTs by mental health catchment area	Monitor extent to which service users are being referred to community-based services as primary channel of care	Target to increase % of GP referrals to community-based care within a pre-defined timescale	Annual data via NMD/WISDOM database
5	% of service users offered a psychological therapy	Incentivise development of Holistic MHS	Target to make available some form of counselling, family or psychological therapy service available through all CMHTs within a pre-defined timescale	Annual data via NMD/WISDOM database
6	No. Of Involuntary Committals per 100,000 of Population	Incentivise minimisation of involuntary committals and un-necessary detention, and incentivisation of appropriate treatment	Target to reduce involuntary committal rate to align with best practice benchmarks internationally	Annual rate monitored via Mental Health Commission annual reports
7	% of service users rating MHS provision good or better	As above	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey
8	% of service users' families rating MHS provision good or better	As above	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey
9	% of Approved Inpatient Units fully compliant with the Mental Health Act 2001 and Rules, Regulations and Codes of Practice issued thereunder	Ensuring quality of acute and long-stay MHS facilities complies with regulatory requirements	100% of approved centres to be fully compliant within a pre-defined timescale	Annual inspections by Inspectorate of Mental Health Services

Source: Indecon

Outcomes from Mental Health Service Intervention

Arguably the most important indicator category is the development of appropriate outcome-based indicators designed to capture the overall effectiveness of mental health interventions. It is also regarded as the most complex and challenging area of performance measurement.

A detailed examination of existing evidence and development of a comprehensive set of outcome-based performance measures was outside the scope of this report. Further work is required to devise a set of outcome measures appropriate to the Irish context. However, based on initial consideration of international approaches and features of the Irish system, a preliminary set of KPIs was developed which are summarised in the table below. These measures focus on the recovery-model of mental health services recommended in *A Vision for Change*.

Proposed Key Performance Indicators – *Preliminary Summary of Indicators of Outcomes from Mental Health Service Intervention*

	Indicator No. and Description	KPI Objective	Organisational Responsibility for Implementation and Delivery	Indicator Target Setting and Timeframe	Indicator Data Frequency and Method of Collection
	Outcome Indicators to monitor and incentivise Development of Recovery-oriented MHS				
1	% of service users of working age in open paid employment	Demonstration of impacts and outcomes from MHS interventions on quality of life of service users	HSE in tandem with DETE and with training and employment agencies	Increase % of discharged service users who are in paid employment within a pre-defined timescale following discharge	Annual data monitored via NMD/WISDOM database
2	% of service users living in appropriate and affordable housing	As above	HSE in tandem with DoEHLG and housing authorities	Increase % of service users who reside in appropriate independent or supported housing within a pre-defined timescale	As above
3	% of service users participating in a formal third-level or vocational qualification	As above	HSE in tandem with DES and 2nd and 3rd level education institutions	Target to increase proportion of service users participating in formal education within a pre-defined timescale	As above
4	% of service users happy with their quality of life as good or better	As above	HSE	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey

Source: Indecon

Key Performance Indicator Sub-Set

While all of the KPIs recommended in this report have been chosen for their specific contribution to demonstrating performance or financial accountability in the mental health services, it may be useful to select a set of high-level indicators that can provide an overview of progress. For this reason, Indecon proposes the below sub-set of KPIs that could provide such an overview.

These indicators have been selected on the basis that, firstly, they focus on the transformation of services (proportion of staff in community mental health teams, balance of funding in community-based services and the overall investment in mental health). Secondly, two of these indicators provide high-level evidence of trends on least restrictive treatment (first admission and involuntary committal rates). Thirdly, two of these indicators provide a snapshot of trends in quality and scope of service (recovery plans, availability of psychological therapy). Finally, the indicator on quality of life provides a service user assessed measure of the extent that services are achieving valued outcomes.

The Key Performance Indicator Sub-Set is presented below:

Proposed Key Performance Indicator Sub-Set

	Indicator No. and Description	KPI Objective	Indicator Target Setting and Timeframe	Indicator Data Frequency and Method of Collection
1	*Recurrent Expenditure* on MHS - € million and % breakdown by Hospital/Inpatient and Community-based MHS and by service area and MHCA*	Improve transparency in and accountability for expenditure of allocated recurrent funding by service area and geographically	Level and breakdown of recurrent expenditure to align with optimal configuration based on population need and resource requirements	Annual via DoHC and HSE mental health budget planning and expenditure controls
2	*AVfC Development Expenditure* - € million and % breakdown by Service Area** and MHCA*	Improved transparency in and accountability for expenditure of allocated AVfC Development Funding	Annual expenditure to reconcile with allocated funding by service area and catchment area	Monthly and Annual data via HSE
3	Overall national ratio of staff in Community Mental Health Teams to total no. of MHS staff	Monitoring of progress in reducing current over-staffing of adult inpatient services and reconfiguring resources to increase staffing of CMHTs across MHS	National ratio to target 39% of MHS staff employed in CMHTs	Annual data based on Mental Health Commission census of CMHT staffing
4	First-time admission rate per 100,000 population	Incentivise shift in service provision to least restrictive community care settings	Reduce ratio to align with best practice benchmarks internationally within a pre-defined timescale	(Data already collected by HSE and reported annually by HRB)
5	% of service users in receipt of an individual care and recovery plan	Incentivise application of a 'recovery' approach to MHS provision in line with MHC Quality Framework Standard 1.1	Target to have all MHS service users to be in receipt of individual care and recovery programme within a pre-defined timescale	Annual data via NMD/WISDOM database
6	% of service users offered a psychological therapy	Incentivise development of Holistic MHS	Target to make available some form of counselling, family or psychological therapy service available through all CMHTs within a pre-defined timescale	Annual data via NMD/WISDOM database
7	No. Of Involuntary Committals per 100,000 of Population	Incentivise minimisation of involuntary committals and un-necessary detention, and incentivisation of appropriate treatment	Target to reduce involuntary committal rate to align with best practice benchmarks internationally	Annual rate monitored via Mental Health Commission annual reports
8	% of service users rating their quality of life as good or better	Demonstration of impacts and outcomes from MHS interventions on quality of life of service users	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey

**Service area refers to area of community-based MHS, i.e. General Adult, Child & Adolescent, **Older People, Rehabilitation, **Intellectual Disability and Forensic and other Specialist Services.*
Mental Health Catchment Area (MHCA) refers to super-catchment areas
Source: Indecon

Overall Conclusions and Recommendations

The key overall conclusions from this review are as follows:

- There are gaps in the detailed information available to support ongoing monitoring of the funding and delivery of mental health services;
- Particular gaps exist in the information required to ensure accountability for the allocation of funding to support the delivery of the recommendations of *A Vision for Change*, including in relation to recurrent, capital and development funding;
- There is limited data reported on a regular basis in the public domain about the provision and capacity of mental health facilities, and there is an absence of regularly reported data on community mental health service facilities. Additional new information is needed so that the facilities and human resource provision at service and catchment area levels can be monitored to ensure they meet the recommendations of *A Vision for Change*;
- Additional data is required to facilitate ongoing assessment of the scope and quality of service provision, and the outcomes from mental health service interventions for service users;
- While the Inspector of Mental Health Services has the power to inspect community based mental health services, there is currently no statutory requirement for inspection of such services. Furthermore, there is no statutory basis for licensing of community based mental health services;
- The WHO's and the UN's human rights guidance can inform the creation of an appropriate framework for performance assessment supported by well-chosen indicators. Indecon supports this approach; and
- International evidence shows more widespread and detailed usage of performance indicators in mental health services than is currently the case in Ireland.

Recommendations

A number of recommendations arise from the assessment undertaken in this report and the above conclusions. These recommendations are set out overleaf. Indecon believe it is important that urgent attention is given to considering these measures within the context of ensuring successful implementation of *A Vision for Change* and achieving full transparency and accountability in the funding and delivery of mental health services.

Recommendations

1 A range of new Key Performance Indicators should be implemented and published to facilitate the ongoing monitoring of funding, progress on implementation of *A Vision for Change* and outcomes of mental health service delivery

2 Key Performance Indicators should be supported by targets and associated timeframes for delivery which take account of existing gaps in progress, the constraints on public funding and the State's obligation to progressively realise the right to health

3 The proposed Mental Health Minimum Data Set should be implemented as a matter of priority in order to facilitate measurement of some of the Key Performance Indicators recommended in this report

4 Further exploration of outcome-based measures is required to develop a comprehensive set of indicators appropriate to assessing the outcomes for service users from mental health services

5 The Assistant National Director for mental health should hold overall responsibility for the HSE's mental health budget to enable financial accountability at national level

6 Executive Clinical Directors should assume responsibility for all resources allocated to mental health within their geographical and functional remits to enable accountability for the expenditure of mental health budgets

7 The HSE's Service Plan needs improved transparency in relation to the level of detail provided on actual and planned mental health service expenditures. This should include a breakdown of annual mental health funding allocations by service area and mental health catchment area

8 There is a need to ensure consistency between the figures presented on actual and planned mental health expenditures in the annual Revised Estimates published by the Department of Finance and the HSE's annual Service Plan

9 The implications of any recruitment moratorium on the implementation of *A Vision for Change* should be shown in the HSE's annual Service Plans

10 The funding model for the mental health service upon which the HSE's implementation plans are based should be published

11 The HSE should publish its implementation plan for *A Vision for Change* on its website and report on an annual basis on progress achieved relative to measurable targets

12 The Government should consider the feasibility of introducing an appropriately designed legal framework to underpin the provision of comprehensive and community-based mental health services, and to ensure transparent planning and reporting on the funding and delivery of mental health services by the HSE

13 The powers of the Mental Health Commission should be extended to include the registration and approval of all mental health services (not just inpatient units) and the Inspector of Mental Health Services should inspect all mental health services on a regular basis

Source: Indecon

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

1

Introduction, Background and Approach

Introduction, Background and Approach

1.1 Introduction

This report is submitted to Amnesty International Ireland (AI) by Indecon International Economic Consultants. The report concerns an assessment of the requirements to ensure accountability in the delivery of mental health services in line with the recommendations of *A Vision for Change* and develops a performance assessment framework for that purpose.

1.2 Background and Objectives of Review

—1.2.1 Background

This report takes place within the context of AI's work in the mental health sphere and Indecon's previous review completed for AI in September 2009 which examined government spending and progress on implementation of the Government's policy on the development of mental health services in Ireland, *A Vision for Change*, which was published by the Department of Health and Children in 2006.

AI's mental health campaign, focuses on using the human rights framework to demand action from Government. It campaigns for a social approach in response to mental health that is focuses on people's rights, in particular the right to live a full life in the community. One of AI's main campaign objectives is that Government introduces legislation that improves accountability and underpins the provision of appropriate comprehensive and community-based mental health services. *A Vision for Change* "details a comprehensive model of mental health service provision for Ireland [and] describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness."[7]

Indecon acknowledges that the HSE's performance monitoring reports and related indicators represent a significant step forward. Indecon is also aware that the HSE is currently developing additional new performance indicators and we support this initiative in principle. Gaps remain however in the level of detailed information provided compared to that required to facilitate a comprehensive assessment of progress on the implementation of the recommendations set out in *A Vision for Change*. It is hoped that this report will represent a useful input to addressing these gaps and to ensuring full transparency and accountability for the funding and delivery of high quality mental health services.

7 A Vision for Change – Report of the Expert Group on Mental Health Policy (2006). Government Publications Office - http://www.hse.ie/eng/Publications/services/Mentalhealth/Mental_Health_-_A_Vision_for_Change.pdf

—1.2.2 Indecon Review 2009

This current report follows and builds on the previous Indecon review, which was completed for AI in September 2009. This review examined government spending on mental health services and assessed the extent of progress on implementation of *A Vision for Change*. The data and information gaps highlighted by Indecon's previous review form the basis for this current report. The key findings of the previous review are summarised in the box below.

Box 1.1: Key Findings from Indecon 2009 Review

- There is a lack of available detailed data/information that would be required to facilitate the ongoing monitoring of funding, expenditure and human resource allocation across the mental health services and the assessment of progress on the implementation of *A Vision for Change*
- Significant skill shortages in the development of community-based mental health services and deficiencies in staffing of Community-based Mental Health Teams at regional and catchment area levels
- An over-reliance on traditional acute and long-stay inpatient beds within the Mental Health Services compared with the recommendations of *A Vision for Change* that is unlikely to be consistent with achieving the best value for money
- If the recent and current rate of progress on the main mental health service areas identified in *A Vision for Change* is maintained, the HSE will not achieve the recommended levels of resourcing of the Mental Health Services within the timeframe envisaged by its Implementation Plan
- The report concluded that the setting of performance indicators and supporting data would be essential in order to ensure accountability and monitor whether progress is being achieved

Source: Indecon, Review of Government Spending on Mental Health and Assessment of Progress on Implementation of A Vision for Change. Submitted to Amnesty International Ireland (1st September 2009).

A number of the recommendations from the first review are relevant to this report. The key recommendations from the Indecon 2009 review for AI are summarised in the box below.

Box 1.2: Recommendations from Indecon 2009 Review

- New performance indicators and supporting up-to-date data should be developed and published in order to enable monitoring of *A Vision for Change*. It also recommended that performance indicators and related targets reflect best practice internationally. Data should include more detailed and higher frequency data on funding and expenditures by service area and on a regional basis, in addition to more detailed data on human resources by skill mix at regional and catchment area level
- The targets for implementation of *A Vision for Change* should be reconfigured to realistic levels and a new set of annual targets formulated which take account of the current position and of the constraints in public expenditure
- In order to ensure the most effective use of scarce public expenditure and to improve value for money, an increased focus is required on reducing the overall dependency in mental health services on acute and long-stay inpatient beds and to continue to increase the provision and usage of community-based services and teams
- In order to further enhance value for money and effectiveness, progress is required in ensuring the appropriate staffing and specialist supports services in community-based mental health teams
- A reconfiguration of human resources in mental health services is required to ensure that resources are allocated on an equitable and efficient basis, both in terms of the functional and geographical distribution of these resources
- Changes in resource allocations will be required to successfully support the required reconfiguration of existing resources in mental health services and the attainment of the required overall level and composition of resources in line with *A Vision for Change*
- It is essential that the planned capital investments are made to ensure that required levels of community-based facilities provision are addressed across the mental health services
- An increased overall national allocation of human staffing resources is required in the Health and Social Care and Other Patient and Client Care personnel categories
- The geographical allocation of mental health service resources should be closely aligned with regional and local catchment area-level population levels and should also take account of local deprivation patterns
- Particular focus should be given to addressing the human resource shortfalls compared to recommended levels that exist in community-based mental health teams providing Child and Adolescent and Adult Intellectual Disability Mental Health Services as well as Mental Health Services for Older People

Source: Indecon, Review of Government Spending on Mental Health and Assessment of Progress on Implementation of A Vision for Change. Submitted to Amnesty International Ireland (1st September 2009).

1.2.3 Objectives and scope of review

This present report was commissioned in order to develop many of the recommendations from the initial review. This report considers both financial accountability for and performance assessment of mental health services in Ireland.

The objectives of the present exercise were as follows:

- Financial accountability: With a focus on the HSE and its relationship to the Department of Health and Children, to review existing systems and to identify information requirements and develop a preliminary set of Key Performance Indicators (KPIs) for consideration to assist in ensuring accountability in the funding of, and expenditure on, mental health services in line with the policy set out in *A Vision for Change*;
- Performance assessment of development of mental health services in line with goals set out in *A Vision for Change*. This report considers in particular the ongoing monitoring and assessment of progress in relation to:
  - Facilities Capacity – including indicators to facilitate monitoring and incentivise provision of facilities required to support development of Community-based teams and specialist services;
  - Human/Staffing Resources and Deployment – with particular focus on KPIs to facilitate monitoring of progress on development of community-based mental health services in line with *A Vision for Change*;
  - Quality of Mental Health Service Provision – focusing on development of appropriate KPIs to facilitate ongoing monitoring and incentivise the provision of recovery-oriented, holistic, and least restrictive, locally provided mental health services; and
  - Mental Health Outcomes – development, based on international best practice, of a preliminary set of KPIs to support ongoing monitoring of outcomes for service users from mental health service intervention.

Box 1.3: Key Performance Indicator - Definition

A Key Performance Indicator (KPI) is a high-level measure that shows whether and how well a programme is achieving its objectives. KPIs are typically used in external reporting, such as in a strategy statement or performance review report. An effectively designed KPI will usually be associated with an appropriate pre-specified target.

Source: Indecon

1.3 Summary of Approach

This review was guided by the following inputs:

- The findings of Indecon's 2009 review completed for AI (summarised above) - particularly in relation to identified deficiencies in data collection and existing monitoring systems in each of the mental health services areas of focus for the report above;
- The WHO guidance and UN human rights principles and the elements of the right to the highest attainable standard of mental health;
- The findings in relation to international experience and best practice in the development and application of mental health information and performance assessment frameworks. This includes guidance on mental health planning and performance assessment developed by the WHO (see further below);
- National guidelines on development and application of performance indicators set out by the Department of Finance;
- Developments since publication of *A Vision for Change* and the HSE's Implementation Plan (released in 2009);
- Consultations with the HSE including with Martin Rogan, Ian Daly and Brendan Doody; and
- The work undertaken to date by AI in relation to how legislation could improve accountability and underpin the provision of comprehensive and community-based services as recommended in *A Vision for Change*.

1.4 International Experience and Best Practice

In formulating an effective framework to support ongoing performance assessment and ensure transparency and accountability in mental health services in Ireland, this report reflects consideration of the experience and guidance available internationally from a range of domains and countries.

In general, development of comprehensive performance assessment frameworks for mental health is at a relatively early stage, though progress in some jurisdictions has been more advanced than in others. While it is important to caution against the indiscriminate application of external approaches to the Irish context, given the different stages of development of the mental health services and the disparate policy and administrative systems in different counties, lessons can be learned both from the experiences of, and the approaches adopted by, different organisations and governments.

In this report we have drawn from the experience and policy guidance available from the following organisations and countries:

- World Health Organisation (WHO);
- United Nations (UN);
- United Kingdom;
- United States;
- Canada; and
- Australia.

Application of Best Practice Approaches

Aspects of the experiences and approaches applied in each of the individual countries above as they relate to areas of performance assessment examined in this report are considered in the subsequent chapters. It is instructive however to describe the key features of best practice approaches in this area which guide this report, particularly as this relates to fulfilment of the human right to the highest attainable standard of mental health and other characteristics of 'good' performance indicators.

The Human Right to the Highest Attainable Standard of Physical and Mental Health

An important feature of best practice in relation to the application of performance monitoring and assessment frameworks within the context of mental health services concerns the need to ensure that such frameworks – and supporting performance indicators – can serve to demonstrate how services are fulfilling the human rights of the individual service user.

In developing the proposed framework for performance assessment in funding and delivery of mental health services in Ireland set out in this report, importantly, the approach applied reflects the policy and guidance of the WHO and the United Nations human rights framework.

The WHO Constitution defines mental health as follows:

> "Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community."

The right to health is protected under Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), to which Ireland is a party since 1989. Article 12 ICESCR states:

> "States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[8]

The right to the highest attainable standard of physical and mental health has since been recognised in a number of other human rights treaties including, most recently, Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD), which Ireland has signed but not yet ratified.

The UN Committee on Economic, Social and Cultural Rights has clarified the meaning of the right to health in human rights terms as, not a right to be healthy, but a right to the facilities, goods, services and conditions that are conducive to the realisation of the highest attainable level of health. [9] Thus it is clear that the right to health is not confined to the right to mental health services but rather includes a wide range of responsibilities on the part of the Government to provide for the conditions in which people can lead healthy lives.

8 Article 12 of the International Covenant on Economic, Social and Cultural Rights,.

9 CESCR General Comment 14 on the right to the highest attainable standard of health (article 12) UN Doc E/C.12/2000/4 paras 8 - 9.

That Committee has emphasised that the right to health is not a stand-alone right but is closely related to and dependent upon other rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, privacy, access to information and the prohibition on human or degrading treatment and torture.[10]

In respect of mental health services, the UN Committee on Economic, Social and Cultural Rights has identified four elements to the State's obligations in meeting the right to the highest attainable standard of health, as follows:

- "*Availability*. Functioning public health and healthcare facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.
- "*Accessibility*. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party." Accessibility in turn has four overlapping dimensions, namely (a) Non-discrimination, (b) Physical accessibility, (c) Economic accessibility (affordability), and (d) Information accessibility.
- "*Acceptability*. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
- "*Quality*. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."[11]

Human rights law and standards do not demand that the State be overburdened financially. Instead the right to health imposes an obligation on States to ensure the satisfaction of, at the very least, core minimum essential levels of services required under the right to health.[12] This is an immediate obligation; failure to comply constitutes a breach of the State's international law obligations. It then requires that such core minimum services be improved and expanded over time in accordance with the principle of progressive realisation.

The principle of progressive realisation recognises the economic realities of individual States. Thus the human rights framework accepts that certain elements of the right to health will not become reality overnight, but will take some time to realise, depending on the resources available to the State in question. This should not be misinterpreted as rendering the right to health meaningless.[13] Progressive realisation requires the State *to take steps* (which must be deliberate, concrete and targeted)[14] *to the maximum of its available resources* with a view to progressively realising the right to health over time. It thereby imposes an immediate obligation on States to move *as expeditiously and effectively* as possible towards that goal by using all appropriate means.[15]

Indecon acknowledges the need to take account of the current severe constraints in the public finances, which are impacting across the health services. It is important to also note that human rights do not require States to spend more than the maximum available resources. The UN Committee on Economic, Social and Cultural Rights has emphasised that, even in times of serious resource constraints, the State is still under an obligation to use its available resources as effectively and efficiently as possible to realise the right to the highest attainable standard of health.[16]

10 ibid paras 8-11.
11 ibid para 12.

12 Committee on Economic, Social and Cultural Rights General Comment 3 on the nature of States parties obligations under article 2(1) of the Covenant UN Doc E/1991/23(14/12/90), para 10.

13 ibid para 8.
14 ibid para 2.
15 ibid para 9.
16 ibid paras 9 and 11.

Effective planning is also a key component of the right to health. Human rights guidance has identified the key features of effective planning as including: "clear objectives and how they are to be achieved, time frames, indicators and benchmarks to measure achievement, effective coordination mechanisms, reporting procedures, a detailed budget that is attached to the plan, financing arrangements … evaluation arrangements, and one or more accountability devices".[17] In order to measure whether or not the State is improving its health system over time and thereby progressively realising the right to health, it is essential that there be effective and transparent monitoring and accountability mechanisms in place.[18] In human rights terms, accountability goes beyond ensuring that funds are spent as intended; effective systems of accountability should ensure that health systems are improving and the right to health is being progressively realised over time.[19]

The importance of setting mental health within the broader human rights context is evident in AI's mental health campaign, which has a long-term goal of ensuring that the right of all people in Ireland to the highest attainable standard of mental health is fully realised. In particular, AI notes

> "Human rights can and should provide a framework and overarching principles for Government's direction of policy implementation in relation to mental health services. This framework goes beyond ensuring the protection of individual's civil rights, as for example, through implementation of the Mental Health Act, 2001. Recent years have seen a heightened determination by the WHO that states should view and address mental health as a human rights issue. It has urged governments to address global neglect of mental health, and the human rights abuses, discrimination and social exclusion routinely experienced by people directly affected by mental health rights, using human rights-based approaches."[20]

This approach is in line with the National Economic and Social Forum's recommendation that human rights be given "more concrete expression in terms of standards of services that clients can expect…"[21]

Indecon is in agreement with this approach and the above aspects have important implications for the demonstration of accountability within the context of the Irish mental health services and the attainment of the goals set out in *A Vision for Change*. In particular, in the context of this report, the WHO's and the UN's human rights guidance provide an overarching guide to formulation of an appropriate framework for performance assessment supported by well-chosen indicators.

WHO guidance on mental health information systems and performance indicators

The WHO, in its assessment of Mental Health Information Systems (MHIS),[22] highlights a number of principles, based on the experiences of several countries, in relation to the development of health information systems and mental health information systems. One of these principles concerns the use of well-defined indicators.

In relation to the application of performance indicators more generally, the WHO guidance states:

> "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. As an important way of measuring change in a system, they are an essential tool in an MHIS."[23]

17 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt UN Doc.A/HRC/711 (31 January 2008) para 96.

18 ibid paras 48 and 99-106.

19 ibid para 101.

20 Amnesty International Ireland 'Minimum Requirements for A Vision for Change Implementation Plan' (unpublished submission to the Minister of State with responsibility for Equality, Disability and Mental Health, February 2009)

21 National Economic and Social Forum (NESF) Fifth Period Report on the Work of the NESF: Report No.37 (2008), p.162.

22 World Health Organisation (2005), Mental Health Information Systems - Mental Health Policy and Service Guidance Package.

23 Ibid. Page 4.

The WHO recommends a four-staged approach to developing performance indicators suitable for application in the context of a mental health information system. A schematic outline of the four steps and associated tasks recommended by the WHO is presented in the figure below.

Figure 1.1 WHO recommended four-step approach to developing and evaluating a mental health information and performance indicator system

Source: *Indecon, based on World Health Organisation (2005)* [24]

24 Ibid. Chapter 3.

Characteristics of 'good' performance indicators

It is important firstly to define the term 'indicator' or 'performance indicator'. One useful definition is that presented by McEwan and Goldner (2001) in their very useful and comprehensive research on the application of performance assessment frameworks in the context of the Canadian mental health services:

> "Performance indicators for mental health services and supports help convey whether a program, or set of programs, does what it is intended to do and whether it does it well."[25]

National guidance on the use of performance indicators developed by the Irish Department of Finance, defines an indicator as:

> "An indicator is a set of measurements of a specific variable over time (and/or location)."[26]

In developing performance indicators, an important requirement is the need to ensure parsimony in the selection of measures to facilitate clarity and ease of use. In research undertaken for the WHO, Bodart and Shrestha (2000)[27] note that while judgment and intuition are crucial in defining and selecting appropriate indicators, the selection process may be assisted through posing the following questions:

- Validity: What is the indicator supposed to measure?
- Reliability: Does the indicator provide a consistent measure?
- Cost (proportionality): What will be the cost of measuring the data and is this proportionate to the intended benefits of using the proposed indicator?
- Relevance: What is the relative importance of the subject matter to be addressed and the decision to be made based on the indicator?
- Specificity: Does the indicator actually capture changes that occur in the situation under study?
- Sensitivity: Is the change shown by the indicator a true change in the situation under study?
- Balance: Does the proposed indicator contribute to a balanced overall indicator set, in terms of requirements to examine inputs, processes/ activities, outputs and outcomes?
- Data capture: How, when and where would the necessary data be captured?

In Ireland, the Department of Finance's guidelines identify a number of characteristics of a 'good' indicator, as follows:[28]

The variable in question should be relevant to the purpose for which the indicator is required;

- The variable should be clearly defined;
- The measurements should be reliable, i.e. the same measurement taken by two different people should give the same value for the indicator;
- The measurements should be as precisely defined as required;
- The measurements should be readily available, i.e. the cost of collecting the measurements as regularly as required should not outweigh the usefulness of the indicator; and
- The measurements should be available within a reasonable time frame, i.e. the measurements should still be useful for the purpose of the indicator at the time when they become available.[29]

While the above attributes pertain to programme performance indicators more generally, it is notable that they are broadly consistent with those highlighted by the WHO guidance and the key criteria set out by Bodart and Shrestha (2000), described above.

25 McEwan, K. and Elliot M. Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports – A Resource Kit.* Prepared for the Federal/Provincial/ Territorial Advisory Network on Mental Health (2001)

26 CSF Performance Indicators: Proposals for 2000 – 2006 Programming Period. Department of Finance/ CSF Evaluation Unit (1999). Page 3.

27 Bodart C & Shrestha L. *Identifying Information Needs and Indicators.* In: World Health Organisation, Design and Implementation of Health Information Systems. Geneva, World Health Organisation, 2000. Pages 49-72.

28 Department of Finance (1999). Op. Cit.

29 Ibid. Page 3.

Purpose of indicators in context of mental health services

In the context of mental health services, indicators can be used to measure various aspects of the mental health system, including in particular:

- Needs – including definition of service requirements of different groups within the population;
- Inputs – pertaining to the financial, human and other resources required to carry out the activities of the mental health services;
- Processes – the activities of the mental health services in transforming inputs into outputs;
- Outputs and Results – the outputs resulting from the combination of financial and human resources, and activities of mental health services, in terms of service provision and results achieved from the perspective of the service user while utilising the service; and
- Outcomes – the identifiable long-term benefits of mental health interventions for service users.

Domains of mental health performance framework

International best practice in health system performance measurement typically defines performance indicators within a number of 'domains'. In particular, the Canadian Institute for Health Information has developed a framework for health system monitoring and performance assessment based on the application of eight domains, as follows:[30]

- Acceptability
- Accessibility
- Appropriateness
- Competence
- Continuity
- Effectiveness
- Efficiency
- Safety

Each of the above domains is defined in the schematic below.

Figure 1.2 Health System Performance Measurement Domains

Acceptability	Care/ service provided meets expectations of client, community, providers and paying organizations
Accesibility	Ability of clients/ patients to obtain care/ service at the right pace and right time, based on needs
Appropriateness	Care/ service provided is relevant to client/ patient needs and based on established standards
Competence	Individuals knowledge/ skills are appropriate to care/ service provided
Continuity	Ability to provide uninterrupted, coordinated care/ service across programs, practitioners, organizations and levels of care/ service, over time
Effectiveness	Care/ service, intervention or action achieves desired results
Efficency	Achieving desired results with most cost effectiveuse of resources
Safety	Potential risks of an intervention or the environment are avoided or minimized

Source: *McEwan and Goldner (2001)*[31]

30 Canadian Institute for Health Information and Statistics Canada (2000), *Canadian Health Information Roadmap Initiative Indicators Framework.*

31 McEwan and Goldner (2001), Op. Cit. Page 72.

Notably, the performance domains described on the previous have inputted to the design of performance assessment systems for mental health services in a number of countries. These include the Canadian framework and the Australian performance assessment framework for mental health services.[32]

Accountability

An aspect that is related to the efficiency performance measurement domain and which is important in the context of this review is the issue of accountability and, in particular, financial accountability.

Given its importance in the relation to the delivery of mental health services as set out in *A Vision for Change*, it is instructive to define the meaning of accountability in this context.

Accountability may have various meanings depending on the context. More generally, accountability can be defined as the allocation or acceptance of responsibility for actions to a specific organisation or individual(s). In the human rights context, accountability is a composite right involving rights to due process, to effective remedies, to equal treatment, etc. Generally, this principle includes accountability for transparent decision-making and clarity around, and awareness of, the responsibilities of duty-bearers and rights-holders (individuals whose rights are at stake - people with mental health problems). It requires human rights benchmarks by which progress is measured as well as reward and sanction for success and failure in achieving positive human rights impact. It includes accountability for both process (how the decision was made) and result (who gains / loses in human rights terms from the policy / practice). Where special responsibilities, privileges and powers are granted to particular individuals and institutions, they must be matched by appropriate levels of accountability.[33]

In relation to the right to the highest attainable standard of health, accountability has been described as:

> "The process which provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. Equally, it provides government with the opportunity to explain what it has done and why."[34]

In the context of mental health services, a useful definition is presented in the very useful research undertaken in Canada by McEwan and Goldner (2001), namely:

> "'[T]he obligation to demonstrate that policies and programs are achieving intended results'… Intended results should be explicit in the agreed upon goals and objectives for the mental health services and supports within a province, territory or defined health region. Performance then is defined as the degree of progress toward stated goals and objectives."[35]

A further definition is set out in the Mental Health Accountability Framework developed by the Ontario Government, as:

> "Accountability focuses on results that are measurable and, where possible, evidence-based. Through a continuous process of setting expectations, monitoring performance, reporting on outcomes, and making improvements, organizations / programs and services / supports can be as efficient and effective as possible and can contribute to meeting system-wide goals."[36]

32 See *Key Performance Indicators for Australian Public Mental Health Services*, Report of Performance Indicator Drafting Group, Information Strategy Committee, AHMAC National Mental Health Working Group (November 2004).

33 Amnesty International Ireland *Our Rights, Our Future: Human Rights Based Approaches in Ireland: Principles, Policies and Practice*, pp.56-57.

34 Potts, Helen, *Accountability and the Right to the Highest Attainable Standard of Health*, University of Essex Human Rights Centre, p.7

35 McEwan, K and Elliot M.Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports- A Resource Kit.* Prepared for the Federal /Provinical/territorial Advisory Network on Mental Health (2001).

36 Government of Ontario, Mental Health Accountability Framework. See: http://www.health.gov.on.ca/english/public/pub/ministry_reports/mh_accountability/mh_accountability_e.pdf.

In Ireland, *A Vision for Change* set out a number of values which inform and underpin the service philosophy proposed. In relation to accountability, the policy recommends the following:

> "Accountability: clinical and corporate governance should be put in place to ensure the accountability of mental health services"[37]

The consultation process which informed the formulation of *A Vision for Change* also highlighted the importance of accountability, as follows:

> "The need to ensure that an improved mental health policy is funded in a manner that enables it to deliver its service objectives competently, accompanied by a reciprocal need for clarity about clinical governance, leadership, quality and standards, *accountability* and ensuring value for money in the use of public funds."[38]

This review focuses on the identification of a preliminary set of KPIs which is appropriate to incentivise accountability – and the related requirement of transparency – in the funding and delivery of mental health services.

Financial accountability constitutes an important component of overall accountability and relates to the importance of incentivising good governance and financial management, and ensuring transparency and accountability in relation to both funding and expenditure on mental health services. Financial accountability also relates closely to the requirement to demonstrate effectiveness and efficiency, and therefore value for money, in the expenditure of public resources.

Australian model for promotion of accountability

One example of good practice in relation to ensuring accountability in the delivery of mental health services can be found in the Fourth National Mental Health Plan (2009-2014), which has recently been published by the Australian government.

The Australian model identifies a "multi-level approach to building an accountable and transparent mental health system." An important element in this approach is the promotion of accountability through establishing comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.

The different components of the Australian mental health plan are profiled in the figure overleaf.

37 *A Vision for Change* (2006), Page 15.

38 Ibid Page 13 Italics are Indecon's emphasis.

Figure 1.3 International Best Practice - Accountability - Example of Strategy to Ensure Accountability in Delivery of Mental Health Service - Australian National Mental Health Plan (2009-2014)

Table 1: Regular national level reports contributing to comprehensive information about mental health services in Australia

Title	Purpose	Prepared/ Released by	How the report will be developed 2009-14	Frequency
National Mental Health Report	Principle report for monitoring progress of mental health reform in Australia. Present analysis of reform against specified indicators.	Australian Government for AHMC	Focus to be on reporting progress and outcomes of Fourth Plan. Key contextual indicators used in previous National Mental health Reports to be continued, to allow monitoring of long term trends in mental health resourcing and service mix. Special commentaries to be added to allow stakeholder opinion and analysis to inform national debate.	Annual
Mental Health Services in Australia	Presents the source descriptive data on the activity of mental health services, primarily based on annual National Minimum Data Sets. Also includes descriptive information on activities of services operating beyond the health sector which are of relevance to mental health.	Australian Institute of Health and Welfare, funded by Australian Government	Publication to be developed as the comprehensive report for all source data that describe mental health services in Australia. Increasing range of source data and customised analyses to be developed for on-line access	Annual
COAG Action Plan on Mental Health Annual Progress Report	Serves as the key accountability instrument for the Action Plan- summarises progress in the Action Plan's implementation and available data on outcomes.	Prepared under auspice of AHMC for COAG	Report scheduled to conclude at end of Action Plan in 2011. Progress indicators are incorporated in indicators developed for Fourth Plan and will be published in National Mental Health Report.	Annual to 2011

Source: *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009–2014. Commonwealth of Australia, 2009*

Indicator target setting

For indicators to be effective, they should ideally be compared to performance targets or benchmarks. Targets represent commitments made in advance to achieve a stated level of performance. According to McEwan and Goldner (2001):

> "A good target is one that clearly relates to an organisational objective and is realistic — that is it is achievable but also presents a challenge for improved performance."[39]

Targets may also have associated milestones, or intermediate targets, in contexts where the achievement of specific objectives is envisaged to take place in a staged manner over a defined period.

Indecon accepts that such targets, including targets based on the recommended levels of service development and provision as set out in *A Vision for Change*, may need to be adjusted in line with overall expenditure budgets. However, effective targets and aligned performance indicators are needed to ensure value for money.

1.5 Mental Health System Information in Ireland

Reflecting the best practice approaches described above, in developing appropriate performance measures, this assessment reviews the existing use of performance indicators in relation to the funding, development and delivery of mental health services in Ireland. This includes reviewing the existing level of data/information available and identifying the gaps in data/information relative to the requirements of best practice performance assessment.

In terms of existing data/information, the mental health services have always collected a basic level of activity and service user data on inpatients. In particular, the National Psychiatric Inpatient Reporting System (NPIRS), which is run by the Health Research Board, has provided a continuous source

39 McEwan, K. and Elliot M. Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports – A Resource Kit*. Prepared for the Federal/Provincial/ Territorial Advisory Network on Mental Health (2001)

of information on inpatient activity for over 30 years.

In addition, the annual reports of the Inspectorate of Mental Health Services provide important information on the quality of inpatient services, while the annual reports on Community Mental Health Team (CMHT) Staffing provide information on the development of CMHTs.

Historically, however, much of the information gathered on the mental health services has been paper based and collated manually, and demands on this system have increased substantially with the introduction of new legislative and service management, planning and resource allocation requirements. Furthermore, there has been a lack of information on community-based and outpatient mental health service provision.

The specific gaps in existing information provision as they relate to each of the components of mental health service funding, facilities and human resources inputs, service provision and quality and outcomes for service users are examined in the subsequent chapters of this review.

Full implementation of accountability for mental health service delivery will require the provision of a number of components of additional data/ information on funding, service development and provision and quality. One initiative that could assist with providing this information is the development of a National Minimum Data Set. It will also require ICT systems to support data collection and reporting.

National Minimum Data Set and WISDOM ICT system

To address the increasing range and complexity of information requirements and the existing deficiencies, *A Vision for Change* recommended a shared National Minimum Data Set (NMD) for mental health.

This entails all four of the major information seekers, namely the Department of Health and Children, the HSE, the Mental Health Commission (MHC) and the Health Research Board, reaching agreement on a set of data items, agreeing data definitions, collection frequency, sharing protocols and utilisation of information sourced from mental health services.

We understand from the HSE that the MHC and the HRB have signed off on the NMD items required for their own purposes, and that the HSE and the Department intend to finalise the data set in the coming months.

Indecon understands that the NMD will be incorporated within the WISDOM service user database system. WISDOM is being developed jointly by the Health Research Board and the HSE and is currently being piloted in County Donegal. WISDOM has evolved from the COMCAR community database and is very much patient/service user-focused and is designed to enable tracking of all mental health service users and their relationship with the service over time, including service users moving between inpatient- and community-based services. We understand, however that WISDOM will have the capability to incorporate the additional service-related data items sought and agreed by the DoHC, the MHC, the HRB and the HSE.

Indecon is supportive of these developments in principle.Their effectiveness will depend on a range of factors including consistent national implementation as well as collection of data that can support the performance indicators recommended in this report. In order to reflect these developments, this report will show the data/information that should be collated as part of the NMD and associated WISDOM ICT system.

HSE Healthstat

It is also important to set the proposed indicator framework developed in this report within the context of the existing work undertaken by the HSE as part of its Healthstat databank.

Healthstat was established by the HSE in 2005 with the objective of developing a co-ordinated approach to monitoring and measuring performance in the public health services.

Healthstat reports on hospital and community health service performance on a monthly basis and the database operates alongside the HSE's annual

National Service Plan monitoring reports and the agency's Corporate Plan objectives. The hospital measures currently monitored through Healthstat are listed in the table below and are divided into measures which pertain to access to services, integration to ensure that services are patient-centred, and resources, in terms of whether a hospital is using its human and financial resources effectively and efficiently.

The databank currently provides detailed results across 29 teaching, regional and general hospitals and 32 Local Health Offices and these results are published online. We understand that further development of the databank is planned to include additional general and specialty hospitals, and health and social care services provided in the community by Local Health Offices.

Table 1.1
Healthstat Measures Tracked on Monthly Basis

Access	Integration	Resources
Waiting times for:	Day case rates	Staffing & Absenteeism
Planned procedures	Average lengths of stay	Management of Social Work, Occupational Therapy, Physiotherapy, Radiology and Consultant Clinics
Emergency Dept Admissions	Day-of-procedure admission rates	Budget / spend
Diagnostics	Delayed discharges	Meeting activity targets
Therapies	Use of inpatient beds	
Outpatient clinics		

Source: HSE

Given the need to ensure that any new performance monitoring indicators reflect the existing work undertaken by the HSE in measuring service performance, where new measures are proposed in this report, it is important to consider how any proposed new indicators for the mental health services relate to existing measures tracked within the Healthstat databank.

1.6 Existing Performance Assessment

In developing a framework of performance indicators for the mental health service, this report also considers the existing work underway in this area. This includes in particular the existing pattern of utilisation and reporting on performance applied by the Department of Health and Children and the Health Service Executive. Specific aspects are considered in the subsequent sections of this report.

At a macro level, however, it is instructive to briefly reflect on the current performance measurement systems that are operated by the DoHC and the HSE. At Department level, annual reporting on performance assessment in the mental health and other health services is presented in the Department's *Annual Output Statement for the Health Group of Votes*. The Annual Output Statement for 2009 is the third such statement issued by the Department with the objective of matching outputs and strategic impacts to financial and staffing resources for the financial year. For each care programme within the Health Votes 39, 40 and 41, including mental health, the output statement provides an overall summary of high-level objectives and impact indicators. It also presents a high level summary of budgeted expenditures and a breakdown of total gross expenditure, in addition to details on human resources. However, there is very limited use of specific performance indicators, while information presented is at a high level of aggregation, with no detail on resources by mental health service area. There are also some inconsistencies between some of the outturn figures for expenditure presented in the output statement and those published by the HSE, which are described further in Section 2.

A number of documents published by the HSE are relevant in assessing existing information provided in relation to the development of the mental health services. The following specific documents have been reviewed as part of this exercise and are discussed in detail elsewhere in this report:

- HSE, Vision for Change Implementation Plan, 2009-2013;
- HSE National Service Plan (annual); and
- HSE Performance Management Reports (monthly).

The existing range of performance metrics for mental health monitored by the HSE as part of its ongoing performance assessment programme are set out in the figure overleaf.

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

Figure 1.4 Existing HSE Performance Metrics – Mental Health

Performance Activity/ Key Performance Indicator	Reported	Expected Activity/Target 2009	Projected Outturn 2009	Expected Activity/Target 2010
Admissions				
Total number of admissions to acute inpatient units (adults and children)	Monthly	15,905	15,718	15,702
No. of children/adolescents admitted to adult HSE mental health services (reported on a quarterly basis)				Target of no admissions for <17 years by end 2010
<16 years and length of stay	Quarterly		*12	
<17 years and length of stay	Quarterly		42	
<18 years and length of stay	Quarterly		101	
Admissions to HSE CAMH Units				
<16 years	Quarterly		55	Expected level of activity to accommodate >160 admissions in 2010
<17 years	Quarterly		28	
<18 years	Quarterly		16	
No. of readmissions as a % of total admissions	Monthly	68%	11,274 (72%)	10,677 (68%)
Total no. of involuntary admissions	Monthly	1,372	1,372	1,372
Inpatient Services				
No. of inpatient places per 100,000 population	Quarterly	25.0	28.5	26.6
First admission rates to acute units (that is, first ever admission), per 100,000 population	Quarterly	105.6	105.0	105.5
Inpatient readmission rates to acute units per 100,000 population	Quarterly	260.3	265.8	235.8
Median length of stay in inpatient facilities	Quarterly	12.0	11.4	10.5
Rate of involuntary admissions per 100,000 population	Quarterly	10.3	10.3	9.3
Self Harm				
No. of repeat deliberate self harm presentations in ED	Bi-annually	Reduce by 1% each year	1% reduction to 21% repeat presentations	Further reduction of 1% to 20% repeat presentations
Child and Adolescent Mental Health				
No. of Community Child and Adolescent Mental Health Teams (per Vision for Change)	Monthly	50	50	55
No. of Day Hospital Teams (per Vision for Change)	Monthly	2	2	3
No. of Paediatric Liaison Teams (per Vision for Change)	Monthly	3	3	3
Referrals/ patients seen				
No. of new child/adolescent referrals received by Mental Health Service	Monthly		891	Reporting to commence in 2010
No. of new child/adolescent referrals accepted by Mental Health Service	Monthly		650	For reporting in 2010
No. of new child/adolescent patients seen by a member of community CAMH team	Monthly		640	
Children and Adolescent waiting time to first appointment with CAMH				
New cases seen by wait time to first appointment	Monthly			
0-1 month	Monthly		279	70% seen within 3 months
1-3 months	Monthly		145	
3-6 months	Monthly		87	
6-12 months	Monthly		68	
12 months	Monthly		62	
Children and Adolescent Waiting Lists				
Total number on waiting list at end of each quarter by wait time:	Quarterly			
<3 months	Quarterly		797	To reduce numbers on waiting list by >5%
3-6 months	Quarterly		555	
6-12 months	Quarterly		578	
>12 months	Quarterly		687	

** Note that from 1/7/09 Mental Health Commission guidelines changed; there was only 1 admission after this date to an adult HSE mental health service <16 years*
Source: *HSE, National Service Plan, 2010*

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

There are a number of very useful measures tracked by the HSE. However, there is very limited utilisation of indicators to support financial transparency and to facilitate the monitoring of progress on the transformation of the mental health service in line with the recommendations of *A Vision for Change* apart from those instituted for Child and Adolescent Mental Health services. This report seeks to address these gaps.

1.7 Proposed Indicator Framework

This report develops a proposed framework of Key Performance Indicators (KPIs) which is structured on the basis of the schematic presented in the figure below. Importantly this approach reflects consideration of best practice approaches internationally and feasibility of implementation within the context of the existing characteristics of the Irish mental health services and the findings of Indecon's review for AI completed in 2009. The approach used here is designed to capture the key features of an indicator set appropriate to addressing what we judge to be the critical issues relevant to financial accountability and performance management in the Irish mental health services within the context of implementation of *A Vision for Change*.

Figure 1.5 Structure of Proposed Indicator Framework

Framework Dimensions	Indicator Characteristics	Mental Health Services Performance Domains
Proposed Key Performance Indicators (KPIs) • Transformation Indicators • Ongoing Performance Indicators	**Performance Measurement Dimensions Input** • Financial Accountability • Infrastructure Provision • Human Resource **Processes** • Scope & Quality of Services • **Outcomes** Outcomes from MHS interventions	• Financial Accountability in Service Funding and Expenditure • Acceptability • Accessibility • Appropriateness • Competence • Continuity • Effectiveness • Efficiency • Safety
→	→	
KPI objectives	Link with recommendations of *A Vision for Change* and human rights principles	
→	→	
Organisational responsibility for implementation and delivery of objectives	Organisation/Agency responsible to achieving policy objectives	
→		
Indicator Target Setting and Timeframes	• Quantitative/Qualitative Target • Timeframe for attainment, incl. intermediate targets/milestones	
→		
Indicator Data Frequency and Method of Collection	• Monthly, Quarterly, Annual data • Data/Information source and method of collection (e.g. census, survey, budgetary MIS)	

Source: *Indecon*

In terms of types of indicators, reflecting the particular context and objectives of this exercise, two broad types of indicators are considered, namely:

- *Transformation indicators* – designed to facilitate monitoring of achievement of mental health service reconfiguration and development goals set out in *A Vision for Change*; and
- *Ongoing performance indicators* – designed to facilitate the ongoing monitoring of performance and financial accountability in the MHS.

Outcome indicators and recovery-based model of mental health intervention
The WHO's guidance notes that, traditionally, planners have tended to focus on input and process indicators, both in evaluating services and in data collection, with outcome indicators proving to be more challenging. Outcome indicators are, however, seen as essential within the context of planning at overall and service levels and such indicators can "provide an invaluable means of evaluating the impact of interventions, from mental health promotion to preventive and treatment interventions such as medication and psychotherapy."[40] Furthermore, the ultimate measure of achievement of both *A Vision for Change* and the right to the highest attainable standard of mental health is in the outcomes achieved by service users in terms of their ability to realise their abilities and participate in their communities.

In the context of the Irish mental health services an aspect of the development of mental health information systems and associated performance assessment frameworks concerns the recovery-based model enunciated in *A Vision for Change*. Under this model, interventions are designed not simply with a view to addressing the symptoms experienced by service users but with the objective of maximising the quality of life of individuals. According to *A Vision for Change*:

> "A 'recovery' approach should inform every level of the service provision so service users learn to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks, and pursue dreams and goals that are important to them and to which they are entitled as citizens."[41]

Given the need to ensure accountability and monitor progress on implementation of *A Vision for Change*, this report gives greater focus to suggested performance indicators which relate to needs, inputs and processes. A preliminary examination of outcome indicators and their application in the context of the Irish mental health services is presented in Section 6 of this report.

40 WHO (2005), Op. Cit. Page 4.

41 *A Vision for Change*, Page 5.

1.8 Structure of Report

The remainder of this report is structured as follows: the review commences in Section 2 by addressing the overarching issue of financial accountability and identifying a framework of KPIs to incentivise sound governance and financial management, and to ensure transparency and accountability in relation to both funding and expenditure on mental health services in line with the goals of *A Vision for Change*. Section 3 examines mental health services facilities and proposes a set of KPIs to support the assessment of progress on delivery of required facilities. Section 4 examines human resources in mental health services and develops a set of key performance indicators designed to facilitate monitoring of progress on the reconfiguration of staffing and the development of community-based mental health services. Section 5 considers the important aspect of scope and quality of service provision and sets out a range of KPIs to facilitate ongoing monitoring and incentivise the provision of recovery-oriented, holistic, and least restrictive, locally provided mental health services. Section 6 presents a preliminary examination of the requirements for development of a set of KPIs for the assessment of outcomes from investment in the mental health services. Finally, Section 7 brings together the key findings and outputs from the preceding chapters and set out overall conclusions and an integrated set of cross-cutting recommendations.

2

Financial Inputs and Accountability

Financial Inputs and Accountability

2.1 Introduction

In the absence of sound financial management and planning, it is not possible to ensure accountability for the effective and efficient use of funds invested in mental health services. The previous Indecon review prepared for AI highlighted a number of deficiencies in relation to the existing financial management and oversight structures governing the ongoing operation and development of the mental health services. This section addresses financial accountability from a forward-looking perspective. It identifies the requirements in terms of a framework of measures/indicators to incentivise good governance and financial management, and to ensure transparency and accountability in relation to both funding and expenditure on mental health services.

2.2 Information and Assessment Needs

The first step towards formulation of an appropriate set of key performance indicators to support financial accountability is to identify the particular requirements in terms of information and performance assessment in this context.The information and performance assessment needs in relation to financial accountability are essentially driven by the following aspects:

- The requirements to ensure transparency and accountability in relation to the implementation of the recommendations for funding and expenditure to support the transformation and reconfiguration of the mental health services as set out in *A Vision for Change* i.e. financial accountability in relation to mental health service transformation; and
- The requirements to ensure transparency and accountability in relation to the ongoing financial governance and management of the mental health services, i.e. monitoring of ongoing financial accountability.

We elaborate upon each of these aspects below.

—2.2.1 Financial accountability in the context of service transformation and ongoing performance

A Vision for Change set out a policy to drive the transformation of the Irish mental health services over a five to seven year timeframe. In formulating its recommendations, the policy highlighted the following overarching characteristics of funding of the mental health services in Ireland:

- Resources provided to the mental health services at government level have been historically "disproportionately low in relation to general health spending";
- There was an inequitable geographic distribution of current resources across mental health services catchment areas;
- "Mental health services currently have significant resources, including human resource, capital and revenue." However, these resources are not aligned with the requirements of the population;
- The requirement for funding for mental health services to be used to provide specialist services as opposed to services which fall within the remit and responsibility of other agencies (e.g. housing);
- There is an absence of "the type of management structures, capacity and resources required to evaluate the quality and value of mental health services provided"; and
- Notably, in the context of accountability and transparency in relation to funding and expenditure, the policy stated that "in the context of ever-rising demands for health resources, mental health expenditure will have to be increasingly monitored to ensure that the services demonstrate both effectiveness and efficiency".[42]

42 *A Vision for Change* (2006), Op. Cit. Page 177.

The above characteristics underline the particular challenges faced in relation not only to the overall level of resources provided to the mental health services but also the need to transform the existing services to ensure equitable, effective and efficient provision of services, both functionally and geographically.

The above aspects also highlight the need for transparency and accountability through ongoing monitoring to ensure effectiveness and efficiency of expenditures.

A Vision for Change has also highlighted the following factors that need to be taken into account in shaping the approach to financing of the new mental health services framework:[43]

- "Substantial change in the organisation and delivery of mental health services is required;
- Resources, both capital and revenue, in the current mental health service should be retained within mental health, with the reconfigured mental health services having priority in their disposal;
- In addition to the re-allocation and re-modelling of existing resources, extra funding and personnel are required to finance the policy;
- Resources need to be remodelled within re-organised catchment-based services to ensure equity and priority in service developments;
- The new management systems at service team, catchment and national levels must ensure performance management and accountability and introduce financial incentives for service providers;
- Core services must be adequately funded, but there must also be scope to reward excellence and for funding to follow service volume activity;
- Recognition must be given to the need for extra funding for areas that exhibit social and economic disadvantage with associated high prevalence of mental ill health;
- In relation to capital expenditure, bridging finance from government will be required in implementing the recommendations of this policy;
- This new policy should have an implementation plan phasing in the new systems and standards of care over an agreed period (the recommended term being seven years); and
- New funding should follow the implementation of the recommendations in this policy and a mechanism by which this can be achieved should be devised."

Specifically in relation to funding requirements to support the implementation of the policy, *A Vision for Change* set out two approaches to resourcing the transformation required, namely the reorganisation and re-configuration of existing capital and resources, and the provision of new funding.

In relation to new funding, the policy identified the following requirements:

- New, non-capital development funding to support implementation of the policy over a seven-year period – estimated at €151 million in 2005 prices or €21.6 million per annum over a seven year period; and
- Capital funding to support provision of required new facilities – estimated at €796.5 million in 2005 prices.

As noted in Section 1, financial accountability concerns the requirement to incentivise good governance and financial management. In the context of the mental health services, it pertains to the need to ensure transparency and accountability in relation to both funding and effectiveness and efficiency (and therefore value for money) of investment in the mental health services.

43 *A Vision for Change* (2006), Op. Cit. Page 177.

There are two specific aspects that require consideration in relation to accounting for mental health funding and expenditure, namely:

- The requirement to ensure that both development and ongoing recurrent and capital funding for the mental health services is allocated in line with the recommended policy; and
- The requirement to ensure that allocated funding is spent on projects in line with intended application and timescales.

Meeting these requirements necessitates full transparency in relation to funding allocations and budgeting of expenditures, and the application of systems to ensure full control of expenditures. However, to identify the specific requirements to ensure transparency and accountability it is also necessary to review the existing position in terms of the approach to budgetary planning and funding in relation to mental health services, and the extent of existing information gaps that need to be addressed. These aspects are examined below.

2.3 Review of Existing Information and Indicators

—2.3.1 Budgetary planning and funding allocation process

It is instructive to recap on the findings from the Indecon review in relation to the existing approaches and mechanisms for budgetary planning and funding allocation for the mental health services.

The previous Indecon review noted the following specific aspects regarding the process of determination of annual funding allocations to the mental health services:

- There are no protected line items in place within the overall health budget for recurrent expenditures on specialised mental health services (such as, for example, child and adolescent services); and
- Annual current expenditure budgets for mental health services have traditionally been set on an incremental basis, subject to certain adjustments in addition to new funding that may become available on an ad hoc basis to cover new service development money. Earmarked current expenditure funding lines are not protected within the overall health vote. This remains the case for the mental health programme in particular.

In relation to capital expenditure, since the previous Indecon review, a new multi-annual programme of investment was announced in Budget 2010.[44] This programme is to be supported through the release of funding from the sale of mental health service assets. An allocation of €50 million was provided for via a dedicated subhead for new capital development monies in the Revised Estimates Volume for 2010.

Indecon strongly welcomes the new multi-annual programme of investment announced in Budget 2010. Nevertheless, there is an absence of clarity about how this funding will be provided beyond the current financial year in line with the levels of required investment recommended in *A Vision for Change*. Furthermore, though the Minister announced a number of new facilities including community nursing units, acute units and community mental health centres in Primary Care Centres, there is no detailed plan published that sets out all of the projects and costings that make up the €50 million budget for 2010.

42 Ibid. Page 177.

44 Budget 2010-Fanancial Statement (http://www.budget.gov.ie/Budgets/2010/FinancialsStatements.aspx).

—2.3.2 Existing financial data/information

Before considering the requirements to support financial accountability in the future it is instructive to review the existing level and detail of data/information on budgeting and expenditure for the mental health services.

Department of Health and Children – Annual Output Statement

The Department of Health and Children (DOHC) produces an *Annual Output Statement for the Health Group of Votes*. The Annual Output Statement for 2009 is the third such statement issued by the Department with the objective of matching outputs and strategic impacts to financial and staffing resources for the financial year. The statement provides:

- An overall summary of high-level objectives and impact indicators for each programme within the Health Votes 39, 40 and 41;
- An overall summary of the budgeted expenditures for the Health Votes;
- A breakdown of total gross expenditure by health service programme;
- Individual sections providing details on each health service programme; and
- Details of health service employment and staffing numbers by programme.

In relation to mental health services, covered under Programme 7, an individual section of the Annual Output Statement sets out the overall high-level objective of the mental health services, the key development strategies (including the development of the services in line with the recommendations of *A Vision for Change*), a series of three impact indicators and a breakdown of outputs by programme area within the mental health services. The table below sets out the detail provided in relation to financial information in the 2009 Annual Output Statement.

Table 2.1 Department of Health and Children - Annual Output Statement for Health Group of Votes 2009 – Details of Financial Inputs for Mental Health Services

Programme	Budget 2008 € million	Outturn Expenditure 2008 € million	Budget 2009 € million	% Change on Outturn
Mental Health Programme Expenditure				
Current	1,078	1,011	1,008	0
Capital	52	42	12	-71
Administration and Other Support*				
Pay	33	31	31	0
Non-Pay	27	26	25	-4
Total Gross Programme Expenditure	1,190	1,110	1,076	-3
HSE	1,168	1,093	1,056	-3
DoHC	22	17	20	18

** Administrative resources are HSE only and are assigned to each programme on an indicative basis only.*
Source: *Department of Health and Children, Annual Output Statement for Health Group of Votes, 2009*

Importantly, in relation to transparency and accountability, the following observations are pertinent:

- The figures provided on financial resource inputs are aggregate in nature, presenting a breakdown of overall mental health services programme expenditure between current and capital expenditures, and on HSE administrative support expenditures;
- However, no detail is published in relation to expenditure by service area, particularly in relation to the division of expenditure between inpatient and community-based services, and by mental health service catchment area; and
- The 2008 outturn figure shown in the Department's Annual Output Statement for 2009 does not agree with the HSE's year-end 2008 Performance Monitoring Report figure for expenditure on the mental health care group. This has meant that it is not possible to determine the actual change in allocated funding for mental health between 2009 and 2010. This highlights an important requirement to ensure consistency between Departmental and HSE funding and expenditure figures published on an annual basis if full transparency and accountability is to be attained.

Revised Estimates Volume

Appendix 1 of the HSE Vote within the Revised Estimates provides a breakdown of estimated current (i.e. non-capital) expenditures for the year ahead and of outturn current expenditures for the current year, by health care programme and service. The breakdown of provisional outturn 2009 and estimated 2010 current expenditures for mental health services is shown in the table below.

Table 2.2 Breakdown for Mental Health Services within Revised Estimates Volume 2010 – *Current Expenditures*

Care Programme and Service	2009 Provisional Outturn Expenditure €'000	2010 Estimated Expenditure €'000
Mental Health		
Long Stay Residential Care	585,085	567,813
Community Services	275,327	267,199
Psychiatry of Later Life	9,765	9,476
Counselling Services	19,529	18,953
Other Mental Health Services	116,976	113,523
Total	1,006,682	976,964

Source: *Department of Finance, Revised Estimates Volume, 2010*

The Revised Estimates Volume provides a greater level of detail than those published by DoHC in terms of high-level service programmes. In particular, while the historical expenditure figures are provisional, it can be seen that the largest categories of expenditure in 2009 were Long Stay Residential Care (inpatient services) (€585.1 million or 58% of 2009 outturn expenditure) and Community Services (€275.3 million or 27% of expenditure). Moreover, it is notable that there is no change evident in the proportionate breakdown of expenditure between 2009 and 2010, while the breakdown in 2009 was also similar to the 2008 allocations. This suggests that, despite the goals of *A Vision for Change* in relation to the reconfiguration of the mental health service towards a model of provision based primarily on community-based care, current expenditure allocations do not appear to be aligned with this goal.

In terms of the depth of information provided, it is also noteworthy that while a greater level of detail is provided in terms of mental health expenditure areas than is the case under the preliminary, abridged Estimates, no breakdown of current expenditures is available within each category according to service area (General Adult, Child and Adolescent, Older People, Intellectual Disability, Rehabilitation and specialist services) or by service catchment area.

HSE reporting

A number of documents published by the HSE are relevant in assessing existing information provided in relation to the development of the mental health services. The following specific documents have been reviewed as part of this exercise:

- HSE, Vision for Change Implementation Plan, 2009-2013;
- HSE National Service Plan (annual); and
- HSE Performance Management Reports (monthly).

An overview of the key features of each of these documents in the context of identification of information/data on the funding of and expenditure on mental health services is presented below.

HSE, Vision for Change Implementation Plan, 2009-2013

A key document relating to progressing *A Vision for Change*, the HSE's Vision for Change Implementation Plan, "outlines a strategy for implementing this policy document over the five year period from 2009-2013".

The plan is high-level in its focus, and addresses the organisational capacity required to implement 82% of the more than 200 recommendations for which the HSE, in line with recommendation 20.1, has responsibility.[45]

It should be noted that the Implementation Plan has not been published on the HSE's website. Indecon has, however, been provided with a copy of the plan in the context of this and the previous 2009 review.

A specific section of this plan, entitled "Financing the Plan" examines a number of issues around the requirements for funding to support transformation and reconfiguration of the mental health services in line with the recommendations of *A Vision for Change*. In relation to facilities requirements, the plan states as follows:

> "HSE has now identified a Mental Health Infrastructure programme which is currently estimated will cost between €766m and €946m. This will include community mental health team infrastructure, day hospitals, child and adolescent inpatient units, acute units, a neuropsychiatry unit, long stay community facilities, challenging behaviour units, a new Central Mental Hospital, ICRUs [Intensive Care Rehabilitation Unit] for difficult to manage patients and ICRUs for children and adolescents and people with an intellectual disability."[46]

While the facilities projects recommended by *A Vision for Change* are also listed in Section 5, the plan does not, however, provide detail in relation to required expenditure related to each of these areas and performance indicators and associated targets are also not provided.

A number of aspects of human resource inputs are examined in the plan within the context of required reconfiguration of services. However, no detail is provided in relation to estimated costs associated with financing this reconfiguration.

The issue of new development funding to support reconfiguration was also discussed briefly in the plan. Given the importance of this aspect in the context of financial transparency and accountability, this is discussed separately below.

45 HSE, Vision for Change Implementation Plan, February 2009.

46 Ibid. Page 8.

The plan included reference to the development of a human resource and finance plan, which would include the development of "appropriate mechanisms for rebalancing historical funding anomalies across administrative areas".[47] Indecon believes it is important that these proposals are fully implemented as a priority to ensure full transparency and accountability.

In relation to performance measures, while the plan sets out action plans on an annual basis covering the period 2009-2013, detailing priorities, intended actions, dependencies in relation to funding and other feasibility issues, estimated start and completion timescales and responsibilities, no key performance indicators are set out with associated targets.

HSE National Service Plan

The HSE's National Service Plan is published annually and sets out the type and volume of health and personal social services which the body plans to provide during the coming year. According to the introduction to the plan:

> "Under the legislative framework of the Health Act, 2004, Section 31, the primary purpose of the annual HSE National Service Plan is to set out how the Vote (budget) allocated to the HSE will be spent in the given year on the type and volume of health and personal social services delivered to the people of Ireland, within the approved employment levels set out by Government. It is guided by the vision, mission and objectives of the organisation as set out in the three year HSE Corporate Plan 2008 – 2011."[48]

The National Service Plan sets out planned expenditure by care programme, including mental health. In the case of each care programme overall planned resources are indicated in relation to staff (WTEs) and financial inputs. In relation to the latter, a total budget for the year is compared with the budget for the previous year.

The figure overleaf sets out the budget allocation for mental health within the context of the overall budgetary allocations for 2010 by non-acute care group, as indicated in the National Service Plan for 2010. This indicates a budgeted funding allocation for mental health totalling €734 million (in non-capital or current spending) for 2010. This compares with a budget for 2009 of €787 million. The mental health budget shown represents just 5.4% of the HSE's total budget, as stated by the Assistant National Director for Mental Health, Martin Rogan, at the launch of the 2010 capital programme on 1 March 2010.

47 Ibid, Page 90.

48 HSE, National Service Plan – 2010. Page 1.

Figure 2.1 HSE National Service Plan – Current (Non-Capital) Expenditure Budgetary Allocation for Mental Health within Context of Non-Acute care Group Funding for 2010

Non Acute Care Group 2010 Allocation		
Community Care Programme	2009 Budget €m	2010 Budget €m
Primary Care	351	327
Primary Care Reimbursement Service	2,952	2,787
Children and Families	575	536
Mental Health	787	734
Disability	1,583	1,476
Older People	1,275	1,316
Palliative Care	79	74
Social Inclusion	144	135
Multi Care Group	640	597
Other	43	40
Total Community Care	8,429	8,020

Note: 2009 figures have been restated for service- related charges
Source: *HSE, National Service Plan, 2010 (see: http://www.hse.ie/eng/services/Publications/corporate/National %20Service%20 2010.pdf)*

An important issue concerns the consistency of figures presented in different National Service Plan documents. In particular, comparison of the National Service Plan 2010 with the 2009 plan reveals a substantial variation in the budget figures for 2009. National Service Plan 2009 indicated a budget for 2009 for mental health totalling €1.02 billion. National Service Plan 2010, however, indicated a budget for 2009 of €787 million – implying an apparent 23% reduction in 2009 spend relative to what was originally envisaged.[49] The variation makes it difficult to rely on and compare service plan budgets from one year to the next. In the interests of ensuring full transparency and financial accountability, it is critical that consistency is applied to budgeting on an annual basis and that, where variations occur, these can be adequately explained.

Subsequently in the section of the National Service Plan dealing with mental health, the National Service Plan details specific capital projects due to be completed or become operational in 2010, in addition describing a range of "Key Result Areas" in terms of outputs achieved in 2009, proposed deliverables for 2010 and target timescales relating to a number of areas of activity within mental health. There are no financial details provided in relation to these activities however.

Information is also provided in the 2010 National Service Plan in relation to additional revenue costs of €6 million to fully commission two 20 bed acute units to support Child and Adolescent inpatient beds in Cork and Galway which will be ready for commissioning in 2010.[50] Details of proposed capital projects for mental health are presented in the appendices to the plan. In the 2010 plan, these include two projects, namely the above-cited 20-bed child and adolescent mental health service (CAMHS) unit in Cork (costing €3.48 million in 2010 and €8.7 million in total), a further 20-bed CAMHS unit in Galway (costing €3.9 million in 2010 and €8.2 million in total), and a four-bed residential unit designed to re-accommodate existing residents in the St. Lukes unit in South Tipperary (costing €4 million in 2010 and €8 million in total).

A range of KPIs are presented in the National Service Plan which relate to service provision and service users outcomes. Currently, there are no KPIs monitored in relation to funding or expenditure although we understand that work is underway in this important area.

49 Indecon acknowledges that the HSE states in a note to this information that the "2009 figures have been restated for service-related changes," however the meaning of this note is unclear.

50 HSE, National Service Plan, 2010, Page 78.

HSE Performance Management Reports (monthly)
Since 2008 a series of monthly Performance Management Reports have been published by the HSE. Each month two reports are published, namely:

- *Performance Report* (PR) which sets out an analysis of key performance data, including financial, HR resources and activity levels, at a corporate, network (National Hospitals Office) and area (Primary, Community and Continuing Care) level, providing summary information for the HSE's Performance Monitoring and Control Committee, CEO, Management Team and Board to efficiently and effectively manage the organisation;
- *Supplementary PR Report* which provides additional more detailed data by Care Group / Hospital following the same integrated format as the National Service Plan. This includes performance activity, indicators, capital, new service developments and finance data; and
- In addition, each year two biannual *Deliverables* reports are also published by the HSE which report against detailed deliverables set out in the National Service Plan. These two reports complement the June and December Performance Management Reports respectively. The December Performance Monitoring Report provides a detailed report on the service plan for the year.

In relation to coverage of financial resources, the monthly performance reports provide detail in relation to:

- New service developments, including funding budgeted for implementation of recommended developments under *A Vision for Change* and expenditure year-to-date of this funding by project (discussed further below);
- Total expenditure by care group including on mental health in terms of approved funding allocation, actual expenditure year-to-date, planned expenditure year-to-date and variance of actual versus planned expenditure. Detail is not provided however in relation to the breakdown of expenditure within the overall mental health care programme or by catchment area; and
- Details of value for money initiatives in mental health. The October 2009 supplementary report included detail in relation to proposed savings through reduction in overtime and improved drug prescribing practices.

Appendix 1 of the October 2009 supplementary report sets out the 2009 Proposed Capital Programme for the (then) Primary, Community and Continuing Care (PCCC) directorate within the HSE. This identifies planned capital expenditure for the current year by sub-programme, including mental health, by HSE region, facility, project details, number of planned additional beds and replacement beds, the project's current status (if opened, when?; if not, why and when?) and expected completion timescales. In October 2009, three facilities projects were listed. There is a need to provide additional detail in relation to actual capital expenditures to enable assessment of the extent to which expenditures are likely to meet the requirements set out in *A Vision for Change*.

—Development Funding for implementation of *A Vision for Change*
Following publication of *A Vision for Change* in 2006, the Government indicated that it would provide an additional stream of funding over and above ongoing current and capital funding for mental health services with the objective of supporting the development of mental health in line with the recommendations of the policy.

A Vision for Change identified a requirement for additional non-capital funding over and above existing resources amounting to €21.6 million per annum over a seven-year period (or €151 million in total) designed to support the transition towards the mental health service envisaged in the policy. It is not clear, however, whether this should be additional investment over and above existing planned capital investment or whether it would involve a reconfiguration or refocusing of existing plans.

Indecon's review of government spending on mental health services completed for AI in September 2009 included a comparison of allocated versus required annual development funding. The review presented an analysis which indicated the following:[51]

- By end-2007, only 59.3% of the recommended overall level of additional development funding of €151 million had actually been allocated; and
- By end-2007 just over two-thirds of the overall additional development funding allocated in 2006 and 2007 had been committed on projects.

51 Indecon Review of Government Spending on Mental Health and Assesment of Progress on Implementation of A Vision for Change (2009). (Report submitted to Amnesty International Ireland, September 2009, page 13)

The HSE's Implementation Plan for *A Vision for Change* indicated that 94% of the total additional development funding of €51.2 million allocated in 2006 and 2007 would, according to the plan, be "committed" by end-2009. However, it is not clear what is meant by "committed" in this context and no detail has been provided as to how this would be achieved.

The HSE's monthly Performance Reports include a section devoted to "new service developments," including in relation to mental health services. The table below sets out the detail provided in relation to new service development funding and expenditure pertaining to mental health services during 2009. According to the information presented in the report, a total of €750,000 of new service development funding was allocated for 2009 under the heading "Progressing Vision for Change." Of this funding, €187,000 was spent on two projects by October 2009.

Table 2.3 New Service Development Funding and Expenditure to Progress *A Vision for Change*

Project Description	Funding	Timescale	Funding Spent Year-to-Date
Involvement of service users in mental health services further developed*	€500,000	Not stated	€125,000
Early intervention services for mental illness further developed**	€250,000	Q2	€62,000
Child & Adolescent MHS***	€1,050,000	Q2	€60,000

** As sanction has been received to progress these developments in 2009, the finalising of the service agreements with the organisations to progress these initiatives is in train*
*** This funding is to support the DETECT programme and following receipt of sanction to progress this initiative, arrangements have been made to progress this work.*
**** Full year cost of posts for Child & Adolescent Mental Health in 2010 will be €2.85m. In 2009, €1.75m will be spent on a once-off basis on Suicide Prevention and Progressing Vision For Change*
Source: *HSE, Performance Report, October 2009*

The new data provided in the HSE's Performance Reports in relation to new service development funding pertaining to mental health services is a positive step towards increasing transparency and accountability for funding and expenditure in this area. This detail was not provided previously in relation to development funding allocated in 2006 and 2007 and it is critical that future reporting fully describes:

- The allocation of funding on a year-to-year basis relative to the recommended levels of funding under *A Vision for Change*; and
- The expenditure of all development funding allocated on a year-to-year basis, by project and by mental health catchment area.

A related important issue is the need to ensure that allocated funding is spent only on new service development projects in line with recommended policy. We understand that development funding allocated in 2006 and 2007 was time delayed to address core deficits in existing mental health services rather than on required new projects to further the implementation of *A Vision for Change*.

Full accountability requires that all funding allocated is spent only on projects for which the funding is intended, while there is also a need for greater transparency over transfers of funding between projects and/or line items.

These issues highlight the need to formulate and implement appropriate performance monitoring measures, supported by suitable indicators and associated targets, to ensure full transparency in and accountability for the allocation and expenditure of development funding, which is critical to facilitating the reconfiguration of the mental health services in line with the recommendations of *A Vision for Change*. We further address these requirements later in this chapter.

New, restructured model for HSE Vote

Following review of HSE financial management in 2008[52] and reflecting the crisis in the public finances, much tighter controls on spending have been introduced in relation to the HSE Vote. In particular, a new model for restructuring the HSE Vote was set out in the 2008 Revised Estimates Volume, which is designed to bring closer alignment between the HSE's service plan and its Vote by care programme, including mental health.

In addition, under the new financial management and budgeting systems within the restructured HSE Vote, prior Department of Finance sanction is now required to use new development moneys for any purpose other than that for which it was allocated.

The achievement of full financial transparency and accountability will, however, require a number of improvements to be implemented in relation to financial governance, including in relation to the level of detail on both funding allocations and expenditures across mental health service programmes. This report proposes a number of indicators, in addition to specific measures, designed to assist in ensuring financial transparency and accountability, which are set out later in this section and also in our overall recommendations presented in Section 7.

Findings of previous reports on transparency and accountability

The absence of transparency in relation to financial management has also been highlighted in a number of previous reports, which are considered below.

Indecon Review of Government Spending on Mental Health and Assesment of Progress on IMplementation of A Vision for Change(2009)

The challenges in relation to existing information required to support transparency and accountability in the funding of and expenditure on mental health services were also highlighted in Indecon's previous review for AI, which stated:

> "It is important, however, at the outset to highlight the presence of deficiencies in relation to the availability of up-to-date and detailed data/information. In particular, the absence of timely and detailed data/information currently prevents an assessment of progress in terms of both capital investment and current expenditures by service area and on a sub-national/regional or catchment area basis. This includes the absence of data on an intra-year basis which permits the monitoring of funding commitments and expenditures."[53]

52 See 'Study of certain accounting issues related to the Health Service Executive', report of the Considine Working Group, September 2008. Department of Health and Children.

53 Indecon (2009), Op. Cit. Page 3.

Independent Monitoring Group on A Vision for Change (2009)
The Independent Monitoring Group (IMG), which is charged with monitoring and assessing progress on the implementation of *A Vision for Change*, noted the evident weakness in relation to financial accountability in stating:

> "It was not apparent to the Monitoring Group who in the HSE had budgetary responsibility for mental health services or how budgetary decisions affecting mental health services were made."[54]

Furthermore, in its submission to the IMG in association with AI, the Irish Mental Health Coalition noted, inter alia, that:

> "The failure to deliver on targets coupled with the absence of accountability and transparency in how funding is allocated and spent is undermining efforts to progress implementation."[55]

Report on Value for money review of Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services
The existing gaps in relation to data/information provision and use of performance indicators to ensure transparency and accountability in the funding of Irish mental health services have also been highlighted in the recent report on the value for money review of long-stay residential mental health care services, which noted:[56]

- Currently only a minority of services within the Irish mental health context collate any information in relation to performance measurement. Only 22% of community long-stay residences and 30% of inpatient residences use key performance indicators and where such indicators are used they focus on measuring compliance with legislation and with up to date policies rather than on resources, activities and outputs, and outcomes for service users;
- Very limited information exists at service level which enables ongoing assessment of effectiveness, efficiency and value for money;
- The report found that the majority of areas reported that individual units do not have a clear budget allocation;
- As a strategic, objectives-driven approach to the mental health services is developed by the HSE, performance indicators selected to reflect value for money will need to be embedded into its management systems through a close alignment to objective setting at different levels from overall objective to expected results to activities. This will require further refinement of existing activity measures and performances indicators in the content of national service planning; and
- The requirement for the mental health services to collect information to support the implementation of performance indicators through both its existing management information systems and through periodic survey. According to the report: "systems for the collection of performance information need to be further developed and maintained".[57]

The findings of the above reports highlight the importance of implementing sound governance and financial management systems, supported by best practice performance assessment frameworks and supporting indicators, to ensure full transparency and accountability for the allocation and expenditure of funding for the mental health services.

54 A Vision for Change - Independent Monitoring Group – Third Annual Report on Implementation 2008 – April 2009, Page 6.

55 Ibid. Page 10.

56 Health Service Executive, 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. December 2008.

57 Ibid. Page 69.

2.4 International Experience and Best Practice

In developing performance indicators to support the assessment of financial transparency and accountability, we have examined the existing international evidence on best practice approaches to budgetary planning and performance assessment. Informative inputs to this review were identified in the work undertaken in particular by:

- The World Health Organisation (WHO);
- The UK Government; and
- The Australian Government.

—2.4.1 World Health Organisation

The WHO, in its guidance on mental health financing, considered the issue of accountability within the context of budget preparation. According to the WHO, a budget serves the functions of planning, policy, control and accountability. In relation to accountability, the WHO states:

> "Finally, a budget serves the function of accountability. A budget is usually allocated to various departments or sub-organizational units. Each unit is responsible for its resources and expenditures and is accountable for achieving targets and contributing to key strategic goals. Reports from these units at regular intervals, e.g. weekly, monthly and quarterly, allow comparisons to be made between actual performance and budgeted performance. Thus budgets can define responsibility, monitor accountability and even foster a sense of organizational purpose."[58]

The WHO's guidance highlights the importance of implementing sound approaches to budgeting in the context of accountability. Achieving accountability however requires that budgeting should ideally be undertaken by units which are assigned clear responsibility for resources and expenditures and the attainment of related targets and goals, and that reporting enables straightforward comparison between actual and budgeted performance.

—2.4.2 United Kingdom

In terms of the experiences and approaches in different jurisdictions, a number of initiatives and policy developments in the UK are noteworthy in the context of supporting transparency and accountability in the funding of, and expenditure on, mental health services.

National Service Framework for Mental Health
The development of performance indicators in the UK mental health service coincided with the publication in 1999 of the National Health Service (NHS)'s National Service Framework (NSF) for mental health.[59] This set out a number of detailed standards for mental health (across five areas, namely mental health promotion, primary care and access to services, effective services for people with severe mental illness, caring about carers, and preventing suicide) in addition to a basic, but limited, set of proposed performance indicators. These indicators did not, at this stage, include specific indicators designed to support financial transparency and accountability. However, the NSF pointed to further work in the area of high-level performance indicators within the context of NHS and Social Services Performance Assessment Frameworks.

58 World Health Organisation, Mental Health Financing - Mental Health Policy and Service Guidance Package, 2003.

59 A National Service Framework for Mental Health, NHS, September 1999.

The issue of accountability more generally was highlighted in a number of areas of the NSF. Notably, in relation to implementation at local level, the framework envisaged a shared vision and partnership approach, stating that:

> "Agreement must be achieved on the total resource available for mental health, including the Mental Health Grant, Modernisation Fund and mainstream local authority and health authority funding. If the total resource is to be used to maximum effect, there must be local agreement and confidence in the mechanisms employed to delegate budgets and responsibilities while retaining adequate *accountability* [Indecon emphasis] in all sectors." (Page 85)

A particular feature of the implementation plan for the NSF is the operation of Local Implementation Teams (LITs). These teams would, according the strategy, have "clear accountability to chief officers" in the mental health service. A total of 146 LITs (as at 2009) oversee the development of mental health services in their own geographical areas. LITs represent all the main stakeholders in local mental health services, and service users and carers are expected to be core members.[60]

The NSF also referred to the application of 'annual accountability agreements' and 'annual performance agreements,' with the former representing an "annual agreement, between a health authority and its local primary care groups, which will contain key targets, objectives and standards for the provision or commissioning of services," and the latter constituting an annual "agreement between each health authority and its regional office to cover all the key objectives of the health authority for the year" which would incorporate plans set out in the service and financial frameworks and "an assessment of the expected influence on performance against local plans across each of the six areas of the Performance Assessment Framework".[61]

Autumn Assessment

Since the NSF was first launched and to support the LITs, an annual process of assessing and planning mental health services under the NHS was introduced in 2000, called the Autumn Assessment. The annual assessment comprises four main components, namely:

- A self assessment process carried out by LITs and reviewed by the Strategic Health Authority (SHA);
- A themed review on a key topic;
- Finance mapping, including data on total spending on adult mental health in each LIT area; and
- Mapping of adult mental health services.

Finance mapping

Within the context of financial accountability, it is instructive to further examine the finance mapping component with the objective of identifying the key features of this annual process.[62]

Since 2001, as part of the Autumn Assessment process, all LITs in England have submitted detailed financial files to the National Institute of Mental Health in England and the Department of Health. These reports provide detailed data on investment and expenditure on mental health services for both working age and older adults.

Each of the LIT reports is then inputted into a database and a national report is produced (currently by Mental Health Strategies) which details the level of investment in mental health services for working adults (aged 18-64). The figure overleaf lists the type of data/information presented in the annual national report.

60 The National Service Framework – Five Years On, December 2004. Department of Health. Page 57.

61 A National Service Framework for Mental Health. Op. Cit. Page 128.

62 Service mapping is examined in Sections 3 and 4.

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

Figure 2.2 Autumn Assessment – Finance Mapping Component – Listing of Investment Data Mapped

- Total Investment in MHS by year (including reported and unreported/estimated investment)
- Total Real Resources – including uplifts for Inflation
- Profile of investment according to direct, indirect, overhead costs and capital charges
- Detailed breakdown of investment within direct services by group and key priority areas, followed by a comparison of investment by Strategic Health Authority, according to:
  - → Commissioner and Provider type
  - → Priority Services Investment
  - → Planned real increase of investment in direct services
  - → Changes in the percentage of direct services investment
  - → Planned investment per head by SHA
  - → Changes in SHA Investment 2007/08 to 2008/09
  - → Trends in Key Areas Investment

Source: *Mental Health Strategies, National Survey of Investment in Adult Mental Health Services – 2008/09*

The figure below presents an example of the type of information monitored annually by the finance mapping exercise, in this case pertaining to the level of reported investment in mental health services.

Figure 2.3 UK Autumn Assessment – Finance Mapping Component – Reported Investment in Mental Health Service by Direct Service Category

Investment in £ ' millions at 2008/09 Levels

Service Categories	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	%in 2008/09
Access & Crisis Services	204	260	331	399	424	490	543	11.5%
Accommodation	316	379	384	392	401	440	419	8.8%
Carers' Services	11	15	19	20	21	24	27	0.6%
Clinical Services	756	832	922	907	857	903	865	18.3%
CMHTs	527	544	599	594	619	684	686	14.5%
Continuing Care	373	399	425	416	459	510	570	12.0%
Day Services	164	176	164	163	160	154	152	3.2%
Direct Payments	3	6	3	3	6	9	13	0.3%
Home Support Services	63	72	113	99	104	111	116	2.5%
Mental Health Promotion	3	3	3	3	2	4	4	0.1%
Mentally Disordered Offenders	33	55	45	41	52	52	54	1.2%
Other Community & Hospital Professionals	51	49	71	93	78	104	114	2.4%
Personality Disorder Services	0	1	5	11	17	16	22	0.5%
Psychological Therapies	142	147	156	154	150	165	185	3.9%
Secure & High Dependency	377	486	652	715	752	881	906	19.1%
Support Services	47	44	46	47	48	53	57	1.2%
Total Direct Service Categories	3,068	3,456	3,936	4,058	4,150	4,600	4,732	100%
% Real increase over previous year		13%	14%	3%	2%	11%	3%	

Source: *Mental Health Strategies, National Survey of Investment in Adult Mental Health Services – 2008/09*

2.4.3 Australia

A good example of best practice in relation to ongoing performance monitoring in the mental health services is that operated by the Australian government.

Australia monitors the performance of its mental health services through a suite of indicators presented in its National Mental Health Report.[63] The last such report published in 2007 was the 10th report in the series. The report presents data on progress made under Australia's National Mental Health Strategy and examines trends and performance at the national and state and territory levels, over the period 1993 to 2005. Notably, detailed information is provided describing changes in the resources and structure of mental health services in Australia since the commencement of the Strategy. In relation to mental health funding and expenditure, the report notes that:

> "Public reporting on the level of spending on mental health services has been a central function of the National Mental Health Report since its first release in 1994. All governments agreed under the National Mental Health Strategy to maintain expenditure on specialised mental health services and to regularly monitor whether this is occurring through an annual survey of all publicly funded mental health services."[64]

The National Mental Health Report provides detailed data on the following specific aspects of mental health funding and expenditure:

- National expenditure on mental health by public and private funding source;
- Expenditure on mental health on a per capita basis by state and territory government;
- Comparison of expenditure on mental health with overall health expenditure;
- Distribution of expenditure on mental health by service area and geographically;
- Mental health expenditure on community-based versus hospital-based care;
- Per capita spending on community-based services by state/territory;
- Expenditure on community-based mental health services broken down by spending on (a) ambulatory care (b) specialised residential services and (c) services provided by non-for-profit non-government organisations (NGOs);
- Expenditure on stand-alone psychiatric hospitals, community services and general hospitals units; and
- Investment in service mix reform.

The figure overleaf describes the evolution in the breakdown of overall expenditure on community-based versus hospital-based care by Australian states and territories between 1992/93 and 2004/05, highlighting the increased proportion of spending devoted to community-based care over this period.

63 National Mental Health Report, 2006-07, Australian Government. See: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-report07.

64 Ibid. Page 2

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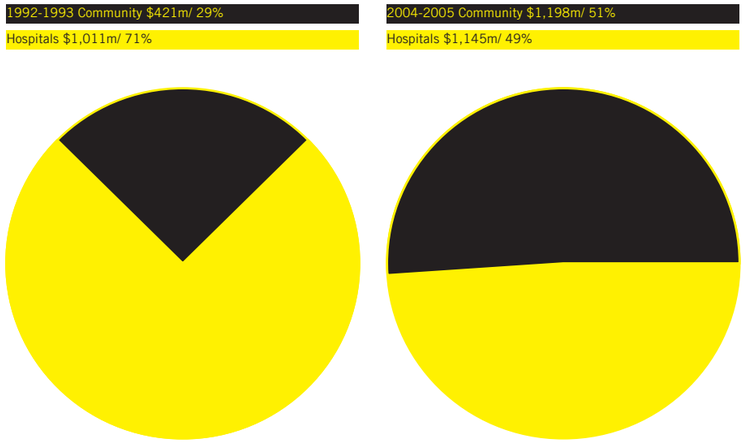
Figure 2.4 Australia - Mental Health Services Financial Indicators
Expenditure on Community-based and Hospital-based Mental Health Services



Source: *National Mental Health Report, 2006-07, Australian Government*

A listing of selected financial indicators monitored at state/territory level by the Australia government in its National Mental Health Report is presented below. It is notable that this includes detailed information/indicators at both the level of overall mental health expenditure in each state/territory and at the level of expenditure on inpatient and community services.

Listing of Indicators of State/Territory-level Mental Health Service Provision Monitored as part of Australian Government's Annual National Mental Health Report – *Expenditure Indicators at State/Territory Level*

Service Component and Indicator
Overall Mental Health Expenditure
• State spending on mental health services ($Millions) • State spending per capita ($) • Per capita spending rank • Average annual per capita spending growth during current National Mental Health Plan
Inpatient Services
• Per capita expenditure on inpatient care ($) • Average cost per patient day ($)
Community Services
• % total service expenditure – Community services – Stand alone psychiatric hospitals – Co-located hospitals
• Ambulatory care – % total service expenditure – Per capita expenditure ($)
• NGOs – % total service expenditure – Per capita expenditure ($)
• Residential services – % total service expenditure – Per capita expenditure ($)

Source: *National Mental Health Report, 2006-07, Australian Government*

The scope and level of detailed data presented in the National Mental Health Report reflects the scale and geographical distribution of Australia's population. While not directly comparable with the Irish context, the approach applied in Australia is nevertheless very informative and demonstrates the benefits in terms of transparency and accountability derived from publication of a detailed annual report on performance of the mental health services.

2.5 Proposed Key Performance Indicators

Reflecting the information and assessment needs and the existing gaps in information identified above, to ensure full transparency and accountability for the planning, funding and effective and efficient delivery of mental health services in line with the goals of government policy, Indecon believes attention must be given to developing appropriate budgeting and information systems to facilitate the introduction of a number of KPIs.

A proposed suite of KPIs to support ongoing accountability for the investment in mental health services is presented in the table below. This also sets out the objective of each indicator, the organisational responsibility for implementation and delivery of the related service component, the nature and setting of supporting indicator targets, and the frequency and method of collection of indicator data/information.

The proposed set of KPIs is designed to support transparency and accountability, in particular to:

- Facilitate ongoing monitoring of budgetary and financial performance in the mental health services; and
- Facilitate monitoring of transformation and re-configuration of mental health services in line with the recommendations of *A Vision for Change*.

The latter objective, in particular, is supported by the setting of appropriate targets. Indecon accepts that such targets may need to be adjusted in line with overall expenditure budgets but that effective targets and aligned performance indicators are needed to ensure value for money.

Table 2.4 Summary of Proposed Key Performance Indicators to Support Ongoing Assessment of *Financial Accountability* in Funding of and Expenditure on Mental Health Services

	Indicator No. and Description	KPI Objective	Indicator Target Setting and Time Frame	Indicator Data Frequency and Method of Collection
	Financial Input Indicators			
1	*Recurrent Expenditure* on MHS - € million and % breakdown by Hospital/Inpatient and Community-based MHS and by MHCA*	Improve transparency in and accountability for expenditure of allocated recurrent funding by service area and geographically	Level and breakdown of recurrent expenditure to align with optimal configuration based on population need and resource requirements	Annual via DoHC and HSE mental health budget planning and expenditure controls
2	*Capital Expenditure* on MHS - € million and breakdown by Hospital/Inpatient and Community-based MHS developments	Improved transparency in and accountability for expenditure of allocated capital funding	Multi-annual programme of capital expenditure by service and catchment area to target requirements implied by AVfC (adjusted to reflect current population and costs)	As above
3	*AVfC Development Funding* - € million and % breakdown by Service Area** and MHCA*	Improved transparency in and accountability for allocation of Development Funding for implementation of *A Vision for Change*	Multi-annual targets by Service Area/Care Plan and Catchment Area consistent with AVfC (adjusted to reflect current population and costs)	As above
4	*AVfC Development Expenditure* - € million and % breakdown by Service Area** and MHCA*	Improved transparency in and accountability for expenditure of allocated AVfC Development Funding	Annual expenditure to match allocated funding by service area and catchment area	Monthly and Annual data via HSE
	Efficiency Indicator			
5	Average Recurrent Cost per Inpatient Bed per Day by MHCA*	Improved systems of financial control to ensure efficiency and value for money of expenditures on long-stay bed provision	Target to reduce average cost to align with best practice benchmarks internationally	Annual via HSE expenditure monitoring and returns

** Service area refers to area of community-based MHS, i.e. General Adult, Child & Adolescent, Older People, Rehabilitation, Intellectual Disability and Forensic and other Specialist Services.*
*** Mental Health Catchment Area (MHCA) refers to super-catchment areas*
Source: *Indecon*

We elaborate overleaf on the rationale for inclusion of the individual indicators proposed.

—2.5.1 Rationale for indicator selection

In relation to each of the indicators proposed, these have been selected on the following bases:

1 Recurrent expenditure on mental health services by hospital/inpatient and community-based mental health service and by mental health catchment area – reflecting the requirement to improve transparency in, and accountability for, expenditure of allocated recurrent funding and incentivise the reconfiguration of services towards greater community-based provision as recommended in *A Vision for Change*;
2 Capital expenditure on mental health services by hospital/inpatient and community-based mental health service – reflecting the need to ensure transparency in, and accountability for, expenditure of allocated capital funding and incentivise the reconfiguration of services towards greater community-based provision as recommended in *A Vision for Change*;
3 *A Vision for Change* development funding, including breakdown by service area and MHCA – reflecting the requirement for greater transparency in, and accountability for, the allocation of funding on a year-to-year basis relative to the recommended levels of funding under *A Vision for Change*;
4 *A Vision for Change* development expenditure, including breakdown by service area and MHCA – reflecting the need to ensure that all funding allocated is spent and only on projects for which the funding is intended; and
5 Average recurrent cost per inpatient bed per day by MHCA – an efficiency indicator to monitor the cost of inpatient services and incentivise value for money in acuter and long-stay provision in line with the recommendations of the recent VFM report on long-stay beds.

2.6 Summary

This chapter considered the requirements for developing a framework of measures/indicators to incentivise good governance and financial management, and to ensure transparency and accountability in relation to both funding of and expenditure on mental health services.

Particular issues in relation to information provision which prevent full transparency and accountability in the funding of and expenditure on mental health services include:

- The need to have transparent formulas for determining the allocation of funding and ongoing budgeting in the mental health services;
- The need for timely and detailed information enabling the ongoing monitoring of recurrent and capital funding commitments and expenditures in the mental health services by service area (including between inpatient/hospital services and community-based provision) and by sub-national/regional catchment area;
- The need for information that will enable full transparency regarding the allocation of development funding recommended under *A Vision for Change* and the expenditure of this funding on an year-to-year basis; and
- In relation to capital expenditure, Indecon strongly welcomes the new multi-annual programme of investment announced in Budget 2010. There is a need for Government to clarify how funding will be provided beyond the current financial year in line with the levels of required investment recommended in *A Vision for Change*.

A set of KPIs have been proposed which are designed to address the above issues and assist in ensuring full transparency and accountability for the planning, funding and effective and efficient delivery of recovery-oriented mental health services.

3

Mental Health Services: Facilities

Mental Health Services: Facilities

3.1 Introduction

This Section considers the requirements in terms of information and performance measures to facilitate the assessment of progress on the development of facilities to support implementation of *A Vision for Change*. Particular focus is given to the development of KPIs to facilitate monitoring and incentivise provision of facilities required to support the development of community-based teams and specialist services.

3.2 Information and Assessment Needs

The main drivers of need in relation to performance assessment in the area of mental health facilities are the recommendations for investment in facilities to support the transformation of the mental health services identified in *A Vision for Change*.

There are two key components which impact on the requirements for performance assessment and monitoring within this context, namely:

- Monitoring of progress on facilities required to support development of community mental health teams and services; and
- Monitoring of progress on reduction in dependence on acute and long-stay inpatient facilities.

We discuss each of these aspects further below.

Development of community-based facilities

Chapter 8 of *A Vision for Change* sets out an overview of the nature of facilities and physical resources required to provide and accommodate the transformed mental health services envisaged in the policy. A summary of required facilities and units to support the development of community-based mental health service provision as recommended in the policy is presented in the figure below.

Figure 3.1 Quantum of Mental Health Service Facilities Recommended by *A Vision for Change* to Support Development of Community Mental Health Teams

Summary of new infrastructure requirement bases for Community Mental Health Teams	No. Units
General Adult CMHTs	78
Early intervention teams	2
Adult liaison teams	13
Rehabilitation and recovery CMHTs	39
CMHTs for older people	39
Mental health of intellectual disability CMHTs	26
Child & adolescent CMHTs	63
C&A – Liaison Teams	7
C&A – Eating disorder teams	1
C&A – Intellectual disability teams	13
C&A – Substance misuse teams	4
CMHTs for homeless people	2
Forensic – Adult	4
Forensic – C&A	1
CMHTs for people with co-morbid mental illness and substance misuse	13
Adult eating disorders	4
Neuro psychiatry	2
Total	311

Source: *A Vision for Change (2006), Page 269*

The main infrastructural requirements to support the development of community-based provision, in terms of numbers of units required, are:

- Community Mental Health Centres/facilities to support General Adult CMHTs – 78 units;
- Centres/facilities to support Child and Adolescent CMHTs – 63 units;
- Centres/facilities to support rehabilitation and recovery CMHTs – 39 units; and
- Centres/facilities to support CMHTs for older people – 39 units.

A Vision for Change recommended that CMHTs be developed in line with recommended ratios of multi-disciplinary staff to population on a catchment and local area basis. This has important implications for the appropriate location of such facilities.

In addition to the facilities required to facilitate the operation of community mental health teams, a range of other inpatient and community-based facilities are required. The recommended level of provision of these facilities as set out in *A Vision for Change* is summarised in the table below.

Figure 3.2 Quantum of Mental Health Facilities Recommended by *A Vision for Change* - Inpatient Beds and Residential Facilities

Acute In-Patient Beds	No. Beds
General Adult Mental Health (50x13) 35 for general adult (including rehabilitation and recovery mental health services, and co-morbid substance misuse) 8 for mental health services for older people 2 for people with eating disorders (may be pooled to 6 per region) 5 for people with intellectual disability and mental illness	650
Child & Adolescent	80
Child & Adolescent High Secure	10
Intellectual Disability High Secure	10
Neuropsychiatry	8
Total *Note: Sufficient general hospital beds are in place but are not correctly located*	758
Crisis (Respite) Houses	No. Houses
Homeless Persons	1(Dublin)
Adult Services	13
Total	14
Continuing Care Beds	No. Beds
Mental Health Services for Older People (Challenging Behaviour)	360
Day Hospitals	No. Units
Mental Health Services for Older People (General Acute)	13
Child & Adolescent	13
Homeless Persons (Dublin)	1
Total	27
Day Centres	No. Units
Homeless Persons (Dublin)	2
Total	2
Service user provided support centres	No. Units
Support Centres/ Social clubs	39
Total	39
Staffed Community Residences	No. Units
Rehabilitation	57 x 10 places
Difficult to Manage Patients - High Support	8 x10 places
Total	65
Intensive Care Rehabilitation Units	No. Units
Difficult to Manage Patients	4 x 30 places
Central Mental Hospital	New Hospital

Source: *A Vision for Change (2006), Page 270*

It should be noted that *A Vision for Change* has not fully described the features of community and other facilities required or how these facilities relate to existing facilities. This points to the need to form a comprehensive picture regarding the existing provision of mental health facilities before fully informed decisions can be made regarding the precise requirements for decommissioning existing facilities or adding new ones.

In addition, the recommended numbers of facilities/units set out in the policy were based on the requirements to service the population as assessed in the 2002 Census. In monitoring progress, it is therefore necessary to adjust these requirements in line with the most up-to-date population figures (the latest is the 2006 Census).

Requirement to reduce dependency on inpatient facilities

An important issue in relation to the reconfiguration of the mental health services concerns the historical over-dependence on inpatient acute and long-stay service provision and reliance, in particular, on older psychiatric units. Many of these older inpatient hospitals have fallen into disrepair and are inadequate to meet the needs of acute service users and some of these units do not attain the standards required by the Mental Health Act.

More fundamentally, however, *A Vision for Change* highlighted the goals of moving towards a recovery-oriented, community-based model of service provision, which would offer, through multi-disciplinary community mental health teams, home-based and assertive outreach care and a comprehensive range of specialist and other support services. The policy emphasised, however, that this type of care could not be provided effectively through mental hospital-based services. The policy recommended that:

> "Mental hospitals must be closed in order to free up resources to provide community-based, multidisciplinary team-delivered mental health care for all. A plan to achieve this should be put in place for each mental hospital." (Recommendation 20.4)[65]

In addition to addressing the particular deficiencies associated with mental hospital-based provision, closure of these facilities is required to free up the substantial level of human resources that have been tied to these units and to re-deploy resources into the community setting. These closures would, however, need to be implemented on a phased basis to facilitate transfer of patients and the formation of community-based teams and facilities. It will be necessary to have in place suitable community-based facilities including adapted community nursing units, continuing care beds and other supported accommodation to facilitate the transfer of patients from hospital units.

An important aspect of acute inpatient facility capacity highlighted by *A Vision for Change* is that while sufficient general hospital beds are available, capacity is not correctly located. This highlights the requirement to monitor provision not only at national level but also at catchment area level.

65 *A Vision for Change* (2006), Page 219.

—3.2.1 Implications for performance assessment requirements

The above review of facilities needs and related issues highlights the requirement for performance assessment systems to monitor the following aspects:

- The requirement to monitor progress in relation to the provision of facilities/ units to accommodate multi-disciplinary teams operating in each of the service areas, both nationally and in relation to the geographic distribution of these facilities based on population patterns and need;
- The requirement to monitor progress in terms of reducing the requirement for inpatient acute and long-stay units/beds, including on a catchment area basis; and
- The requirement to monitor progress in relation to the provision of other community-based residences and support facilities to facilitate transfer of patients from mental hospitals and ensure comprehensive community-based services are available, including continuing care beds, adapted community nursing units and other supported accommodation.

The above aspects are taken into account in the selection of indicators proposed in relation to mental health facilities presented later in this chapter. Before these indicators are developed however, it is important to review the existing information and performance indicators available in relation to mental health facilities as this will have implications for the consideration and feasibility of different measures.

3.3 Review of Existing Information and Indicators

—3.3.1 Existing data on mental health facilities

There is limited data reported on a regular basis in the public domain in relation to the provision and capacity of mental health facilities. Furthermore, the data that is available is largely focused on acute and long-stay bed capacity with limited information in relation to the provision of community-based facilities.

Existing published sources of data/information which examine mental health services facilities comprise a combination of once-off or periodic reviews and ongoing or regular publications. The most recently published sources include:

- Mental Health Commission (MHC) - MHC Annual Reports and report of the Inspectorate of Mental Health Services (most recent being the Annual Report for 2008); and
- Health Service Executive (HSE) - Value for Money review of efficiency and effectiveness of long-stay residential care for adults within the mental health services (2008).

MHC Annual Reports

The Mental Health Commission's annual reports provide details of a number of aspects of facilities provision and capacity based on annual returns by Local Health Managers (LHMs). The data provided includes:

- Details re acute centres and beds in large psychiatric hospitals by facility and by HSE region;
- Details re numbers of long-stay bed numbers in large psychiatric hospitals by HSE region; and
- Details re 24-hour nurse-staffed Community Residences and places by HSE region.

66 Mental Health Commission, Annual Report 2008, Page 71.

67 Health Service Executive (2008), Op. Cit.

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The figure below presents the MHC data on the numbers of acute and long-stay beds by large psychiatric hospital by HSE region as at December 2008

Figure 3.3 Mental Health Commission Data on Mental Health Facilities – Details re Numbers of Acute and Long-Stay Bed Numbers by Large Psychiatric Hospital by HSE Region*

Total bed numbers reported in large psychiatric hospitals on 31 December 2008		
HSE SOUTH	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Finian's, Killarney	0	60
St. Senan's, Wexford	31	88
St. Stephen's, Cork	35	90
St. Otteran's, Waterford	0	94
St. Dympna's, Carlow	0	53
St. Canice's, Kilkenny	0	54
St. Luke's , Clonmel	0	106
Total	66	545
Total bed numbers reported in large psychiatric hospitals on 31 December 2008		
HSE WEST	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Bridget's, Ballinasloe	41	65
St. Conal's, Donegal	0	27
St. Joseph's, Limerick	0	77
Total	41	169
Total bed numbers reported in large psychiatric hospitals on 31 December 2008		
HSE DUBLIN NORTH EAST	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Brendan's, Dublin	30	54
St. Ita's, Portrane	48	85
St. Davnet's, Monaghan	10	26
St. Bridget's Ardee	30	24
St. Vincent's, Fairview	45	42
Total	163	231
Total bed numbers reported in large psychiatric hospitals on 31 December 2008		
HSE DUBLIN MID LEINSTER	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Lornan's, Palmerstown (rehabilitation beds only)	0	22
St. Loman's, Mullingar	44	75
St. Fintan's, Portlaoise	0	27
Newcastle Hospital, Wicklow	27	27
Total	71	151

**As at 31st December 2008 and based on 19 large psychiatric hospitals. Data verified by Local Health Managers.*
Source: *Mental Health Commission, Annual Report 2008*

The figure below presents the data detailed in the MHC's annual report in relation to the overall number of long-stay beds available by HSE region in December 2008. There were 1,096 long stay beds nationally as at December 2008.

Figure 3.4 Mental Health Commission Data on Mental Health Facilities – Details re Overall Long-Stay Beds by HSE Region*

Total number of long-stay beds by HSE area in psychiatric hospitals on 31 December 2008 (intellectual disability and forensic not included)

HSE Area	Total Long-stay beds available by region
South	545
Dublin North East	231
West	169
Dublin Mid Leinster	151
Total	1,096

**As at end- 2008*
Source: *Mental Health Commission, Annual Report 2008*

The number of approved large psychiatric centres providing acute care and the total number of acute beds in these centres across the HSE regions are described in the figure below. According to the MHC figures there were 341 acute beds in large psychiatric hospitals as at December 2008.

Figure 3.5 Mental Health Commission Data on Mental Health Facilities - Details re Acute Beds in Large Psychiatric Hospitals by HSE Region*

Total number of acute beds by HSE area in large psychiatric hospitals on 31 December 2008 (intellectual disability and forensic not included)

HSE Area	Total number of Acute Beds in large psychiatric hospitals	Approved centres providing acute care in large psychiatric hospitals
South	66	2
West	41	1
Dublin North East	163	5
Dublin Mid Leinster	71	2
Total	341	10

**As at 31st December 2008*
Source: *Mental Health Commission, Annual Report 2008*

The figure below details the number of 24-hour nurse-staffed community residences and the total number of places in these facilities as at December 2008. A total of 132 24-hour nurse-staffed community residences were in operation at the end of 2008 providing 1,664 places.

Figure 3.6 Mental Health Commission Data on Mental Health Facilities – Details re 24-Hour Nurse-Staffed Community Residences by HSE Region*

Places by HSE region

HSE Region	Total Number of 24-hour nurse-staffed community residences	Total number of places
HSE West	34	445
HSE South	33	428
HSE Dublin North East	24	323
HSE Dublin Mid Leinster	19	254
Intellectual Disability national total	22	214

**As at end- 2008*
Source: *Mental Health Commission, Annual Report 2008*

In addition to the regional data at HSE region level, the MHC's annual reports also provide a brief descriptive account of developments in inpatient capacity at individual catchment area level.

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Helpfully, within the context of ongoing monitoring and performance assessment, the MHC's data is updated on an annual basis and while there is some lag in reporting, the data available is reasonably timely (latest available end-2008). A limitation of the MHC data is that it is restricted however to coverage of approved inpatient units (including only the large psychiatric hospitals) and community residences only and does not provide details on aspects of mental health facilities such as the number of community mental health centres available to accommodate CMHTs or the availability and capacity of other community-based facilities such as continuing care bed facilities to accommodate older people, crisis houses, day hospitals and day centres, and intensive care rehabilitation units.

The MHC's annual report also considered the important issue of closure of large psychiatric hospitals, although no data is provided on closures. According to the 2008 annual report:

> "During 2008 the Inspectorate requested copies of closure plans for all the large psychiatric hospitals. There was variation between services as to how they were presented, some included plans in the Regional Level 2 HSE Business Plan, others had local five-year plans and a number had yearly objectives set. All services reported that the plans were dependent on additional funding. None of the plans had timelines with financial resources attached. It was disappointing to note that a number of hospitals continued to admit residents to institutional care and that some rehabilitation services were based in institutional settings."[66]

Value for money review of efficiency and effectiveness of long-stay residential care for adults within the mental health services [67]

Referred to in Section 2, the value for money review of long-stay beds profiled the position in relation to inpatient long-stay and community bed capacity based on a census conducted in October 2007. The details presented are shown in the table below. While acute inpatient capacity did not come within the scope of this review, the report indicated a total of 2,790 community beds and a total of 1,919 inpatient beds, or an overall total of 4,709 inpatient and community beds.

Table 3.1
Numbers of Inpatient and Community Beds

Details	No. of Beds as at October 2007*
Community-based beds, *of which*:	2,790
High Support	1,613
Medium Support	547
Low Support	630
Inpatient Beds, *of which*:	1,919
Inpatient Long-Stay	1,439
High Dependency/Secure	181
Rehabilitation	299
Total Community and Inpatient Beds	4,709

** Note: The figures presented do not include acute inpatient beds, which did not fall within the scope of the review.*
Source: Value for money review of efficiency and effectiveness of long-stay residential care for adults within the mental health services (2008)

66 Mental Health Commission, Annual Report 2008, Page 71

67 Health Service Executive (2008), Op. Cit.

The report also presented data on the geographic distribution of beds by HSE region, which is profiled in the table below.

Table 3.2
Geographic Distribution of Inpatient and Community Beds

HSE Region	Total Inpatient and Community-based Beds
Dublin Mid Leinster	845
Dublin North East	793
South	1,513
West	1,501
Central Mental Hospital	57
National Total	4,709

Source: Value for money review of efficiency and effectiveness of long-stay residential care for adults within the mental health services (2008)

Among the key conclusions of the value for money report in relation to facilities capacity were as follows:

- There is an estimated overprovision in bed capacity relative to the recommended levels set out in *A Vision for Change*;
- On the date of census there was 87% occupancy across the inpatient and community units surveyed, with 75% of patients in these units identified as being appropriately placed. Of those inappropriately placed on inpatient units, over 59% would be more appropriately placed in community-based accommodation. 32% of those inappropriately placed in community residences require lower support or independent accommodation;
- There are wide variations in capacity provision at regional level relative to population; and
- More than 88% of community residences have limited disabled accessibility.

—3.3.2 Existing use of performance indicators

Based on the review undertaken for this report, the existing development and publication of performance indicators pertaining to the level of provision and capacity of mental health facilities is currently very limited.

The HSE's national performance indicator and activity suite, reported as part of the executive's National Service Plan, includes a number of KPIs in relation to mental health services. Only one indicator, however, relates to facilities provision, namely the 'number of acute inpatient places per 100,000 of population.' Details in relation to this indicator based on the HSE's National Service Plan for 2010 are shown below.

Figure 3.7 HSE National Performance Indicator and Activity Suite-Mental Health Facilities Capacity Indicators

Performance Activity / Key Performance Indicator	Reported	Expected Activity / Target 2009	Projected Outturn 2009	Expected Activity / Target 2010
Inpatient Services				
No. of inpatient places per 100,000 population	Quarterly	25.0	28.5	26.6
First admission rates to acute units (that is, first ever admission), per 100,000 population	Quarterly	105.6	105.0	105.5
Inpatient readmission rates to acute units per 100,000 population	Quarterly	260.3	265.8	235.8
Median length of stay in inpatient facilities	Quarterly	12.0	11.4	10.5
Rate of involuntary admissions per 100,000 population	Quarterly	10.3	10.3	9.3

Source: *HSE, National Service Plan, 2010*

According to the HSE's performance indicator suite, a target of 26.6 inpatient places per 100,000 of population was set for 2010 with an outturn in 2009 of 28.5 places per 100,000 of population.

No performance indicators in relation to long-stay inpatient facilities and particularly in relation to community-based facilities are currently monitored as part of the HSE's published reporting.

The value for money review of long-stay beds devoted a section to "Key Performance Indicators". It developed a small core of indicators across each of the system performance domains. In relation to facilities, the recommended framework includes an indicator for the number of beds per 100,000 of population, to be tracked via annual survey.

—3.3.3 Conclusions from review of existing information and use of indicators

The key conclusions from the above review of existing information and use of performance indicators in relation to mental health facilities provision are as follows:

- There are large gaps in the level of information reported on a regular basis in the public domain about mental health facilities. Little information is provided on a regular basis about the availability of community-based mental health facilities;
- The data that is available on facilities provision and capacity indicates an over-reliance on acute and long-stay bed provision, and a variation across regions. Reducing the dependence on acute and long-stay bed provision and increasing the availability of community-based capacity are key objectives of *A Vision for Change* and therefore, current facilities do not meet the Government's policy objectives; and
- The existing performance indicators pertaining to mental health facilities are helpful but need further development. There is a particular gap in regularly reported information on the number and location of community-based facilities. This is a key requirement to facilitate monitoring of progress in relation to the recommendations of *A Vision for Change* in the area of facilities provision at community level.

3.4 International Experience and Best Practice

In this section we present selected findings from the review of international experience and best practice approaches in relation to the development and use of performance indicators to monitor facilities provision in mental health services.

—3.4.1 Australia

The Australian government's National Mental Health Report monitors a range of KPIs pertaining to mental health facilities provision at both national and state/territory level. A listing of these indicators is presented in the table below. It can be seen that the Australian framework provides a comprehensive range of KPIs for both inpatient and community services, and at national and state/territory levels. With regard to residential facilities, indicators are also broken down into separate measures covering 24-hour staffed and non-24-hour-staffed residences.

Table 3.3 Listing of Indicators of State/ Territory-level Mental Health Service Provision Monitored as part of Australian Government's Annual National Mental Health Report – Facilities Indicators

Key Performance Indicator Details
Inpatient Services
Total hospital beds
Inpatient beds per 100,000
Acute inpatient beds per 100,000
Non acute inpatient beds per 100,000
% acute inpatient beds located in general hospitals
Stand alone hospitals as % of total beds
Residential services
Adult beds per 100,000: 24-hour staffed Non-24 hour staffed
Older persons beds per 100,000: 24-hour staffed Non-24 hour staffed
Supported public housing places per 100,000

Source: *National Mental Health Report, 2006-07, Australian Government*

3.5 Proposed Key Performance Indicators

Based on the assessment of needs and review of existing information, a set of proposed KPIs designed to support the assessment of progress on delivery of required mental health services facilities was developed. These indicators are set out in the table overleaf.

Table 3.4 Proposed Key Performance Indicators Mental Health Services Facilities

	Indicator No. and Description	KPI objective	Indicator Target Setting*
	General Adult MHS		
1	No. of Long-Stay General Adult Inpatient Beds by MHCA	Reduction in dependence on long-stay inpatient units in line with recommendations of AVfC	Eliminate dependence on long-stay inpatient beds within pre-defined timescale and reconfigure to AVfC targets set out in indicators (2) to (5) below
2	No. of Staffed Community Residences by MHCA	Provision of facilities for patients moving from long-stay and other inpatient units	3 units of 10 places per 100,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible infrastructure*	*Maximise proportion of disability accessible units*
3	No. of Continuing Care Challenging Behaviour Units	As for (2) above	One 30-bed unit per 300,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible infrastructure*	*Maximise proportion of disability accessible units*
4	Intensive Care Rehabilitation Units	As for (2) above, including for people with enduring illness DMB	One 30-bed unit per 1,000,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible infrastructure*	*Maximise proportion of disability accessible units*
5	High Support Intensive Care Residences	As for (2) above	One 20-bed unit per 1,000,000 population
	Of Which - No. Disability Accessible	*Provision of disability accessible infrastructure*	*Maximise proportion of disability accessible units*
6	No. of Community Mental Health Centres by MHCA	Provision of facilities required to support operation of CMHTs at local level as recommended by AVfC	Develop total of 338 centres nationally and ensure geographic division in line with MHCA catchment populations
7	No. of Crisis Houses for Adult Services by MHCA	Monitoring of provision of facilities to support least restrictive, accessible local treatment	Develop 14 facilities nationally located close to local CMHTs
	Child & Adolescent MHS		
8	No. of CAMHS Acute Inpatient Beds by MHCA	Address requirements of AVfC in relation to CAMHS inpatient capacity	Deliver 100 inpatient beds nationally for all aged 0-18 years in five units of 20 beds
9	No. of Community Mental Health Centres for CAMHS by MHCA	Address requirements of AVfC in relation to delivery of community-based CAMHS	Deliver 84 centres (based on 1 centre per team per 50,000 population)
10	No. of CAMHS Forensic CMHT Units	Address requirements of AVfC in relation to provision of specialist MHS	Provide 1 unit with appropriate regional distribution
11	No. of CAMHS Day Hospitals by MHCA	Address requirements of AVfC in relation to CAMHS day hospital facilities	Deliver 14 day hospitals (1 day hospital per catchment of 300,000 total population)
	Specialist Services		
12	No. of Adult Forensic CMHT Units	Address requirements of AVfC in relation to provision of specialist MHS	Provide 4 units with appropriate regional distribution
13	No. of Intellectual Disability CMHT Units	Address requirements of AVfC in relation to provision of specialist MHS	Provide 2 units per 300,000 population

** Note: Based on AVfC recommend coverage ratios*
Source: *Indecon*

It is recommended that each indicator recommended is monitored annually on a catchment area basis as part of the HSE's Geo-mapping Health Atlas.

In relation to data/information collection to facilitate monitoring of mental health service facilities, we understand that the Inspectorate of Mental Health Services is now requiring that all services provide information on their facilities, by super-catchment area. This will essentially provide an annual audit and Indecon is very supportive of this process.

—3.5.1 Rationale for indicator selection

In terms of the rationale underpinning the selection of the above indicators in the area of MHS facilities, the following bases are relevant:

1 No. of Long-Stay Inpatient Beds by MHCA – reflecting the need to monitor progress on reducing and eventually eliminating the current and historical over-dependence on long-stay inpatient units within the mental health services and reconfiguring facilities capacity towards the model set out in *A Vision for Change*;
2 No. of Staffed Community Residences by MHCA (including number of disability accessible units) – related to (1) above and reflecting the need to monitor progress towards achievement of the targets for a reconfigured mental health service as set out in *A Vision for Change* and, in particular, to facilitate the transition of service users from long-stay units;
3 No. of Continuing Care Challenging Behaviour Units by MHCA (including number of disability accessible units) – as per (2) above and to ensure progress on provision of specialised units by region, as recommended in *A Vision for Change*;
4 Intensive Care Rehabilitation Units (including number of disability accessible units) – as per (3) above;
5 High Support Intensive Care Residences (including number of disability accessible units) – as per (3) above;
6 No. of Community Mental Health Centres by MHCA – reflecting the need to provide an overall macro indicator which measures progress towards provision of facilities to support development of CMHTs within each MHCA, as recommended in *A Vision for Change*;
7 No. of Crisis Houses for Adult Services by MHCA – reflecting the requirement to monitor progress on provision of specialised adult mental health services recommended in *A Vision for Change*;
8 No. of CAMHS Acute Inpatient Beds by MHCA – reflecting the requirement to monitor progress towards achievement of A Vision for Change-recommended inpatient bed capacity for CAMHS;
9 No. of Community Mental Health Centres for CAMHS teams by MHCA – reflecting the need to monitor progress towards provision of sufficient numbers of units to support CAMHS CMHTs at regional level, as recommended in *A Vision for Change*;
10 No. of CAMHS Forensic CMHT Units – reflecting the requirement to monitor progress on provision of specialised CAMHS forensic units, as recommended in *A Vision for Change*;
11 No. of CAMHS Day Hospitals by MHCA – reflecting the need to monitor progress on provision of specialist CAMHS day hospitals, as recommended in *A Vision for Change*;
12 No. of Adult Forensic CMHT Units – reflecting the requirement to monitor progress on provision of specialist adult forensic units, as set out in *A Vision for Change*; and
13 No. of Intellectual Disability CMHT Units – reflecting the need to track progress on provision of specialised Intellectual Disability units for adults, as recommended in *A Vision for Change*.

The listing of KPIs selected above represents what Indecon believes to be the indicators that are central to establishing progress on the achievement of a transformed mental health service, as set out in *A Vision for Change*. They also reflect the areas of weakness, in terms of progress to-date, highlighted in Indecon's previous review for AI. It should also be noted that the detailed indicators proposed are in line with international best practice in this area, including, for example, in the UK, as part of the combined mapping framework under the annual Autumn Assessment.

3.6 Summary

This chapter considered the requirements in terms of information and performance measures to facilitate the assessment of progress on implementation of *A Vision for Change* in relation to investment in mental health services facilities. An assessment was undertaken of the needs in terms of ongoing performance monitoring in the area of facilities provision, in addition to a review of existing information and use of indicators in this area. A set of proposed KPIs designed to support the assessment of progress on delivery of required mental health services facilities was developed. The key findings from the review which inputted to the indicator selection were as follows:

- There are some gaps in the level of data reported on a regular basis in the public domain in relation to the provision and capacity of mental health facilities. There is a lack of regular information published about the provision of community-based mental health facilities;
- The data available on facilities provision and capacity indicates an over-reliance on acute and long-stay bed provision, and a variation across regions. Reducing the dependence on acute and long-stay bed provisions and increasing the availability of community-based capacity are key objectives of *A Vision for Change* and therefore, current facilities do not meet the Government's policy objectives;
- The existing performance indicators pertaining to mental health facilities are helpful, but limited, and need further development. There is a particular gap in regularly reported information on community-based facilities. This is a key requirement to facilitate monitoring of progress in relation to the recommendations of *A Vision for Change* in the area of facilities provision, and the proposed suite of KPIs includes additional indicators pertaining to the provision of facilities to support community mental health teams and other facilities to facilitate the transfer and accommodation of patients from long-stay inpatient units; and
- International experience indicates more widespread and detailed usage of performance indicators covering mental health facilities at inpatient and community service levels.

4 Mental Health Services: Human Resource Inputs

Mental Health Services: Human Resource Inputs

4.1 Introduction

Without competent professionals, it will not be possible to deliver quality mental health services in line with new structures recommended in *A Vision for Change* and in order to fulfil the State's obligations regarding the right to the highest attainable standard of mental health. This section examines human resources in the mental health services. It firstly identifies the requirements in relation to information provision and performance assessment in this area, based on the specific recommendations of *A Vision for Change*. It then examines the extent of existing information available and the use of performance indicators in mental health human resources. After presenting an overview of the findings from a review of international experience and best practice approaches, this chapter then develops a set of KPIs designed to facilitate monitoring of progress on the reconfiguration of staffing and the development of community-based mental health services.

4.2 Information and Assessment Needs

In developing a set of suitable performance indicators to support ongoing monitoring of progress on human resource provision in the mental health services, it is firstly necessary to identify the particular requirements in terms of information and assessment in this area.

The specific requirements for performance assessment in relation to mental health human resources are best identified by reference to the recommended structure of and approach to delivery of mental health services set out in *A Vision for Change*. There are two aspects to human resource provision to facilitate this policy, namely:

- The manpower requirements to facilitate the reconfiguration of service provision and, in particular, to support the development of community-based mental health services; and
- The education and training requirements to ensure that service staff are sufficiently skilled to ensure full capability and competent, professional delivery of high quality mental health services.

—4.2.1 Manpower requirements

Overall manpower requirements

The overall manpower/staffing requirements to facilitate the new, re-configured mental health service recommended in *A Vision for Change* were set out on Page 264 of the policy. The table overleaf presents a breakdown of staffing requirements based on an adaptation of the baseline requirements of *A Vision for Change* developed as part of the HSE's Vision for Change Implementation Plan.

The adjusted staffing requirements reflect the inclusion of an uplift to take account of the latest 2006 Census of Population figures. The adjusted figures indicate a requirement for approximately 11,500 Whole-time Equivalent staff based on applying the same coverage ratios relative to population as recommended in the policy. It is estimated that a total of 1,054 additional clinical WTEs are required to fully implement *A Vision for Change*.

A Vision for Change states that investment in additional human resources and provision of the required professional workforce would be "vital to achieve policy implementation and service modernisation", since the workforce element of the service accounts for over 80 per cent of non-capital expenditure.[68] A range of multi-disciplinary support staff that can provide talk therapies, occupational and social work supports, as well as specialist support staff, are necessary in order to implement the recovery model set out in *A Vision for Change*. It is therefore important that the HSE reports regularly and accurately on numbers of staff in the mental health workforce in order that both increases and cuts can be tracked.

68 *A Vision for Change*, p. 180.

In addition to the additional overall level of manpower required, there will also be a requirement to reconfigure the existing mix of staffing in the mental health services. This aspect was examined in Indecon's 2009 review completed for AI, which highlighted the misalignment of existing staffing, including the overprovision of nursing staff and the deficit relative to recommended levels in health and social care staffing

Table 4.1 Overall Manpower/ Staffing Requirements to Support Mental Health Services as Recommended by *A Vision for Change

Stagg Category	Vision for Change - Baseline Requirements - WTEs **	Vision for Change - Adjusted Requirements - WTEs***	%
Medical/ Dental[1]	774	837	7.3
Nursing[2]	4,323	4,677	40.6
Health & Social Care[3]	2,620	2,835	24.6
Management /Admin[4]	1,028	1,112	9.6
Other Patient & Client Care[5]	1,912	2,069	17.9
Total	10,657	11,530	100

** Figures in this table exclude General Support staff*
*** As set out in A Vision for Change (Table A17.2 - Staffing and Facilities Requirements, Pages 261-264)*
**** Baseline requirements uplifted to reflect increased population numbers in Census of Population, 2006*
[1] Includes Team Leader, Consultant and NCHD Posts
[2] Includes Team Coordinator, Senior Nurse and Psychiatric Nurses Posts
[3] Includes Occupational Therapist, Clinical Psychologist, Social Worker, Cognitive Behavioral Therapists, Family Therapist, Addiction Counsellor and 'Other' Therapist Posts. Note: In some services some of these posts are filled by and classified as Nursing Posts e.g. Addiction Counsellors or Cognitive Behavioral Therapists
[4] Includes Practice Manager and Team Secretaries
[5] Includes Care Assistant and Attendant Posts
Source: *HSE, A Vision for Change - Implementation Plan - 2009-2013*

Community Mental Health Team manpower requirements

The manpower/staffing requirements to support the development of community-based mental health teams as recommended by *A Vision for Change* are shown in the table overleaf. This identifies the recommended numbers of teams by service area and the number of multi-disciplinary staff per team relative to the population.

Figure 4.1 Manpower/Staffing Requirements to facilitate Implementation of *A Vision for Change*

Team/ Unit	Total Population per team or unit	Number of Teams required	Team Co-ordinator	Team Leader / Consultant	Practice Manager	Consultant	NCHD	Senior Nurse	Psychiatric Nurse	Occupational Therapist	Clinical Psychologist	Social Worker	Care Assistant	Team Secretary	Attendant	Cog Behaviour Therapist	Family therapist	Addiction Counsellor	Other Therapists	Notes
General Adult CMHTs																				
General Adult Community Mental Health Team (CMHT)	50,000	78	78	78	78	78	78	156	468	195	156	156	195	156		117	78	78		
Adult Eating Disorders CMHT	1,000,000	4	4	4	4		4	8	24	10	8	8	10	8		6	4	4	4	
Rehabilitation CMHT	100,000	39	39	39	39		39	156	390	78	78	78	254	78		39		39	78	
Early Intervention CMHT	2 Teams	2	2	2	2		2	4	12	6	4	4	6	4		4	2	2		
Adult Liaison Service	300,000	13	13	13	13		13	26	78	13	26	26	33	26		20	13	13		
Neuro Psychiatry	2,000,000	2	2	2	2		2	4	12	4	4	2	5	4		4	2	2	4	1 Based in Dublin 1 based in Cork
Perinatal Psychiatry						1		2												
Child & Adolescent CMHTs																				
Community Mental Health Teams	50, 000	78	78	78	78		78		156	78	156	156	78	156					78	
Liaison Teams		7	7	7	7		7		7	7	14	14	7	14					7	
Eating Disorder Team		1	1	1	1		1		2	1	2	2	1	2					1	Tertiary national service
In-Patient Service	20 Beds per unit	5 units	5	5	5		5	10	80	10	20	15		15	25				20	
National High Secure Unit	10 beds							2	13						4					
Substance Misuse and Dependency	1,000,000	4	4	4	4		4	8			4	4	8	8			8	12	8	Team as recommended by substance misuse subgroup
Mental Health of Intellectual Disability CMHTs																				
Community Mental Health Teams – Adult	2 teams per 300,000	26	26	26	26		26	52		26	52	52	26	52					26	26 posts for various occupational therapists
Children & Adolescents	1 team per 300,000	13	13	13	13		13	26		13	26	26	13	26						
Mental Health Services for Older People																				
CMHT for Older People	100,000	39	39	39	39		39	78	234	39	39	39	78	78					39	
Intensive Care Rehabilitation Teams	1,000,000	4	4	4	4		4			10	8	8	8	8		8	4	4		Nursing input drawn from DMP service complement
Forensic Mental Health Services																				
Forensic Teams	1,000,000	4	4	4	4		4	4	8	10	10	8	12	8		12	12	12		
Forensic Teams – Child & Adolescent	2 teams	2	2	2	2	2	2	4	10	4	4	4	6	4		4	4	4		1 team based in C&A secure unit
Forensic Teams Intellectual Disability	1 team	1	1	1	1	1	1	2	5	2	2	2	3	2		2	1	2		
CMHTS for people with Co-morbid Mental Illness and Substance Abuse																				
CMHTs for people with Co-morbid Mental Illness and Substance Abuse	300,000	13	13	13	13		13		26	13	13	26		26				52		26 Psychiatric Nurses to operate as outreach workers
Mental Health Services for Homeless People																				
Service Teams		2	2	2	2	2	2	2	16	4	2	2	4	2		2		4		

Source: *A Vision for Change (2006)*

The implications of the above staff ratios for community teams, when applied to the 2006 population base, are described in the table below.

Table 4.2 Current Human Resources within Community-based Mental Health Teams

Service Area	No. of Teams Required*	Total No. of Staff Required WTEs
Child & Adolescent Mental Health Services CMHTs	84	1,092
General Adult Mental Health Services CMHTs	84	1,770
Mental Health Services for Older People CMHTs	42	508
Intellectual Disability CMHTs	28	424
Rehabilitation Services CMHTs	41	902
Forensic and Other Specialist Services teams	71**	1,155**
Total	350	5,851
% of Est. Overall MHS Staffing Requirement		50.7%

Note:
**Based on recommended CMHT structures and staffing as set out in A Vision for Change adjusted to reflect 2006 population*
*** Based on HSE, Vision for Change Implementation Plan (2009)*
Source: *Indecon, based on A Vision for Change (2006); HSE*, Vision for Change Implementation Plan (2009); and CSO, Census of Population, 2006

Based on 2006 population levels and applying the ratios recommended in *A Vision for Change*, it is estimated that a total of 276 community mental health teams are required. These teams in turn will require an estimated overall multi-disciplinary staffing complement totalling 5,851 WTEs or 50.7% of the estimated total manpower requirement (based on current population levels) across the mental health services.

Regional distribution of manpower

In addition to the overall level and distribution of manpower at national level, another important aspect concerns the allocation of staffing at regional and local levels.

The above analysis is undertaken at national level. However, as *A Vision for Change* recommended that service provision takes place as much as possible at local level, this implies that the regional distribution of human resources must also be aligned with the population and need at local and regional levels.

Indecon's 2009 review for AI highlighted significant variations relative to recommended configuration across regions. This indicates the need to monitor progress on manpower allocations not only at national but also at regional and catchment area level.

Education and training

A Vision for Change acknowledged that the model of development of the mental health services envisaged by the policy has direct implications for education and training of mental health professionals.

The policy set out a number of general principles which it said should inform education and training, as follows:

- All education and training must be directed at equipping personnel to deliver a service that is user-centred and should instil ethical values that respect the worth, rights and integrity of service users;
- Policymakers, planners and employers must understand and acknowledge the centrality of education and training in delivering high quality services to the service user (consequently education and training programmes must be adequately funded and supported);
- Learning, through education, training and reflective practice must be a life-long process processes of education and training must be embedded in the working situation and protected time must be available to educator, trainer and trainee;
- Education and training programmes should be subject to ongoing review, monitoring and evaluation;
- Programmes should incorporate and transmit a broadly based research culture to students; and
- Appropriate administrative structures should be funded and put in place to ensure the delivery of high quality education and training.

Indecon believes it is important that performance assessment in relation to mental health human resources includes reference to developments in relation to education and training of mental health professionals. This would ensure that staff members are equipped with the skills required to provide high quality, recovery-oriented interventions and supports in the community setting.

—4.2.2 Implications for performance assessment

The review of information requirements and performance assessment needs in relation to human resources in the mental health services gives rise to the following key conclusions:

- There is a need to introduce appropriate indicators to facilitate the monitoring of progress on implementation of *A Vision for Change* in relation to both overall manpower and the composition of staffing within the mental health services;
- Indecon believes that the central role of community-based provision within the context of implementation of *A Vision for Change* should be reflected in the consideration of appropriate performance monitoring indicators. This includes the need to monitor progress in relation to:
    - The overall development of community mental health teams and provision of full, multi-disciplinary staffing for these teams;
    - The composition of team development by service area; and
    - The regional and local distribution of CMHTs relative to population and need.
- There is a need to monitor progress in relation to reconfiguration of mental health staffing at both overall national and regional/catchment area levels; and
- It is important that performance assessment in relation to mental health human resources include reference to developments in relation to education and training of mental health professionals.

4.3 Review of Existing Information and Indicators

—4.3.1 Existing data on mental health services human resources

Data/information on the position and developments in relation to human resources in mental health are currently published in the following sources:

- Department of Health and Children (DoHC), Annual Output Statement;
- HSE, Vision for Change Implementation Plan – 2009-2013;
- Mental Health Commission, Annual Reports; and
- Mental Health Commission – Community Mental Health Team staffing reports by local catchment area.

We briefly profile these sources and related headline data below.

Department of Health and Children, Annual Output Statement

DoHC's Annual Output Statement provides a breakdown of Whole Time Equivalent (WTE) staff by care programme within the health services. The table below presents the data provided in relation to mental health services based on the Department's Annual Output Statement for 2009.

Table 4.3 Breakdown of Human Resources in Mental Health Services in December 2008 Nationally and by Staff Category (DoHC Data)

Staff Category	Total WTEs – National – as at December 2008	%
Medical/ Dental	574	6.4
Nursing	4,961	54.9
Health & Social Care	467	5.2
Management /Admin	699	7.7
General Support	1,216	13.5
Other Patient & Client Care	1,121	12.4
Total	9,039	100

Source: *Department of Health and Children, Annual Output Statement 2009 for Health Group of Votes, June 2009 - see http://www.dohc.ie/publications/annual_output_statement_2009.html). Data is provisional*

The Department's data pertains to staffing and indicates an overall staffing complement in mental health services amounting to 9,039 WTEs as at December 2008. The distribution of this staffing is also presented, with the largest proportion of WTEs being in nursing.

HSE, Vision for Change Implementation Plan – 2009-2013

The HSE, Vision for Change Implementation Plan also provided data on the overall breakdown of staffing within the mental health services, which is set out in the table below. According to the HSE figures, a total of 10,476 statutory WTE persons were employed in mental health related services across the health service at the end of 2008.

Table 4.4 Breakdown of Current Human Resources in Mental Health Services in December 2008 Nationally by Staff Category (HSE Data)

Administrative Area and Staff Category	No. of WTEs – Dec. 2008	%
Medical/ Dental	790	7.5
Nursing	5,804	55.4
Health & Social Care	645	6.2
Management /Admin	843	8.0
General Support	1,278	12.2
Other Patient & Client Care	1,116	10.7
Total	10,476	100

Source: *A Vision for Change - Implementation Plan - 2009-2013, Table 1.6*

An issue in relation to the DoHC and HSE data on overall mental health service staffing concerns the apparent significant variation between the data available from each source. This issue was highlighted in Indecon's 2009 review for AI and points to an issue concerning the availability of up-to-date and consistent data on human resource levels in mental health services.

Mental Health Commission, Annual Reports

The Mental Health Commission's (MHC) annual reports provide detailed data, based on annual return by Local Health Managers, on the development and staffing of community mental health teams. This data comprises an overview of human resource allocations as follows:

- Resource and activity data for mental health services for older persons by HSE region and local catchment area;
- Data on staffing of Intellectual Disability CMHTs by HSE region and catchment area;
- Data on staffing of Child and Adolescent CMHTs by HSE region and catchment area; and
- Detailed data on mental health service staffing by catchment area.

The figure below presents an example of the data provided in the MHC's annual report for 2008 in relation to human resources employed in mental health services for older persons by HSE region and local catchment area.

Figure 4.2 Mental Health Commission – Data on Human Resources in Mental Health – Data on Human Resources in Psychiatry of Old Age

Service	Date Est'd	Pop ≥65	Con	NCHD SR	NCHD SHO	ACNO	CMHN	Sec	Other[1]	Acute Psych Beds	Day Hosp	L/S Psych Beds
NAHB Area 6&7	1989	32,500	2.5[2]	1	3	1 (DON)	3	2	1	6	√	40
SWAHB Areas 3 & ½ 4	1991	20,228	2	1	2	0.5	2	2	3	9	√	X
MWHB Limerick	1996	19,000	1	1	1	0	2	1	3.5	10	√[3]	21
SWAHB Area 5 & ½ of 4	1998	15,600	1[4]	1	1	0.5	2	1	7	Access only	√	X
MHB Laois -Offaly	1999	14,036	1.5[4]	1	1	1	4.5	2	2	6	√	66
NEHB Cavan -Monaghan	2000	14,289	1	1	1	1	8	2	6	7	√	30
SEHB Waterford	2000	14,000	1	1	1	0.5	2	1	2.75	6	X	23
SEHB S. Tipperary	2000	10,200	1	-	1	1	2	1	1	5	X	22
MWHB Clare	2000	13,500	1	0	1	0.5	2	1	2	5	X	68
SEHB Wexford	2001	15,000	1	-	1	0	2	1	0.5	8	X	14
MHB Lf/Wm	2001	13,000	1	-	2	0.5	4.8	1	1	Access	√	70
SHB South Lee	2001	18,500	1	-	2	0.2	2.5	1	3	Access only	√[3]	X
NWHB Donegal	2002	17,300	1	-	1	1	5	1.5	2.5	Access only	√	X
NWHB Sligo/Leitrim	2002	14,600	1	1	1	1	4.25	1.5	2	4	√	X
NAHB Area 8	2002	18,600	2	2	2	1	3	1.5	3	7	X	36
SEHB Kilkenny[4]	2002	14,000	1	-	1	-	2	1	1	Access 4-6	-	24
WHB Mayo	2002	17,000	1	-	2	0.5	3	1	3	5	X	25
NEHB Meath	2003	13,000	1	1	1	0	2	1	1	Access 4	X	X
Galway West[4]	2004	25,500	1	1	0	0	1	0.5	1	X	X	X

X Resource not provided to the service
1.Others includes: Occupational therapy, Social work, Psychology, Support workers, Behaviour therapy
2.3.5 Consultants and 2 NCHDs from July '06
3.Day hospital (part-time only)
4.1.5 Consultants from July '06
Source: *Mental Health Commission, Annual Report (2008) (based on data provided by the Irish Association of Consultants in Psychiatry of Old age)*

The figure below profiles an example of human resources data published by the MHC in relation to intellectual disability community mental health teams in the HSE Dublin Mid Leinster region. This shows that, as at the end of 2008, there were four Intellectual Disability CMHTs in the region.

Figure 4.3 Mental Health Commission – Data on Human Resources in Mental Health - *Human Resources in Intellectual Disability CMHTs* - Example of Data Published for HSE Dublin Mid Leinster

Table 1: HSE Dublin Mid-Leinster

Catchment	Dublin South City/ South Kildare/ Wicklow	Laois/ Offaly/ Longford/ Westmeath
Population (ID database)	5,532	830
Teams	3	1
- Consultant psychiatrist	3	0.5 by 2
- NCHD	0	1.5
- Psychology	0.5	0
- Occupational therapy	0	0.5
- Social work	0	0

Source: *Mental Health Commission, Annual Report (2008)*

Details of MHC data published in relation to staffing of Child and Adolescent CMHTs by HSE region and catchment area within HSE Dublin Mid Leinster are shown in the figure below.

Figure 4.4 Mental Health Commission – Data on Human Resources in Mental Health - *Human Resources in Child & Adolescent CMHTs* – Example of Data Published for HSE Dublin Mid Leinster

Table 1: HSE Dublin Mid – Leinster

	Catchment 1	Catchment 2	Catchment 3
Catchment	Dublin SW, Dublin NW, Kildare	Dublin SE, South Co. Dublin, E Wicklow	Laois, Offaly, Longford, Westmeath
Population under 18	n/a	n/a	70,311
Consultant psychiatrist	7.9	8.45	3
NCHD	15	8	5
Nursing	11.9	15.89	6.6
Psychology	10	11.99	3
Social Work	9	10.8	1
Social Care	1	9.69	0
Occupational therapy	0	8.8	2
Number on waiting list	188	No information	89
Length of time on waiting list	From 4 weeks to a year	From 3 to 14 months	From under 3 months to 1 year
Length of time on priority list	No information	No information	No information

Source: *Mental Health Commission, Annual Report (2008)*

An example of the MHC's data on human resources by catchment area is shown in the figure overleaf by reference to the Cavan/Monaghan catchment area within the HSE Dublin Mid Leinster region.

Figure 4.5 Mental Health Commission – Data on Human Resources in Mental Health - *Human Resources by Catchment Area* – Example of Data Published for Cavan/ Monaghan Catchment

Medical Staff	
Post	WTE in post
Consultant psychiatrist	2
NCHD	4
Specialist Registrar	1
Nursing Staff	
Post	WTE in post
ADON (clinical coordinator)	1
CNM3	1
CNM2	7
CNM1	2
CMHN	1
Staff Nurse	18
CNS	7
Health and social care professionals	
Post	WTE in post
Clinical psychologist	1
Social Worker	1.3
Occupational Therapist	0.66

Source: *Mental Health Commission, Annual Report (2008)*

Mental Health Commission – Community Mental Health Team staffing reports by local catchment area

The MHC also published a separate series entitled "Community Mental Health Team staffing reports by local catchment area". BThese are published annually with the last set of reports released in 2008 containing data pertaining to 2008 submitted via Local Health Managers. An example of the detailed data available by local team within each catchment area is shown in the figure below.

Figure 4.6 Mental Health Commission – Data on Human Resources in Mental Health - Community Mental Health Team Staffing Reports by Local Catchment AreaExample of Data for Drimnagh Local Team within Dublin South City Catchment

Drimnagh team	2007	2008
Population	28,326	23,030
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.2	0.2
CMHN	1	1
Psychologist	0.5	0.7
Social Worker	1	1
Occupational Therapist	0.75	0.66
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0.3	0.3

Source: *Mental Health Commission, Community Mental Health Team staffing reports*

Findings of Indecon 2009 review

Indecon's 2009 review for AI highlighted that while the available data/ information on human resources within the mental health services is generally more detailed than is the case for funding and expenditures, there are deficiencies in existing data/information. These relate in particular to:

- Gaps in relation to detailed data on staffing by skill mix at regional and catchment area level, including in relation to mental health services for Older People, Rehabilitation and Specialist services; and
- Gaps in relation to the specification of population levels in some catchment areas required to facilitate identification of appropriate levels of service provision.

Indecon's review included a detailed examination of the current extent and rate of progress of development and staffing of community mental health teams at national, regional and local catchment area levels. The report issued a number of conclusions based on the data available to end-2008, including:[69]

- CMHTs accounted for a reported total of 1,982 WTEs as at December 2008, equivalent to just 18.9% of overall mental health service staffing, indicating a continued high level of utilisation of traditional acute and long-stay inpatient and community residence beds that are not likely to be appropriate to the needs of all patients;
- In total there were 231 CMHTs initiated as at end-2008, against a minimum recommended requirement - taking into account the increase in population since the policy was formulated - of 276 teams across the five main mental health service areas. This represents an overall deficit of 45 teams;
- At service area level, particular deficits in team development and multi-disciplinary staffing were evident in relation to Child and Adolescent teams, teams for older people and rehabilitation services teams;
- A substantial proportion of existing teams that have been initiated are poorly resourced and do not include the required overall complement of staff. In particular, 56% of the minimum recommended number of posts across the CMHTs remains to be filled, while a large proportion of teams do not have the desired mix of filled senior and junior specialist posts; and
- At regional and local levels, the number of community-based teams initiated remains below the required number of teams implied by *A Vision for Change* and the most recent Census of Population in three out of the four HSE regions.

These findings highlight the importance of regular monitoring of human resources in the mental health service to assess progress on the development of community mental health teams as recommended in *A Vision for Change*.

69 Indecon (2009), Op. Cit.

—4.3.2 Existing use of performance indicators

In terms of the existing use and ongoing publication of performance indicators relating to human resources in mental health services, currently these resources are monitored as part of the following publications:

- Department of Health and Children, Annual Output Statement;
- HSE, National Service Plan; and
- HSE, Performance Reports monthly.

Department of Health and Children, Annual Output Statement

The Department's Annual Output Statement devotes a section to mental health which includes a series of output and impact indicators. As part of this, an annual target is set in relation to the number of Child and Adolescent CMHTs. The figure below profiles this indicator based on the Annual Output Statement for 2009. An output target for the recruitment of eight additional Child and Adolescent CMHTs was set for 2008 and a further eight teams in 2009. The 2008 target was partially achieved although no information is available in relation to the staffing of these teams.

Figure 4.7 Department of Health and Children – Annual Output Statement - Mental Health Service Human Resource Indicators

Outputs			
Programme	2008 Output Target	2008 Output Achieved	2009 Output Target
Recruitment of additional Child and Adolescent Mental Health Teams (CAMHTs)	8 CAMHTS Waiting lists and waiting times targeted.	Target partially achieved Recruitment for additional CAMHTs commenced and nearing completion	8 in place

Source: *Department of Health and Children, Annual Output Statement 2009*

HSE, National Service Plan

The HSE National Service Plan's National Performance Indicator and Activity Suite also includes an indicator for the Child and Adolescent CMHTs. However, thus far data for this indicator have not accurately reflected teams with a full complement of staff. No further indicators are available at this stage on mental health human resources within the HSE's performance indicators suite although we understand the executive is progressing work in this area.

HSE, Performance Reports monthly

The HSE's monthly performance reports provide details of overall staffing in addition to performance activity indicators by health service care programme. In relation to mental health services, a number of KPIs are tracked which focus on Child and Adolescent mental health services. These include one indicator of human resource provision in the form of the number of Child and Adolescent teams by HSE region, showing the progression in team development in the year to date relative to the annual target set. No information is available however in relation to the staffing of these teams. The information on this indicator available from the October 2009 PMR is shown in the figure below.

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Figure 4.8 HSE – Performance Reports – Key Performance Indicators on CMHT Development Child and Adolescent CMHTs

Programme	Outurn 08	Target 09	Target YTD	Actual YTD	% var YTD Actual v Target	Same period last year	% var YTD v YTD last year
Recruitment of additional Child & Adolescent Mental Health							
No. of Child & Adolescent Mental Health Teams (as outlined in *A Vision for Change*)	47	55	55	55	0.0%	47	-17.0%
South	11	13	13	12	-7.7%	11	-9.1%
West	11	13	13	12	-7.7%	11	-9.1%
DNE	10	12	12	11	-8.3%	10	-10.0%
DML	15	17	17	20	17.6%	15	-33.3%

Source: *HSE, Performance Report – Supplementary PR Data, October 2009*[70]

—4.3.3 Conclusions from review of existing information and use of indicators

The review of existing information provision and the use of performance indicators in the area of mental health human resources gives rise to the following conclusions:

- Data is published on an annual basis by DoHC and HSE that shows the overall level and composition by category of staff within the mental health services. There is some variation in the numbers reported by these two sources and there is a need to publish a breakdown showing the division in staffing between hospital/inpatient and community-based mental health services;
- Detailed data is published by the MHC in its annual reports and in its CMHT staffing reports by region, local catchment area and local team. While data is currently focused on services for adults, older persons, intellectual disability teams and child and adolescent team staffing, this constitutes the most detailed human resource/staffing data currently published on an annual basis;
- There are gaps in relation to detailed data on staffing by skill mix at regional and catchment area level, including in relation to Mental Health Services for Older People, Rehabilitation and Specialist services; and
- In relation to existing use of performance indicators, the development of Child and Adolescent CMHTs is monitored on an annual basis by the DOHC in its Annual Output Statement and by the HSE as part of its National Performance Indicator and Activity Suite and monthly performance reports. This includes targets set on an annual basis. There is a need for the HSE to also provide actual staffing data pertaining to the development of these and for CMHTs in other areas of the mental health services. There is also a need to develop suitable indicators which track the extent of training of mental health services staff.

We consider these issues further later in this section when we present our proposed KPIs for mental health human resources.

70 See: http://www.hse.ie/eng/services/Publications/corporate/October_2009_supplementary_Report.pdf.

4.4 International Experience and Best Practice

The Australian Government's National Mental Health Plan includes a number of mental health service clinical workforce indicators at state/territory level. These indicators are shown in the figure below.

Table 4.5 Listing of Indicators of State/ Territory-level Mental Health Service Provision Monitored as part of Australian Government's Annual National Mental Health Report – Service Mix Indicators – Clinical Workforce Indicators at State/ Territory Level

Clinical Workforce
Number Full Time Equivalent (FTE) staff
FTE per 100,000
% FTE in community based services
FTE per 100,000 – ambulatory services

Source: *National Mental Health Report, 2006-07, Australian Government*

4.5 Proposed Key Performance Indicators

Based on the identification of information and assessment needs and the review of existing information and usage of performance indicators, we have developed a set of KPIs designed to facilitate monitoring of the key aspects human resource provision to support the implementation of *A Vision for Change*. These indicators are profiled in the table overleaf. Additional proposed KPIs for specialist services are also presented in Annex 2 to this report.

Importantly, it should be noted that data for these recommended indicators should be based on actual staff in place and not on allocated staff posts.

In relation to data/information collection to facilitate monitoring of mental health service human resources, we understand that the Inspectorate of Mental Health Services is now requiring that all services provide information on their staffing, by super-catchment area. This will essentially provide an annual audit and Indecon is very supportive of this process.

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Table 4.6 Summary of Proposed Key Performance Indicators – Mental Health Service Human Resources

	Indicator No. and Description	KPI Objective	Indicator Target Setting*	Indicator Data Frequency and Method of Collection
	Development of Community-based MHS			
1	Overall national ratio of staff in Community Mental Health Teams to total no. of MHS staff	Monitoring of progress in reducing current over-staffing of adult inpatient services and reconfiguring resources to increase staffing of CMHTs across MHS	National ratio to target 39% of MHS staff employed in CMHTs	Annual data based on Mental Health Commission census of CMHT staffing
2	No. of Child & Adolescent CMHTs with full multi-disciplinary staffing by MHCA	Monitoring of progress in development of CMHTs in line with recommendations of *A Vision for Change*	National ratio to target 39% of MHS staff employed in CMHTs 84 fully staffed multi-disciplinary teams with 1,092 staff WTE nationally	As above
3	Adults with Intellectual Disability CMHTs with full multi-disciplinary staffing by MHCA	As above	28 fully staffed multi-disciplinary teams with 424 staff WTEs nationally	As above
4	MHS for Older People CMHTs with full multi-disciplinary staffing by MHCA	As above	42 fully staffed multi-disciplinary teams with 508 staff WTEs nationally	As above
5	General Adult CMHTs with full multi-disciplinary staffing by MHCA	As above	84 fully staffed multi-disciplinary teams with 1,770 staff WTEs nationally	As above
6	Rehabilitation Services CMHTs with full multi-disciplinary staffing by MHCA	As above	41 fully staffed multi-disciplinary teams with 902 staff WTEs nationally	As above
7	Specialist CMHTs with full multi-disciplinary staffing by MHCA**	As above	44 fully staffed multi-disciplinary teams across 9 specialist MHS categories employing total of 810 staff WTEs nationally	As above
	MHS Staff Training			
8	No. of MHS professional staff trained in recovery principles	Incentivising application of recovery-model of mental health care to Irish MHS	Target 100% of MHS patient-contact staff to have received basic training in recovery principles	As above

** Based on AVfC recommended ratios of team provision and staffing relative to current (2006) population levels*
*** See Annex 2 for further details on indicators for human resources in specialist services*
Source: *Indecon*

—4.5.1 Rationale for indicator selection

The rationale underpinning the selection of the above indicators in the area of mental health services, human resources is summarised below:

1 Overall national ratio of staff in CMHT to total no. of mental health service staff – a headline/macro indicator at national level to facilitate monitoring of progress on reconfiguring human resource provision and, in particular, reducing the current over-staffing of inpatient services and under-resourcing of community teams. *A Vision for Change* implies that CMHTs should account for 39% of total menatl health services staffing;
2 No. of Child and Adolescent CMHTs with full multi-disciplinary staffing by MHCA: existing performance indicators for CAMHS monitored as part of the HSE's performance review report include indicators for the number of CAMHS teams but do not measure the staffing resources associated with these teams. This proposed KPI is designed to address this gap by tracking progress in relation to the development of CAMHS teams which have full multi-disciplinary staffing complements in line with the ratios recommended in *A Vision for Change*;
3 Adults with Intellectual Disability CMHTs with full multi-disciplinary staffing by MHCA: currently, no KPIs exist within ongoing HSE performance review reports which facilitate monitoring of progress on development of fully-staffed CMHTs catering for service users with an intellectual disability. This proposed KPI would facilitate ongoing monitoring of progress on this area relative to the recommended levels of community-based cover in *A Vision for Change*;
4 Mental Health Services for Older People CMHTs with full multi-disciplinary staffing by MHCA: a similar rationale to (2) and (3) above but focussing on the monitoring of progress on development and multi-disciplinary staffing of CMHTs for Older People, in line with *A Vision for Change*-recommended staffing ratios;
5 General Adult CMHTs with full multi-disciplinary staffing by MHCA: a similar rationale to (2) and (3) above but focussing on the monitoring of progress on development and multi-disciplinary staffing of General Adult CMHTs, in line with *A Vision for Change*-recommended staffing ratios;
6 Rehabilitation Services CMHTs with full multi-disciplinary staffing by MHCA: a similar rationale to (2) and (3) above but focussing on the monitoring of progress on development and multi-disciplinary staffing of CMHTs providing rehabilitative services, in line with *A Vision for Change*-recommended staffing ratios;
7 Specialist CMHTs with full multi-disciplinary staffing by MHCA: a range of additional KPIs have also been proposed (see Annex 2) in relation to the multi-disciplinary staffing of CMHTs dealing with specialist service areas such as Eating Disorder, Early Intervention, Liaison, Neuropsychiatry, Perinatal Psychiatry, Substance Misuse, Intensive Care Rehabilitation and Forensic/Forensic ID, in line with *A Vision for Change*-recommended staffing ratios; and
8 No. of mental health service professional staff trained in recovery principles: finally, given the focus of *A Vision for Change* on the development of service user-focused mental health service operating on the basis of a recovery model, Indecon believes it is important to ensure that mental health service practitioners are fully trained in the application of recovery-based principles. This proposed KPI is designed to monitor and incentivise the provision of a basic level of training in recovery principles, with an associated target to achieve 100% staff training coverage within a pre-defined timescale.

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4.6 Summary

This section examined human resources in the mental health services. It identified the requirements in relation to information provision and performance assessment in this area, based on the specific recommendations of *A Vision for Change*. It then examined the extent of existing information available and the use of performance indicators in mental health human resources. After presenting an overview of the findings from a review of international experience and best practice approaches, this chapter then developed a set of KPIs designed to facilitate monitoring of progress on the reconfiguration of staffing and the development of community-based mental health services.

The key findings from the review which inputted to the indicator selection were as follows:

- There is a need to introduce appropriate indicators to facilitate the monitoring of progress on implementation of *A Vision for Change* in relation to both overall manpower and the composition of staffing within the mental health services;
- Indecon believes that the central role of community-based provision within the context of implementation of *A Vision for Change* should be reflected in the consideration of appropriate performance monitoring indicators. This includes the need to monitor progress in relation to:
    - The overall development of community mental health teams and provision of full, multi-disciplinary staffing for these teams;
    - The composition of team development by service area; and
    - The regional and local distribution of CMHTs relative to population and need.
- There is a need to monitor progress in relation to reconfiguration of mental health staffing at both overall national and regional/catchment area levels;
- It is important that performance assessment in relation to mental health human resources include reference to developments in relation to education and training of mental health professionals;
- In relation to existing information and use of performance indicators:
    - There are gaps in relation to detailed data on staffing by skill mix at regional and catchment area level, including in relation to Mental Health Services for Older People, Rehabilitation and Specialist services;
    - There are gaps in relation to the specification of population levels in some catchment areas required to facilitate identification of appropriate levels of service provision; and
    - In relation to existing use of performance indicators, the development of Child and Adolescent CMHTs is monitored on an annual basis by the DoHC in its Annual Output Statement and by the HSE as part of its National Performance Indicator and Activity Suite and monthly performance reports.
- There is also a need to provide actual staffing data pertaining to the development of these Child and Adolescents CMHTs;
- There is a need for the HSE to provide regular data on the development of CMHTs in other areas of the mental health services; and
- There is also a need to develop suitable indicators which track the extent of training of mental health services staff.

5

Scope and Quality of Service Provision

Scope and Quality of Service Provision

5.1 Introduction

This section considers the important aspect of scope and quality of mental health services and develops a range of KPIs to facilitate ongoing monitoring in this area. The scope of service provision refers to the extent and range of services provided at national and local levels. Quality of service is distinguished from outcome (which is considered in the next section) on the basis that the former relates to the immediate results for the service user in terms of access to recovery-oriented, holistic, and least restrictive, locally provided services.

5.2 Information and Assessment Needs

Values and Principles of A Vision for Change

In assessing the scope and quality of delivery of mental health services it is instructive to consider the values and principles for mental health service provision enunciated in *A Vision for Change*. Among the values and principles espoused in the policy are the following:[71]

- "*Recovery*: A recovery approach to mental health should be adopted as a cornerstone of this policy;
- *Community Care*: that people with mental health problems should be cared for where they live and if inpatient care is necessary it is to be provided in the least restrictive setting;
- *Comprehensive*: A range of specialist mental health services should be available such as child and adolescent mental health services, adult mental health services, mental health services for older people and more. All specialist mental health services should provide the full range of interventions in a variety of suitable settings;
- *Quality*: Mental health services and the treatment and care offered in them should be of the highest standard; and
- *Accessibility*: Mental health services must be accessible to all who require them; this means not just geographically accessible but that services should be provided at a time and in a manner that means individuals can readily access the service they require."

71 *A Vision for Change* (2006), Op. Cit. Page 15

Quality Framework for Mental Health Services

The *Quality Framework - Mental Health Services in Ireland* was published by the Commission in 2007 in accordance with the key functions of the Commission (under the Mental Health Act 2001). This framework sets out the standards for mental health services in Ireland following a wide consultation process with service users, carers and service providers. It places the service user at the centre. The Quality Framework comprises of eight themes, 24 standards and 163 criteria. The eight themes are set out in the table below.

72 Mental Health Commission, Quality Framework - Mental Health Services in Ireland, 2007. See: http://www.mhcirl.ie/Publications/.

73 Ibid. Page 7..

Table 5.1 Themes within Quality Framework for Mental Health Services Territory Level

Theme No.	Description
1	Provision of a holistic seamless service and the full continuum of care provided by a multi-disciplinary team
2	Respectful, empathetic relationships are required between people using the mental health service and those providing them
3	An empowering approach to service delivery is beneficial to both people using the service and those providing it
4	A quality physical environment that promotes good health and upholds the security and safety of service users
5	Access to services
6	Family/ chosen advocate involvement and support
7	Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service
8	Systematic evaluation and review of mental health services underpinned by best practice, will enable providers to deliver quality services

Source: *Mental Health Commission (2007)*[72]

According to the Commission:

> "The quality framework for mental health services provides a mechanism for services to continuously improve the quality of mental health services. It promotes an empowering approach to service delivery, where services facilitate an individual's personal journey towards recovery."[73]

The Quality Framework is also closely aligned to the recommendations of *A Vision for Change*.

—5.2.1 Implications for performance assessment

The values and principles which govern *A Vision for Change* and the *Quality Framework for Mental Health Services* developed by the Mental Health Commission (MHC) provide a basis to inform the consideration of requirements for performance assessment in this domain. They signal the aspects of service provision that Indecon believes merit close consideration within the context of designing an appropriate system of performance measures that serve to both promote accountability and incentivise the successful transformation and ongoing operation of the mental health services in line with the model set out in *A Vision for Change*.

While there is likely to be a wide range of facets of scope and quality of service provision, the following specific aspects reflect what Indecon believes represent the key challenges facing the mental health services within the context of delivering the scope and quality of service envisaged by *A Vision for Change* and the Quality Framework developed by the MHC:

- The need to bring about a shift in service provision from historical over-reliance on acute and long-stay inpatient beds to a service which is based primarily on provision of interventions and supports in least restrictive and local community care settings;
- The requirement to maximise the application of 'recovery-oriented', patient-centred approaches to service provision;
- The need to expand the use of holistic mental health services;
- The need to ensure that the quality of acute and long-stay facilities complies with regulatory requirements;
- The requirement to provide disability access to all inpatient and community-based mental health service facilities; and
- The need to maximise the overall level of satisfaction with service provided on the part of service users and their families.

In developing KPIs for assessing the scope and quality of mental health service provision, Indecon believes that careful consideration should be given to selecting potential indicators which would facilitate the monitoring of progress in addressing the above challenges.

In terms of the information requirements to facilitate the development and implementation of performance indicators to address the above aspects, these would include the following:

- Data on the numbers of patients/service users in acute and long-stay inpatient units versus service users in community-based care;
- Data which facilitates the measurement of application of recovery-based approaches to patient care;
- Data which describes the extent of availability of a range of holistic therapies and supports. Examples of such services would include counselling, therapeutic and rehabilitative activities, family therapy and psychological therapy services;
- Information/data which enables the identification of referral patterns for acute inpatient admissions;
- Information regarding the quality standards achieved by inpatient facilities;
- Data regarding the extent of disability accessibility of mental health facilities; and
- Information in relation to satisfaction levels among service users.

With a view to developing an appropriate set of KPIs in the area of scope and quality of service provision, we first examine below the nature of information availability and the existing use of performance indicators in this area.

5.3 Review of Existing Information and Indicators

Based on a review of existing published sources, data/information pertaining to the scope and quality of mental health service provision is currently available from the following sources:

- Health Research Board - National Psychiatric Inpatient Reporting System – census of inpatient population;
- Health Research Board - National Psychiatric Inpatient Reporting System and the annual report on *Activities of Irish Psychiatric Units and Hospitals* (HRB Statistics Series No. 7);
- HSE, National Service Plan – National Performance Indicator and Activity Suite;
- HSE, Performance reports monthly;
- Mental Health Commission – Inspectorate of Mental Health Services – Approved Centres Inspection Reports;
- Value for money review of long-stay residential care for adults within the mental health services (the most recent profile of long-stay services); and
- Survey of service users and family members' experience of the services carried out by the National Service User Executive.

Selected data/information from the above sources is profiled below.

Health Research Board - National Psychiatric Inpatient Reporting System - census of inpatient population

The HRB administers the National Psychiatric Inpatient Reporting System (NPIRS), which records data on all admissions to, and discharges from, psychiatric inpatient facilities in Ireland annually. The NPIRS database also provides the basis for the decennial censuses of the inpatient population, the most recent of which was carried out in 2006.

Details of Irish psychiatric inpatient numbers are presented in the figure overleaf. The last census in 2006 indicated a total inpatient population of 3,389 persons. It is notable that the number of inpatients has been on a downward trend since the first census was undertaken in 1963.

Figure 5.1 National Psychiatric Inpatient Reporting System – Census of Inpatient Population

Table 2.1 Irish psychiatric in-patient numbers 1963 - 2006

Year	Number	Year	Number	Year	Number	Year	Number
1963	19,801	1974	15,156	1985	12,097	1996	5,212
1964	18,989	1975	14,967	1986	11,643	1997	4,817
1965	18,641	1976	14,473	1987	10,621	1998	4,820
1966	18,084	1977	14,352	1988	9,500	1999	4,469
1967	17,841	1978	13,968	1989	7,897	2000	4,230
1968	17,218	1979	13,838	1990	7,334	2001a	4,321
1969	16,802	1980	13,342	1991a	8,207	2002	3,891
1970	16,403	1981a	13,984	1992	6,130	2003	3,658
1971a	16,661	1982	13,428	1993	5,806	2004b	3,556
1972	15,856	1983	12,802	1994	5,581	2005c	3,475
1973	15,471	1984	12,484	1995	5,327	2006a	3,389

a MSRB/HRB Census completed on 31st March each year
b Mental Health Commission, 2005
c Mental Health Commission, 2006
Source: *HRB, Irish Psychiatric Units and Hospitals Census, 2006 bulletin*

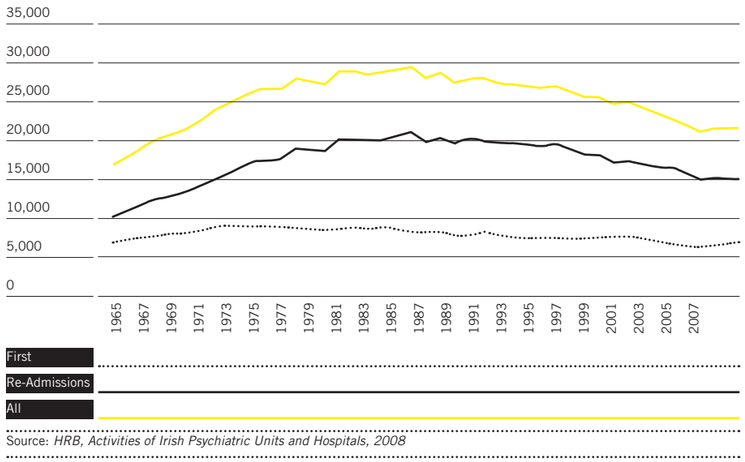
Health Research Board - Activities of Irish Psychiatric Units and Hospitals

The Health Research Board administers the National Psychiatric Inpatient Reporting System (NPIRS), which records data on all admissions to, and discharges from, psychiatric inpatient facilities in Ireland annually. This yields the annual report, *Activities of Irish Psychiatric Units and Hospitals*, which provides a detailed breakdown of activity in inpatient units.

The overall number of admissions to psychiatric hospitals is compared with the numbers of first-time admissions and the number of readmissions over the period 1965-2008 in the figure overleaf, based on data published in the *Activities of Irish Psychiatric Units and Hospitals*, 2008 report.

76 Ibid. Page 57.

Figure 5.2 Overall Number of Admissions and Number of First Admissions and Readmissions to Psychiatric Hospitals - 1965-2008



Source: *HRB, Activities of Irish Psychiatric Units and Hospitals, 2008*

There were 20,752 admissions to Irish psychiatric units and hospitals in 2008, a rate of 489.5 per 100,000 of total population. Readmissions accounted for 70% of all admissions in 2008, implying a small reduction compared with the rate in 2007 (72%). The readmission rate, while partly affected by the nature of serious mental illness, may indicate a poor quality of care, premature discharge or inadequate provision of community supports, if this rate is high within a relatively short period, i.e. readmissions occur within a short timeframe.

HSE, National Service Plan – National Performance Indicator and Activity Suite

The HSE's National Performance Indicator and Activity Suite includes a number of KPIs in relation to admissions activity levels and rates relative to population. These indicators, which are monitored on an annual basis, are profiled in the figure overleaf. They include a number of KPIs relating to acute inpatient admissions and rates. The indicator set does not currently include measures concerning the numbers of admissions or the numbers of service users in community-based facilities. Indecon believes this would be an important area for future monitoring in relation to assessing the balance between inpatient and community-based mental health service provision.

Figure 5.3 HSE, National Performance Indicator and Activity Suite - Annual Acute Inpatient Admission Indicators

Performance Activity/ Key Performance Indicator	Reported	Expected Activity/ Target 2009	Projected Outturn 2009	Expected Activity/ Target 2010
Admissions				
Total number of admissions to acute inpatient units (adults and children)	Monthly	15,905	15,718	15,702
No. of readmissions as a % of total admissions	Monthly	68%	11,274 (72%)	10,677 (68%)
Total no. of involuntary admissions	Monthly	1,372	1,372	1,372
Inpatient Services				
No. of inpatient places per 100,000 population	Quarterly	25.0	28.5	26.6
First admission rates to acute units (that is first ever admission), per 100,000 population	Quarterly	105.6	105.0	105.5
Inpatient readmission rates to acute units per 100,000 population	Quarterly	260.3	265.8	235.8
Median length of stay in inpatient facilities	Quarterly	12.0	11.4	10.5
Rate of involuntary admissions per 100,000 population	Quarterly	10.3	10.3	9.3

Source: HSE, National Service Plan, 2010

HSE, Performance reports (monthly)

As part of its monthly performance reports, the HSE monitors a number of indicators in the mental health services. As noted in previous chapters, these indicators currently focus on Child And Adolescent Mental Health Services.

The indicators and associated data published in the supplementary report to the HSE's October 2009 performance report are shown in the figure overleaf. In relation to indicators that measure quality of service provision, these include:

- No. of new child / adolescent referrals received by mental health services;
- No. of new child / adolescent referrals accepted by mental health services;
- Total number of child / adolescent patients seen by a member of the CAMH teams; and
- Total number of child / adolescent patients (wait to 1st appointment) seen by a member of the CAMH teams by HSE region, with separate indicators showing wait times of 0 to 1 month, 1 to 3 months, 3 to 6 months, 6 to 12 months and over 12 months.

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Figure 5.4 Quality of Service KPIs Monitored as part of HSE Performance Reports (Monthly)

Performance Activity	Outurn 08	Target 09	Target YTD	Actual YTD	% var YTD Actual v Target	Same period last year	% var YTD v YTD last year
Child & Adolescent Mental Health No. of Child & Adolescent Mental Health Teams (as outlined in *A Vision for Change*)							
	47	**55**	**55**	**55**	**0.0%**	**47**	**-17.0%**
South	11	13	13	12	-7.7%	11	-9.1%
West	11	13	13	12	-7.7%	11	-9.1%
DNE	10	12	12	11	-8.3%	10	-10.0%
DML	15	17	17	20	17.6%	15	-33.3%
No. of new child/ adolescent referrals received by Mental Health Services							
				1,118			
South				238			
West				290			
DNE				241			
DML				349			
No. of new child/ adolescent referrals accepted by Mental Health Services							
				803 (72%)			
South				150 (63%)			
West				230 (79%)			
DNE				164 (68%)			
DML				259 (74%)			
Total number of child/ adolescent patients seen by a member of the CAMH teams							
				784			
South				131			
West				191			
DNE				144			
DML				318			
Total number of child/ adolescent patients (wait to 1st appointment) seen by a member of the CAMH teams (wait time 0 to 1 month)							
				432			
South				55			
West				109			
DNE				49			
DML				219			
Total number of child/ adolescent patients (wait to 1st appointment) seen by a member of the CAMH teams (wait time 1 to 3 months)							
				148			
South				32			
West				32			
DNE				37			
DML				47			
Total number of child/ adolescent patients (wait to 1st appointment) seen by a member of the CAMH teams (wait time 3 to 6 months)							
				86			
South				10			
West				6			
DNE				40			
DML				30			
Total number of child/ adolescent patients (wait to 1st appointment) seen by a member of the CAMH teams (wait time 6 to 12 months)							
				54			
South				24			
West				7			
DNE				7			
DML				16			
Total number of child/ adolescent patients (wait to 1st appointment) seen by a member of the CAMH teams (wait time >12 months)							
				64			
South				10			
West				37			
DNE				11			
DML				6			

Source: *HSE, Supplementary PR Data – October 2009*

The above measures represent good indicators of service scope and availability and Indecon would be supportive of initiatives to extend such indicators to other service areas.These indicators do not, however, permit an assessment of the quality of service delivered.

Inspectorate of Mental Health Services – Approved Centres Inspection Reports

The Inspectorate of Mental Health Services is required by law[74] to visit and inspect every Approved Centre (i.e. approved in-patient facility) annually and may, as the Inspectorate thinks appropriate, visit and inspect any other premises where mental health services are being provided.

The functions of the Inspectorate include ascertaining the degree of compliance by approved centres with Codes of Practice prepared by the Commission under the Mental Health Act and to ascertain whether any regulations made under Section 66 of the Act (regulations in relation to approved centres) and any Rules made under Section 59 (providing for the use of ECT) and Section 69 (providing for the use of seclusion and mechanical means of bodily restraint) are being complied with. The Inspectorate submits its reports on all inspections to the MHC.

There are currently 66 centres approved by the Commission to operate as residential mental health facilities.[75]

An example of the outputs from one such approved centre inspection is presented in the figure below.

While the overall inspection report is comprised of a number of sections containing very detailed results pertaining to each section of the Mental Health Act (and relevant regulations, rules and codes of practice) falling within the inspectorate's remit, we present below the outcomes in relation to two aspects, namely the Quality of Care and Treatment (Part 1 of the inspection report), and Evidence of Compliance with Regulations, Rules and Codes of Practice (Part 2). This relates in particular to the development of individual care plans for service users.

Figure 5.5 Inspectorate of Mental Health Services- Example of Inspection Report Findings for an Approved Centre

Part 1: Quality of Care and Treatment

2. Multidisciplinary (MDT) care plans should be developed further to encourage inclusion of the resident's view and their active participation in their own care plan.

Outcome: A new MDT care plan had been developed in conjunction with peer advocates and was due to be introduced as a pilot in May 2009 in all wards.

Part 2: Evidence of Compliance with Regulations, Rules and Codes of Practice
Article 15: Individual Care Plan

Level of Compliance	Description	2008	2009
Fully Compliant	Evidence of full compliance with this Regulation	X	
Substantial compliance	Evidence of substantial compliance but improvement needed		
Compliance initiated	An attempt has been made to achieve compliance but significant progress is still needed		X
Compliance initiated	Service is unable to demonstrate structures or processes to be compliant with this regulation		
Not inspected	Inspection did not cover this Article		

Source: *Inspectorate of Mental Health Service, Approved Centres Inspection Reports, 2009*

74 Under Section 51(1)(a) of the Mental Health Act, 2001

75 See http://www.mhcirl.ie/Registration_of_Approved_Centres/List_of_Approved_Centres_05_01_10.pdf.

As each Approved Centre is inspected on an annual basis and comparative annual results are profiled in the inspection reports, this provides the most comprehensive current source of information concerning the degree of compliance with regulations, rules and codes of practice governing the relevant aspects of the mental health legislation within approved inpatient units. The inspections do not however cover all community-based facilities.

The MHC notes that:

> "Quality is a complex concept, but at its simplest, can be expressed as a comparison or measured degree of achievement against certain standards, against prior performance, or against others in a similar field."[76]

The degree of compliance with regulations, rules and codes of practice constitutes only one aspect of quality of care and, indeed, one that is based on minimal requirements rather than necessarily maximum attainable levels of service quality. Nevertheless, the information available from inspectorate's reports provides a measure of quality that is feasible to monitor on an ongoing basis.

Value for money review of long-stay residential care

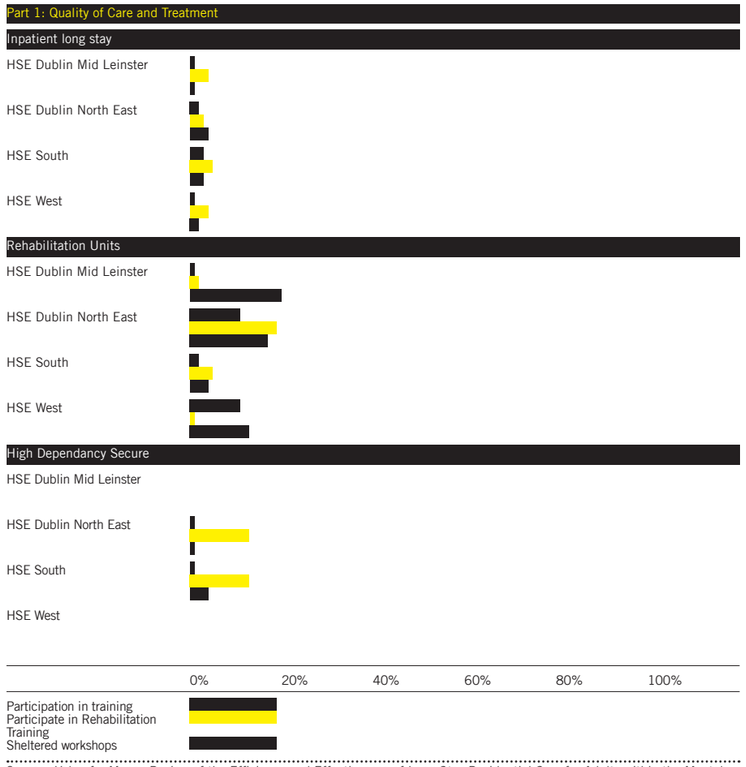
The value for money review of long-stay residential care for adults in the mental health services was based on a census of long-stay hospital and community residential services as at October 2007. This enabled a detailed profile of inpatients based on a number of characteristics including a number of indicators of quality of care, namely:

- % of service users in inpatient and community residences who participate in structured social activities;
- % of service users who participate in therapeutic activities;
- % of service users who participate in rehabilitative training;
- Accessibility to local services; and
- % of community residences with full disability access.

The figure overleaf presents an example of one of the above findings of the 2007 Census undertaken as part of the review, namely the proportion of service users in inpatient units who participated in therapeutic activities. This represents a good indicator of service scope and quality from the perspective of increasing the provision of recovery-oriented and holistic treatments.

76 Mental Health Commission, Annual Repot 2008, including the report of the Inspector of Mental Health Services. page 57

Figure 5.6 % of Service Users in Inpatient Units Who Participate in Therapeutic Activities



Source: *Value for Money Review of the Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services (2008)*

The highest rate of participation in therapeutic activities was evident in inpatient rehabilitation units whereas the participation rates in such activities were generally significantly below 10% in the majority of long-stay and high dependency secure inpatient units.

Given the need to monitor service provision to ensure that the scope and quality of services are aligned with the values and principles espoused in *A Vision or Change* and in the Quality Framework developed by the MHC, Indecon would be supportive of initiatives involving ongoing monitoring of selected measures which track the use of recovery-oriented and holistic service provision.

National Service User Executive Survey of Members on Vision for Change

In 2009, the National Service User Executive (NSUE) conducted its first survey on user satisfaction with the mental health services. NSUE was established in 2008 and its mission is to represent the interests of all service users and their families. The survey covered overall satisfaction with the services provided, views on improvement in the services, experiences of self-advocacy and priorities for change. The 2009 survey is intended as a baseline for future review and appraisal of service delivery. It is intended that the survey will be repeated annually.[77]

77 National Service User Executive, *Second Opinions: Summary Report of the NSUE Survey of Members on Vision for Change*. Blackrock, Co. Dublin, NSUE (2009).

—5.3.1 Conclusions from review of existing information and use of indicators

The key conclusions from the above review of existing information and use of performance indicators in relation to the scope and quality of mental health service provision are as follows:

- There is a need to develop an expanded set of indicators which are updated on an annual basis and which facilitate the monitoring of performance in relation to the scope and quality of mental health service provision. These indicators must, at a minimum, address the balance between inpatient and community-based care, and the extent of access to and provision of recovery-oriented, least restrictive and holistic approaches to mental health interventions;
- Detailed data is published on an annual basis by the HRB in relation to the activities of psychiatric hospitals and units. This includes data on a range of aspects of inpatient admissions activity;
- There is a need to provide more comprehensive published sources of information concerning the usage of community-based services;
- The HSE's National Service Plan includes a number of KPIs in relation to admissions activity levels and rates relative to population and in relation to Child and Adolescent Mental Health Services. It is necessary, however, to extend the existing suite of indicators to include additional indicators which facilitate the description and monitoring of performance in relation to other areas of the mental health service, including General Adult, Intellectual Disability and Older People Mental Health Services, rehabilitative services and other specialist services;
- The information available from the Inspectorate of Mental Health Services annual reports provides a measure of the quality of care provided in inpatient units – based on the extent of compliance with legislative-based rules, regulations and codes of practice – that is feasible to monitor on an ongoing basis;
- Indecon would be supportive of initiatives involving ongoing monitoring of selected measures which track the use of recovery-oriented and holistic service provision, such as the extent of participation of inpatients in and satisfaction with therapeutic activities and rehabilitative training;
- Annual inspections of mental health facilities should include monitoring of the extent of provision of access for people with disabilities; and
- The first national survey of mental health service users' experiences of services is a welcome initiative.There is a need to further develop measures of satisfaction with the services on the part of service users and their families.

5.4 International Experience and Best Practice

In Australia, the government's National Mental Health Plan includes a number of outcome indicators pertaining to quality improvement in the mental health services. These indicators are shown in the figure overleaf.

78 Department of Health, *Implementing the NHS Performance Framework: Application to Mental Health Trusts*. London, Department of Health (November, 2009)

79 Ibid.

80 Healthcare Commission, *National NHS Patient Survey Programme: Survey of Users of Community Mental Health Services*, available at http://www.cqc.org.uk/_db/_documents/Full_2008_results_with_historical_comparisons.pdf

Figure 5.7 International Best Practice – Indicators of Mental Health Service Quality Improvement and Innovation Proposed in Australian National Mental Health Plan 2009-2014

Priority area 4: Quality improvement and innovation
Outcome
The community will have access to information on service delivery and outcomes on a regional basis. This will include reporting against agreed standards of care including consumer and carer experiences and perceptions. Mental health legislation will meet agreed principles and, in conjunction with any related legislation, be able to support appropriate transfer of civil and forensic patients between jurisdictions. There will be explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.
Indicators for which data is currently available
• Proportion of total mental health workforce accounted for by consumer and carer workers • Proportion of services reaching threshold standards of accreditation under the *National Mental Health Standards* • Mental health outcomes for people who receive treatment from state and territory services and the private hospital system
Indicators requiring further development
• Proportion of consumers and carers with positive experiences of service delivery

Source: *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009-2014. Commonwealth of Australia, 2009*

In the UK, the NHS Performance Framework provides the current basis for monitoring and assessing mental health service performance.The framework is related to contractual agreements with mental health service providers:

> "The NHS Performance Framework sits alongside the expected performance monitoring linked to the Standard National Contract by which PCTs hold provider organisations to account. The submission of information to support the Performance Framework is mandated in the Standard National Contract for trusts."[78]

The framework encompasses the performance domains of finance, service performance, quality and safety, and user experience. It is underpinned by a set of indicators and a scoring system that determines performance thresholds. The indicators are:

1 "Proportion of adults on Care Programme Approach receiving secondary mental health services in settled accommodation;
2 Proportion of adults on Care Programme Approach receiving secondary mental health services in employment;
3 The proportion of those patients on Care Programme Approach discharged from inpatient care who are followed up within 7 days;
4 The proportion of those on Care Programme Approach reviewed in at least the last 12 months (formal/informal/community);
5 The proportion of users on new Care Programme Approach who have had a HoNOS assessment in last 12 months;
6 Proportion of patients who had recorded incidents of physical assault to them;
7 The number of episodes of absence without leave (AWOL) for the number of patients detained under the Mental Health Act 1983;
8 The number of new cases of psychosis served by early intervention teams per year against contract plan;
9 The number of admissions to the trust's acute wards that were gate kept by the crisis resolution home treatment teams;
10 Provision of comprehensive CAMHS;
The number of admissions to adult facilities of patients who are <16 years of age;
12 Delayed transfers of care to be maintained at a minimum level;
13 Data quality on ethnic group; and
14 Data completeness of the MHMDS."[79]

78 Department of Health, *Implementing the NHS Performance Framework: Application to Mental Health Trusts.* London, Department of Health (November, 2009)

79 Ibid.

It is noteworthy that the service performance indicators address the scope of service provision (e.g. comprehensive Child and Adolescent Mental Health Services; access to Early Intervention and Crisis Resolution Services), its quality (follow-up and review of individual care programmes) as well as outcomes for service users (indicators on employment and housing status of service users).

England also has a well-tested mechanism for assessing user satisfaction with the mental health services. The Healthcare Commission has conducted user satisfaction surveys on community-based mental health services since 2004. Similar to the Irish survey, the English survey explores questions about being adequately listened to and treated with respect and dignity as well as whether the person felt their views were taken into account with regard to treatment. However, it is much more detailed than the initial Irish survey; it breaks down responses for different types of health professionals; goes into greater depth in its questions about the person's involvement in their care plan and receipt of information; includes questions about the experience of involuntary detention, and covers a number of other areas.[80] The English survey will be carried out in future by the Care Quality Commission.

5.5 Proposed Key Performance Indicators

Based on the assessment of performance monitoring needs, a review of existing information and use of indicators, and a review of international approaches, we have developed a short list of potential KPIs to support ongoing assessment of the scope and quality of mental health service provision. These indicators are presented below.

Table 5.2 Proposed Key Performance Indicators – Indicators of Scope and Quality of Mental Health Service Provision

	Indicator No. and Description	KPI Objective	Indicator Target Setting	Indicator Data Frequency and Method of Collection
	Development of Community-based MHS			
1	First-time admission rate per 100,000 population	Incentivise shift in service provision to least restrictive community care settings	Reduce ratio to align with best practice benchmarks internationally within a pre-defined timescale	(Data already collected by HSE and reported annually by HRB)
2	% of service users in receipt of an individual care and recovery plan	Incentivise application of a 'recovery' approach to MHS provision in line with MHC Quality Framework Standard 1.1	Target to have all MHS service users to be in receipt of individual care and recovery programme within a pre-defined timescale	Annual data via NMD/WISDOM database
3	% of acute inpatient admissions referred via local CMHT crisis service	Incentivise provision of least-restrictive, accessible, local MHS and reduce likelihood of patients being inappropriately admitted to acute facilities	Target to increase % of referred admissions and usage of community services as primary referral point over a pre-defined timescale	Annual data via NMD/WISDOM database
4	No of GP referrals to adult CMHTs by mental health catchment area	Monitor extent to which service users are being referred to community-based services as primary channel of care	Target to increase % of GP referrals to community-based care within a pre-defined timescale	Annual data via NMD/WISDOM database
5	% of service users offered a psychological therapy	Incentivise development of Holistic MHS	Target to make available some form of counselling, family or psychological therapy service available through all CMHTs within a pre-defined timescale	Annual data via NMD/WISDOM database
6	No. Of Involuntary Committals per 100,000 of Population	Incentivise minimisation of involuntary committals and un-necessary detention, and incentivisation of appropriate treatment	Target to reduce involuntary committal rate to align with best practice benchmarks internationally	Annual rate monitored via Mental Health Commission annual reports
7	% of service users rating MHS provision good or better	As above	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey
8	% of service users' families rating MHS provision good or better	As above	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey
9	% of Approved Inpatient Units fully compliant with the Mental Health Act 2001 and Rules, Regulations and Codes of Practice issued thereunder	Ensuring quality of acute and long-stay MHS facilities complies with regulatory requirements	100% of approved centres to be fully compliant within a pre-defined timescale	Annual inspections by Inspectorate of Mental Health Services

Source: *Indecon*

80 Healthcare Commission, *National NHS Patient Survey Programme: Survey of Users of Community Mental Health Services*, available at http://www.cqc.org.uk/_db/_documents/Full_2008_results_with_historical_comparisons.pdf

—5.5.1 Rationale for indicator selection

The rationale underpinning the selection of the proposed indicators focussing on the scope and quality of service provision is set out for each indicator below:

1 First-time admission rate per 100,000 of population: If services are being provided in the community, and particularly via crisis intervention and home-based services, as well as prevention, one would expect a reduction in the rate of first-time admissions to inpatient facilities relative to the population. In addition, this indicator is currently among the KPIs monitored on an ongoing basis by the HSE;

2 % of patients in receipt of an individual care and recovery programme incorporating a self-management plan: building on the work of the MHC and, in particular, the Quality Framework for Mental Health Services, the rationale for inclusion of this KPI is to assist in incentivising the application of a recovery-based approach to mental health service intervention. Specifically, this indicator would facilitate the monitoring of progress on the extent to which service users are provided with an individualised care and recovery plan in line with standard 1.1 of the Quality Framework, i.e. "that describes the levels of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multidisciplinary team." An associated target to have all service users to be in receipt of an individualised care/recovery plan within a pre-defined timescale would incentivise the roll-out of this specific quality of service goal;

3 % of acute inpatient admissions referred via local CMHT crisis service: this proposed KPI is designed to monitor progress on, and incentivise, the development of a mental health service which operates on the basis of provision of least-restrictive, accessible, local services, and reduce the likelihood of patients being inappropriately admitted to acute facilities. A local crisis service would be designed to address specific issues faced by service users and act as a bridge to other treatment programmes. This indicator would assist in monitoring progress on the development of such facilities over a pre-defined timescale and would track extent to which admissions are referred primarily through community services;

4 No of GP referrals to adult CMHTs by mental health catchment area: this KPI would facilitate monitoring of the extent to which (adult) service users are being referred via their GP to community-based services and is designed to incentivise an increase in the utilisation of community-based rather than inpatient-based care over time;

5 % of service users offered a psychological therapy: to incentivise the development of holistic mental health service, the inclusion of an indicator which monitors the extent to which service users are offered a psychological therapy provides one useful measure of progress in this important area. An appropriate target would entail ensuring availability of some form of holistic counselling, family or psychological therapy service available in all CMHTs within a pre-defined timescale;

6 Number of Involuntary Committals per 100,000 of Population: a commonly used indicator internationally, the purpose of this proposed KPI would be to incentivise the minimisation of involuntary committals and unnecessary detentions, particularly in the long-stay sector, and to incentivise the application of appropriate, recovery-based treatment for service users. An associated target would aim to measure whether the involuntary committal rate is in line with international best practice;

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7 % of service users rating mental health service provision as good or better: ultimately, a service-user focussed mental health service must reflect the experience of users and their satisfaction with the scope and quality of services they have accessed. One commonly used measure internationally is to monitor on an ongoing basis the levels of satisfaction among service users with mental health service provision. This would be undertaken via an annual survey which would track service users' experience across a number of aspects and measure their satisfaction on an appropriate scale;

8 % of service users' families rating the mental health service provision as good or better: similar to indicator (6) above, but in this case focussed on service users' families. Given the likelihood that families also come in close contact with the mental health service, this provides a second input on satisfaction with quality of service provision;

9 % of Approved Inpatient Units fully compliant with the Mental Health Act 2001 and Rules, Regulations and Codes of Practice issued thereunder: the Inspectorate of Mental Health Services undertakes annual inspections of approved inpatient facilities to ensure compliance with the Mental Health Act 2001 and related rules, regulations and codes of practice. Inclusion of a KPI which tracks the proportion of approved facilities that are compliant and targets to achieve 100% compliance within a pre-defined timescale would assist in incentivising and enhancing the quality of facilities and services provided in these centres; and

5.6 Summary

This chapter considered the important aspect of scope and quality of service provision. Quality of service is distinguished from outcome (which is considered in the next chapter) on the basis that the former relates to the immediate results for the service user in terms of access to recovery-oriented, holistic, and least restrictive, locally provided services.

The key findings from the review which inputted to the indicator selection were as follows:

- In developing key performance indicators for assessing the scope and quality of mental health service provision, Indecon believes that careful consideration should be given to the need to facilitate the monitoring of progress in addressing the following challenges:
    - The need to bring about a shift in service provision from historical over-reliance on acute and long-stay inpatient beds to a service which is based primarily on provision of interventions and supports in least restrictive and local community care settings;
    - The requirement to maximise the application of 'recovery-oriented', patient-centred approaches to service provision;
    - The need to expand the use of holistic mental health services;
    - The requirement to reduce the likelihood of patients being inappropriately admitted to acute and long-stay facilities;
    - The need to ensure that the quality of acute and long-stay facilities complies with regulatory requirements;
    - The requirement to provide disability access to all inpatient and community-based mental health service facilities; and
    - The need to maximise the overall level of satisfaction with service provided on the part of service users and their families.
- The HRB publishes data on an annual basis in relation to the activities of psychiatric hospitals and inpatient units in addition to a periodic census of the inpatient population;
- The HSE's National Service Plan includes a number of KPIs in relation to admissions activity levels and rates relative to population and in relation to child and adolescent mental health services. It is necessary, however, to extend the existing suite of indicators to include additional indicators which facilitate the description and monitoring of performance in relation to other areas of the mental health service, including General Adult, Older People and Intellectual Disability Mental Health Services, rehabilitative services and other specialist services;
- The information available from the Inspectorate of Mental Health Services' annual reports provides a measure of the quality of care provided in inpatient units – based on the extent of compliance with legislative-based rules, regulations and codes of practice – that is feasible to monitor on an ongoing basis;
- Indecon would be supportive of initiatives involving ongoing monitoring of selected measures which track the use of recovery-oriented and holistic service provision, such as the extent of and user satisfaction with participation of inpatients in therapeutic activities and rehabilitative training;
- Annual inspections of mental health facilities should include monitoring of the extent of provision of access for the disabled; and
- There is a need to further develop measures of satisfaction with the services on the part of service users and their families.

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6

Outcomes from Mental Health Intervention

Outcomes from Mental Health Intervention

6.1 Introduction

While considered by many practitioners internationally to be the most important indicator category, the development of appropriate outcome-based indicators designed to capture the overall effectiveness of mental health interventions is regarded as the most complex and challenging area of performance measurement.

This chapter presents a preliminary examination of outcome indicators of mental health service intervention. Particular focus is given to the evidence from international experience and approaches applied in this challenging area of performance assessment. Based on this review, a preliminary set of KPIs is developed which reflect the particular features and challenges faced by the Irish mental health services in delivering effective outcomes for service users.

6.2 International Experience and Best Practice

—6.2.1 WHO guidance

The World Health Organisation (WHO's) guidance on quality improvement in mental health considered the important issue of intervention outcomes.[81] In relation to the application of monitoring and performance indicators in this area, the WHO noted that "outcome indicators can be used to measure standards related to the positive impact of interventions". This includes:

- Clinician assessments of outcome in outpatient settings;
- Clinician assessments of outcome at discharge from inpatient settings;
- Satisfaction of people with mental disorders; and
- Satisfaction of family members or other carers.

The WHO's guidance also references Rosenblatt et al (1998)[82] who identified four major categories of outcome measures in mental health, namely:

- *Clinical status outcome*s focus on impairment in both psychological and physical status. Measures of clinical status are defined as processes that document and assess the physical, emotional, cognitive and behavioural signs and symptoms related to a disorder;
- *Functional status outcomes* are related to the ability to fulfil effective social and role-related functions. Examples of functional outcomes are the ability to work, attend school, live independently and maintain positive and life-enhancing relationships;
- *Life satisfaction and fulfilment outcomes* include quality of life and well-being measures and are related to self-esteem, hope, empowerment and recovery; and
- *Welfare and safety outcomes* include suicide, substance abuse, involvement with the criminal justice system, victimisation and homelessness.

81 World Health Organisation, *Mental Health Policy and Service Guidance Package, Quality Improvement for Mental Health*, 2003.

82 Rosenblatt A, et al. (1998), *Managing what you measure: creating outcome-driven systems of care for youth with serious emotional disturbances.* Journal of Behavioral Health Services Research 25:177-93.

—6.2.2 United States

Ohio Mental Health Consumer Outcomes Initiative

The Ohio Mental Health Consumer Outcomes System is a state-wide approach to measuring consumer outcomes in Ohio's mental health system. A set of surveys measure how consumers are faring over time in the areas of symptom distress, functioning, quality of life, safety and health.[83]

The Consumer Outcomes System is an ongoing project with the objective of developing outcome measures for mental health service users/consumers served by Ohio's public mental health system.

The Ohio Mental Health Outcomes Task Force (OTF), convened in 1996 by the Ohio Department of Mental Health (ODMH), created the Outcomes System. Throughout the development process, the OTF emphasised the values of recovery/resiliency for consumers and families members.

The Consumer Outcomes System has three main purposes:

1 Assist consumers and clinicians in developing goals and measuring progress using the consumer's individual Outcomes scores;
2 Promote quality improvement at the agency, board and state level using aggregate consumer Outcomes scores; and
3 Demonstrate accountability of the public mental health system for tax dollars expended.

There are four domains assessed within the consumer outcomes system, namely:

- Clinical status;
- Quality of life;
- Functional status; and
- Safety and health.

83 For a description of the Ohio Mental Health Consumer Outcomes System see the Outcome Overview at: http://www.mh.state.oh.us/what-we-do/protect-and-monitor/consumer-outcomes/index.shtml

According to the Ohio system overview, the Outcomes System was developed to address the following values and assumptions:

Recovery philosophy drives service provision;
- System, providers and consumers share responsibility for environment of
- hope and for service planning;
Services driven by consumer-identified needs and preferences;
- Accurate information needed for continuous improvement of consumers'
- outcomes and for accountability;
Methodologically sound and cost-effective outcomes measurement;
- Balance between improved information and reasonable implementation;
- A common set of desired outcomes is required for consistent state-wide
- measurement ("state-wideness");
Ability to benchmark at both local and state levels is a critical component of
- the use of outcomes data for all stakeholders;
Without a standard set of measurements to capture outcomes, comparability
- across settings would be impossible to achieve (one-of-a-kind programs within counties can be compared with like programs in other counties);
Outcomes data should be used with other data for continuous quality
- improvement;
Outcomes findings are indicators requiring further exploration and planning;
- All stakeholders should be able to use the Outcomes findings;
- Outcomes should be measured primarily from consumer perspective;
- Measures should complement the clinical judgment of practitioners; and
- Incremental and innovative addition to Ohio's mental health system
- improvement.

The figure overleaf sets out the domains and outcomes for consumer monitoring in the Ohio system. The process of identifying the domains and measures used in Ohio had significant input from consumers and families.

The figure overleaf provides a more detailed schematic identifying what the

Figure 6.1 Domains and Service User Outcomes applied in Ohio Mental Health Consumer Outcomes System

Clinical Status
1. Level of symptom distress
2. Number of psychiatric emergencies
3. Ability to understand, recognize and manage/seek help for symptoms both physical and psychiatric.
Quality of Life
1. Satisfaction with areas of life including family relationships, social involvement, financial resources, physical health, control over life and choices, individual safety, participation in community living, life situation, productive activity, and overall satisfaction with life.
2. Feeling a sense of overall fulfilment, purpose in life, hope for the future, and personal empowerment.
3. Attainment of personal goals related to culture, spirituality, sexuality, individuality, developmental stage and liberty.
Functional Status
1. Identifying, accessing, and using community resources to fulfil needs, such as spiritual, social, cultural, recreational, etc. by participation in organizations which are not primarily mental health organizations.
2. Developing and managing interpersonal relationship
3. Managing money.
4. Managing personal hygiene and appearance, utilizing skills such as use of public transportation, phone books, grocery store, laundromats, etc. to maintain oneself as independently as necessary, and maintaining a home environment in a safe, healthy and manageable fashion.
5. Advocating successfully for self with mental health professionals, landlords, families, public safety personnel.
7. Engaging in meaningful activity, e.g., work, school, volunteer activity, leisure activity.
8. Abiding by the law sufficiently to avoid incarceration.
Safety and Health
1. Does not want to or does not harm self.
2. Does not want to or does not die from suicide.
3. Does not want to or does not harm others.
4. Free from physical and psychological harm or neglect in the individual's social environment to include home, school, work and service settings.
5. Person is physically healthy.
6. Treatment effects, including medication, are more positive than negative.
7. Safety and health is not threatened due to disabilities, being treated with lack of dignity or discrimination in response to lifestyle or cultural differences.
8. Person terminates services safely.
9. Person who receives little or no service has secure sense that they can obtain more/additional services in a timely manner.

Source: *Ohio Mental Health Consumer Outcomes System – Outcomes Review*

Ohio system measures for both adults and youths, and how the framework is administered.

—6.2.3 Canada

Figure 6.2 Ohio Outcomes System – Details of Outcomes Measured for Adults and Youths

Ohio Scales for Adults		Ohio Scales for Youth		
Adult Form Completed by Consumer	Staff Form Completed by Service Provider	Youth Form Completed by Youth Ages 12-18	Parent Form Completed by Parent or Guardian for Youth Ages 5-18	Worker Form Completed by Service Provider for Youth Ages 5-18
What is Measured				
Overall Quality of Life * -Quality of Life -Financial Status **Safety and Health** **Symptom Distress** * **Overall Empowerment*** -Self-Esteem/ Self-Efficacy -Power/ Powerlessness -Community Activism and Autonomy -Optimism and Control over the Future -Righteous Anger	**Functional Status** -Social Contact -Social Interaction -Social Support -Housing Stability -Forced Moves -Activities of Daily Living -Meaningful Activities -Primary Role -Addictive Behaviours -Criminal Justice -Aggressive Behaviour **Community Functioning** * **Safety and Health**	**Problem Severity** * **Functioning*** **Hopefulness About Life or Overall Well-Being** **Satisfaction with Behavioural Health Services**	**Problem Severity** * **Functioning*** **Hopefulness About Caring for the Identified Youth** **Satisfaction with Behavioural Health Services**	**Problem Severity** * **Functioning*** **Restrictiveness of Living Environment Scales (ROLES)**
Administered				
Initial: At admission into one of the target services **Second:** At six months after admission **Third:** At twelve months after admission **Ongoing:** Annually thereafter **At Termination:** Administer if Outcomes-qualifying services have occurred on three or more separate days since previous administration		**Initial:** At admission into one of the target services **Second:** At three months after admission **Third:** At six months after admission **Fourth:** At twelve months after admission **Ongoing:** Annually thereafter **At Termination:** Administer if Outcomes-qualifying services have occurred on three or more separate days since previous administration		

* Outcomes followed by an asterisk are incorporated into Ohio's SOQIC Standardised Documentation initiative forms.

Source: *Ohio Mental Health Consumer Outcomes System – Outcomes Review*

Resource kit on accountability and performance indicators for mental health services

McEwan and Goldner's (2001) resource kit on accountability and performance indicators for mental health services and supports, developed for federal/provincial/territorial advisory network on mental health in Canada devoted a section to "client outcomes". In this, the authors consider the quality of life dimension to mental health service client outcomes.

Notably, reference is made to the Canadian Mental Health Association's consideration of the concept of accountability, as follows:

> "The most fundamental issue, though, is that system, program, or individual supports should improve the consumer's quality of life, as defined by him or her. This is the touchstone of any real notion of accountability."[84]

As part of the resource kit, the authors developed a comprehensive suite of "suggested performance indicators." These indicators were classified under the eight domains of health system performance referred to previously in Section 1. Under the domain 'effectiveness' the authors proposed ten indicators designed to capture the outcomes from mental health service interventions. These indicators, in addition to their management and application, are listed in the figure overleaf.

A number of individual measures are proposed under each indicator heading

84 Canadian Mental Health Association. (1995). *The elements of accountability. New Directions for Mental Health*, Technical Paper. Vancouver: CMHA, BC Division

Figure 6.3 Outcome Indicators of Mental Health System Effectiveness

Indicator	Indicator type (Input, process, outcome)	Level of Measurement (system, program, client)	Utility Context (policy, program, clinical)
12.6.1 Community Tenure	outcome	system, program	program, clinical
12.6.2 Mortality	outcome	system	policy
12.6.3 Criminal Justice System Involvement	outcome	system	policy
12.6.4 Clinical Status	outcome	program, client	clinical
12.6.5 Functional Status	outcome	program, client	clinical
12.6.6 Employment Status	outcome	program, client	clinical
12.6.7 Housing status	outcome	program, client	clinical
12.6.8 Financial status	outcome	program, client	clinical
12.6.9 Quality of Life	outcome	program, client	clinical
12.6.10 Patients not diagnosed	process	program	policy, program, clinical

Source: *McEwan and Goldner (2001)*

and the authors provide a rationale for the indicator selection in each case.

System-level performance assessment in Alberta

Arising from the Provincial Mental Health Plan for Alberta, in 2007 the Alberta Mental Health Board developed a system–level performance assessment framework for mental health. The Board published a report on the outputs from this exercise in June 2008 [85] which represented the first attempt to collaboratively and comprehensively measure the effectiveness of Alberta's mental health system.

As part of this exercise, at least one measure was chosen for each of the six quality domains. According to the Board:

> "By including a single measure for each domain, at minimum, a degree of balance was accomplished: The report focuses on a wide range of perspectives related to overall quality. At the same time, limiting each domain to a maximum of two measures ensured there was a balance in the corresponding workload of those tasked with collecting, reporting and analysing the necessary information. A consensus-based process was adopted to choose the final measure(s) from the menu of those available in the framework. Two of the criteria used to determine inclusion in the report were how well each measure contributed to the definition of the domain and whether information existed or could be produced within the report creation period."[86]

Subsequently, the Board adopted a framework of indicators which it published in 2007. [87]

The measures and indicators that fall within the domain headed 'effectiveness' in the Alberta framework are set out in the figure below. Notably, each indicator has an associated target, with timeframes also attached to some of these indicators.

85 *System Level Performance for Mental Health in Alberta*, Alberta Mental Health Board, June 2008. See: http://www.amhb.ab.ca/Initiatives/statistics/Pages/ReportsandPublications.aspx#performancemonitoring.

86 Ibid. Pages 1-2.

87 Alberta Mental Health Board, *Performance Monitoring Framework for Alberta's Mental Health System,* 2007. See: http://www.amhb.ab.ca/Initiatives/statistics/Documents/Performance%20M

Figure 6.4 Performance Monitoring Framework for Alberta's Mental Health System – Measures and Indicators Proposed under 'Effectiveness' Domain

Objective	Measures	Indicators	Initial Targets
1. There is an increased public confidence in the mental health system.	- # of Albertans who indicate confidence in the mental health system	- Results of survey(s)	- Report baseline
2. Suicidal behaviour/suicides: There is a decrease in suicidal behaviour throughout Alberta.	- Rates of suicidal behaviours per 100,000 - Rate of Emergency Room visits for self harm per 100,000 (component of overall suicidal behaviour rate). - Rate of Hospitalisations for self harm per 100,000 (component of overall suicidal behaviour rate).	- ER reporting (Ambulatory Care Classification System – ACCS) - Hospital Reporting (Discharge Abstracts)	- 10% reduction in rate of suicidal behaviour over 3 years - 10% reduction over 3 years - 10% reduction over 3 years
- Suicides in Alberta are prevented or minimised. (See 'Health Status' section of this document.)	- # and % of Alberta Suicide Prevention Strategy goals that are implemented. - Suicide rates per 100,000.	- Regional Action Plan(s) - Vital Statistics reports	- Report baseline
- Potential Years of Life Lost (PYLL) are reduced.	- PYLL (Potential Years of Life Lost) rates per 100,000.	- Vital Statistics reports	- Report baseline
3. Clinical Effectiveness: Clients receive effective services that meet expected treatment goals.	- # and % of clients that meet expected clinical improvement (outcome) goals of program. Sub-measures: - # and % of acute care clients that show a decrease in symptoms post treatment. - # and % of rehabilitation clients that show improved quality of life. - # and % of clients that show an improved or maintained level of functioning.	- Pre/ Post symptom measurement scales, e.g. Global Assessment of Functioning (GAF), Axis V diagnosis results. - Quality of Life Scale Results. - GAF Axis V diagnosis results. - Pre/ Post Level of Functioning scales.	- 80% of clients demonstrate effective results of clinical treatment (Target subject to revision based on review of baseline results) - Report baseline - Report baseline
4. Mental health clients have their co-morbid (addictions and development disabilities) services co-located and integrated.	- # and % of addictions, and - # and % of developmental disability services that are co-located and integrated with mental health services (same location).		- ~75% of services to be co-located and collaborative
	- % of mental health clients that are screened for addictions and developmental disabilities.	- Screening results	- Report baseline (100% of new clients)

Source: *Alberta Mental Health Board, Performance Monitoring Framework for Alberta's Mental Health System, 2007*[88]

—6.2.4 United Kingdom

Patient-Reported Outcomes Measurement

In the UK, the Health of the Nation Outcome Scales (HoNOS), developed from 1993-1996, is the basis for its mental health outcomes indicators. The HoNOS addresses 12 domains that cover behaviour, cognition, physical health, mental health symptoms, social relations, general functioning, housing and other activities.[89] Completion of the HoNOS for each service user is an indicator in the NHS Performance Framework for Mental Health Trusts discussed above.

More recently, the UK has been engaged in developing outcome measures based on patient experience. The UK's National Health Service (NHS) has as a central feature the provision of choice to patients over treatment and care. Patients' experience of treatment and care is a major indicator of quality. There has been a huge expansion in the development and application of questionnaires, interview schedules and rating scales that measure states of health and illness from the patient's perspective.

Patient-reported outcome measures (PROMs) are a mechanism through which information can be collected in relation to how service users/patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. PROMs questionnaires can be completed by a patient or individual about themselves, or by others on their behalf.

In the UK, PROMs have been utilised in the context of a range of

88 Ibid. Pages 8-9

89 Wing, J.K., A.S. Beevor, R.H. Curtis, S.B.G. Park, S. Hadden and A. Burns, *Health of the Nation Outcome Scales (HoNOS).* British Journal of Psychiatry 172:11-18 (1998).

applications. These have included PROMs which are developed for use in clinical trials and economic evaluation of health care programmes. In addition, some measures have been applied to assist health professionals in assessing and caring for individual patients. In a wider context, PROMs have been proposed for assessing the health care needs of populations.

The NHS's Next Stage Review final report on quality of care on the health services highlighted the potential for increased application of PROMs as a measure of the effectiveness of care from the patients' perspective and it is likely that PROMs will become more widespread in the health system in the UK.

The Department of Health has also been examining the potential to apply PROMS to the assessment of effectiveness of care in relation to Long-Term Conditions (LTCs). In a report published in August 2009, the Department, in association with Oxford University, examined the scope to pilot the use of PROMs for LTCs.[90]

The review provided a useful description of PROMs, as follows:

> "PROMs are measures of an individual's health-related Quality of Life. They are short, self-completed questionnaires, which measure health-related Quality of Life at a single point in time, using items that have been validated as being of importance to patients themselves. Strictly speaking, Patient-reported outcomes are changes in reported health-related Quality of Life over time, assessed through collection of PROMs at (at least) two points in time. Once other influences such as age or co-morbidities have been controlled for, the "outcome" may be attributed to the care that the individual has received over this period."[91]

As part of the examination, the review considered the potential application of PROMs to mental health services. It stated however that:

> "It is not proposed that mental health conditions will form part of the pilot study although there is scope to add it at a later date should the evidence support it. The Department of Health has done some scoping work on the evidence for PROMs in mental health and the area is very complex. The initial findings were that there was little consensus over what outcomes to measure, making it difficult to design a feasible national programme. Hence dimensions of mental health will not be included in this pilot. The Department of Health is looking again at the issues (specifically for depression and schizophrenia) within the research and development programme for PROMs. We are also exploring the possibility of putting together an expert group to discuss the various issues and move the PROMs in mental health agenda forward."[92]

This is a rapidly evolving area. Indecon understands that the NHS is currently piloting PROMs in relation to assessing patient outcomes in other areas of health service provision. The increased emphasis being placed in patient-centred care is likely to mean that further developments will emerge in the coming years in relation to the application of PROMs in the context of mental health services.

90 Department of Health and Oxford University, *Piloting Patient Reported Outcome Measures (PROMs) for Long-term Conditions (LTCs)*, August 2009. See: http://www.commissioningdevelopmentprogramme.co.uk/CommissioningQuality/Documents/QandAPilotingPROMsforLTCsAugust2009update.doc#_Toc237658711.

91 Ibid. Page 2.

92 Ibid. Pages 4-5.

Scotland

Another notable development in the UK in the area of outcomes from mental health service intervention has been the work undertaken by the Scottish Recovery Network (SRN). The SRN was formally launched in 2004 as an initiative designed to raise awareness of recovery from mental health problems.

A particular outcome of the SRN's work has been the development of the Scottish Recovery Indicator (SRI). The SRI is a mental health service development tool which was "designed to help mental health services ensure that their activities are focused on supporting the recovery of the people who use their services. In doing so it highlights issues in relation to inclusion, rights, equalities and diversity."[93]

The SRI was initially based on a tool called the Recovery Oriented Practices Index (ROPI), developed by New York State Office for Mental Health. A representative group was formed to lead on the refinement and adaptation of ROPI in Scotland. This led to the development of the SRI and following a test phase across a number of mental health services in Scotland, the final version of the indicator tool was launched in May 2009.

The SRI was developed as a result of two Scottish mental health policy initiatives, namely the Review of Mental Health Nursing in Scotland[94] (which required a tool to help nurses assess their practice) and the subsequent extension of this model beyond nursing as part of the Delivering for Mental Health initiative.[95]

According to the latter plan, the development of this tool would cover the following aspects:

- Equality, non-discrimination and respect for diversity;
- Social inclusion;
- Recovery, the degree to which services are structured to deliver better outcomes across a range of domains, including employment, housing, education and training opportunities, family and social life; and
- Rights, in particular the Millan Principles, including in particular, the principles of reciprocity, benefit, and participation.[96]

The SRI operates on the basis of information collated from five different sources, namely:

- Assessments;
- Care plans;
- Service information, policies and procedures;
- Interviews with service providers; and
- Interviews with current or previous service users.

Services then judge themselves against a series of nineteen indicators under eight headings, namely:

- Meeting basic needs;
- Personalised services and choice;
- Strengths based approach;
- Comprehensive service;
- Service user involvement/participation;
- Social inclusion and community integration;
- Advance planning; and
- Recovery focus.

93 See http://www.scottishrecoveryindicator.net/ for a full description of the Scottish Recovery Indicator tool.

94 The Scottish Government, *National Review of Mental Health Nursing in Scotland*, April 2006 – see: http://www.sehd.scot.nhs.uk/nrmhns/.

95 The Scottish Government, *Delivering for Mental Health*, 2006 – see: http://www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/DFMH.

96 For further details in relation to the Millan Principles see the report of the Millan Committee on Review of the Mental Health (Scotland) Act 1984, 2001, (Web: http://www.scotland.gov.uk/health/mentalhealth-law/millan/Report/rnhs-00.asp.)

A detailed listing of each of the indicators monitored as part of the SRI under each of the above headings is presented in the figure below. Assessment is based on the application of a five-point scale, where 1 equates to "no, or very minimal, adherence to the indicator", and 5 represents "full adherence to the indicator".

Figure 6.5 Domains and Indicators used in the Scottish Recovery Indicator

Domain/Part	Indicator
Part 1: Meeting basic needs	1a Assessments cover basic needs in detail. 1b Services related to basic needs are provided.
Part 2: Personalised services and choice	2a Information provided to explain the service identifies personal choice as fundamental. 2b Care plans contain personalised self-set goals. 2c Services show considerable variation reflecting efforts to address individual needs and expressed preferences.
Part 3: Strengths based approach	3a Assessments identify and explore strengths. 3b Care planning integrates strengths into goals. 3c Information provided to explain the service promotes strengths.
Part 4: Comprehensive Services	4 Provide or access responses in each area below
	Medication *Vocational/employment* *Alcohol and drug misuse* *Talking therapies* *Family/social system based treatment* *Trauma services* *Staying well* *Health improvement*
Part 5: Service user involvement/participation	5a Services have policies and procedures for promoting service user involvement. 5b Services promote diverse service user involvement throughout the service planning process.
Part 6: Social inclusion and community integration	6a Services make efforts to involve extended support networks in care and treatment. 6b Services provide a range of responses designed to promote inclusion and community integration.
Part 7: Advance planning	7a Services encourage advance planning. 7b Services have policies and procedures for encouraging people to participate in their own care and treatment even when under compulsion.
Part 8: Recovery focus	8a Care plans address individual goals related to life roles, meaningful activity and relationships. 8b Services use recovery oriented practice. 8c Services provide routine training to all staff in topics related to recovery oriented practice. 8d Services provide routine supervision to all staff in relation to recovery oriented practice.

Source: *Scottish Recovery Network (see: http://www.scottishrecoveryindicator.net/)*

The Scottish Recovery Indicator model provides an internationally based framework for assessing the quality of interventions provided by mental health service practitioners and the outcomes for service users. While the tool was developed specifically for the Scottish Mental Health Service, Indecon believes that with appropriate adjustment, there could be scope to apply many of its features to the Irish Mental Health Service.

—6.2.5 Australia

In Australia, the government's National Mental Health Plan includes a number of outcome indicators, which fall within the priority area 'social inclusion and recovery'. These indicators are shown in the figure below.

Figure 6.6 Indicators of Mental Health Service Outcome Proposed in Australian National Mental Health Plan 2009-2014

Priority area I: Social inclusion and recovery

Outcome

The community will understand the importance and role of mental health and wellbeing, and recognise the impact of mental illness. People with mental health problems and mental illness will be embraced and supported by their communities to realise their potential, and live full and productive lives. Service delivery will be organised to deliver more coordinated care across health and social domains.

Indicators for which data are currently available

- Participation rates by people with mental illness of working age in employment
- Participation rates by young people aged 16-30 with mental illness in education and employment

Indicators requiring further development

- Rates of stigmatising attitudes within the community
- Percentage of mental health consumers living in stable housing
- Rates of community participation by people with mental illness

Source: *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009-2014. Commonwealth of Australia, 2009*

—6.2.6 Conclusions from review of international approaches

Indecon believes that a number of the outcome indicators evident from the review of international approaches may potentially be applicable in the Irish context. Further work would, however, be required to assess the operational feasibility of introducing such indicators as part of ongoing performance assessment in the Irish mental health services. Given the importance of outcomes indicators as a measure of the achievement of the human right to the highest attainable standard of mental health, Indecon recommends that such indicators be developed for the Irish mental health services.

6.3 Proposed Key Performance Indicators

Based on the initial consideration of international approaches and features of the Irish system, a preliminary set of KPIs was developed, which is presented below. These measures focus on the recovery-model of mental health services recommended in *A Vision for Change*.

Table 6.1: Proposed Key Performance Indicators – Preliminary Summary of Indicators of Outcomes from Mental Health Service Intervention

	Indicator No. and Description	KPI Objective	Organisational Responsibility for Implementation and Delivery	Indicator Target Setting	Indicator Data Frequency and Method of Collection
	Outcome Indicators to monitor and incentivise Development of Recovery-oriented MHS				
1	% of service users of working age in open paid employment	Demonstration of impacts and outcomes from MHS interventions on quality of life of service users	HSE in tandem with DETE and with training and employment agencies	Increase % of discharged service users who are in paid employment within a pre-defined timescale following discharge	Annual data monitored via NMD/WISDOM database
2	% of service users living in appropriate and affordable housing	As above	HSE in tandem with DoEHLG and housing authorities	Increase % of service users who reside in appropriate independent or supported housing within a pre-defined timescale following discharge	As above
3	% of service users who have completed a third-level or vocational qualification	As above	HSE in tandem with DES and 2nd and 3rd level education institutions	Target to increase proportion of service users participating in formal education within a pre-defined timescale	As above
4	% of service users happy with their quality of life	As above	HSE	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey

Source: *Indecon*

—6.3.1 Rationale for indicator selection

The overall rationale for this proposed indicator set is to facilitate the ongoing monitoring and demonstration of impacts and outcomes arising through mental health service interventions in terms of the quality of life enjoyed by service users. The rationale underpinning the selection of the above proposed indicators to monitor the outcomes from mental health service intervention is set out for each indicator below.

1 % of service users of working age in open paid employment: ultimately, the extent to which service users are experiencing full recovery must be assessed on the basis of a range of indicators. One indicator that is commonly used internationally is the extent to which service users are engaged in open market employment. While employment will not be appropriate to all individuals, an increase in the proportion of service users who do successfully engage in active employment would provide one measure of the success or otherwise of mental health service interventions over time in terms of the social inclusion of service users. For service users where open market, paid employment is a feasible option, an appropriately designed target for this indicator could involve targeting an increase in the proportion in paid employment within a pre-define timescale;

2 % of service users living in appropriate and affordable housing: constituting a further measure of the extent to which service users successfully re-establish or maintain their lives in the community, this proposed indicator is also in widespread use internationally. An appropriately designed indicator would also have an associated target to increase over time the proportion of service users who reside in appropriate and affordable housing within a pre-defined timescale;

3 % of service users who have completed a third-level or vocational qualification: participation in education and the extent of educational attainment represent further commonly-used measures of the extent of recovery of service users and integration within the community. This KPI is designed to capture the extent to which mental health service interventions are ultimately contributing to quality of life outcomes for service users in terms of education, specifically in terms of the extent to which service users are participating in a formal third-level or vocational education programme within a specific timeframe. An appropriate target would aim to increase over time the proportion of service users who have completed a qualification within a pre-defined timescale;

4 % of service users rating their quality of life as good or better: as an overall outcome-based measure, this proposed KPI would track on an annual basis the proportion of service users (both current and ideally also former service users) who attain specified levels of satisfaction with their quality of life following mental health service intervention.

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

6.4 Summary

While considered by many practitioners internationally to be the most important indicator category, the development of appropriate outcome-based indicators designed to capture the overall effectiveness of mental health interventions is regarded as the most complex and challenging area of performance measurement.

A preliminary review of international approaches to outcomes-based performance assessment in the mental health services was undertaken. This identified a number of useful developments and applications. Indecon believes that a number of the outcome indicators evident from the review of international approaches may potentially be applicable in the Irish context. Further work would, however, be required to assess the operational feasibility of introducing such indicators as part of ongoing performance assessment in the Irish mental health services.

7

Conclusions and Recommendations

Accountability in the delivery of a Vision for Change – a performance assessment framework for mental health services

Conclusions and Recommendations

7.1 Overall Conclusions

The key overall conclusions from this review are as follows:

- There are gaps in the detailed information available to support ongoing monitoring of the funding and delivery of mental health services;
- Particular gaps exist in the information required to ensure financial accountability for the allocation of funding to support the delivery of the recommendations of *A Vision for Change*, including in relation to recurrent, capital and development funding;
- There is limited data reported on a regular basis in the public domain in relation to the provision and capacity of mental health facilities, and there is a particular absence of regularly reported data on community mental health service facilities. Additional new information is required to facilitate the monitoring of mental health facilities and human resource provision at service and catchment area levels to ensure that provision is aligned with the recommendations of *A Vision for Change*;
- Additional data is required to facilitate ongoing assessment of the scope and quality of service provision, and the outcomes from mental health service interventions for service users;
- The World Health Organisation's (WHO) and the UN's human rights guidance provide an overarching guide to formulation of an appropriate framework for performance assessment supported by well-chosen indicators. Indecon supports this approach; and
- International evidence shows more widespread and detailed usage of performance indicators in mental health services than is currently the case in Ireland.

7.2 Recommendations

A number of recommendations arise from the assessment undertaken in this report and the above conclusions. These recommendations are set out overleaf.

Table 7.1: Recommendations

1	A range of new Key Performance Indicators should be implemented and published to facilitate the ongoing monitoring of funding, progress on implementation of *A Vision for Change* and outcomes of mental health service delivery
2	Key Performance Indicators should be supported by targets and associated timeframes for delivery which take account of existing gaps in progress, the constraints on public funding and the State's obligation to progressively realise the right to health
3	The proposed Mental Health Minimum Data Set should be implemented as a matter of priority in order to facilitate measurement of some of the Key Performance Indicators recommended in this report
4	Further exploration of outcome-based measures is required to develop a comprehensive set of indicators appropriate to assessing the outcomes for service users from mental health services
5	The Assistant National Director for mental health should hold overall responsibility for the HSE's mental health budget to enable financial accountability at national level
6	Executive Clinical Directors should assume responsibility for all resources allocated to mental health within their geographical and functional remits to enable accountability for the expenditure of mental health budgets
7	The HSE's Service Plan needs improved transparency in relation to the level of detail provided on actual and planned mental health service expenditures. This should include a breakdown of annual mental health funding allocations by service area and mental health catchment area
8	There is a need to ensure consistency between the figures presented on actual and planned mental health expenditures in the annual Revised Estimates published by the Department of Finance and the HSE's annual Service Plan
9	The implications of any recruitment moratorium on the implementation of *A Vision for Change* should be shown in the HSE's annual Service Plans
10	The funding model for the mental health service upon which the HSE's implementation plans are based should be published
11	The HSE should publish its implementation plan for *A Vision for Change* on its website and report on an annual basis on progress achieved relative to measurable targets
12	Government should consider the feasibility of introducing an appropriately designed legal framework to underpin the provision of comprehensive and community-based mental health services, and to ensure transparent planning and reporting on the funding and delivery of mental health services by the HSE
13	The powers of the Mental Health Commission should be extended to include the registration and approval of all mental health services (not just inpatient units) and the Inspector of Mental Health Services should inspect all mental health services on a regular basis

Source: *Indecon*

Indecon believes it is important that urgent attention is given to considering these measures within the context of ensuring successful implementation of *A Vision for Change* and achieving full transparency and accountability in the funding and delivery of mental health services.

1 ***A range of new KPIs should be implemented and published to facilitate the ongoing monitoring of funding, progress on implementation of A Vision for Change and outcomes of mental health service delivery.***
This assessment has identified a range of areas where improved performance monitoring is required to ensure transparency and accountability in the delivery of mental health services in Ireland, and to monitor and incentivise progress on the implementation of the Government policy on the development of the mental health services, *A Vision for Change*.

A framework of KPIs has been developed which sets out a number of indicators relating to the following specific aspects: (i) service funding, (ii) facilities provision, (iii) human resources, (iv) service scope and quality, and (v) the outcomes for mental health service users arising from service intervention.

Indecon believes that the proposed framework of indicators provides a strong basis for the Department of Health and Children (DoHC) and the HSE to develop effective systems which would address the current weaknesses in relation to transparency and accountability in the funding of the mental health services. The proposed performance assessment framework is also designed to facilitate the monitoring of progress on the transformation of the mental health service in line with the goals of *A Vision for Change*.

Given the above imperatives, Indecon recommends that priority should now be given by the Department and the HSE to finalising and implementing an effective suite of performance indicators based on the framework set out in this report.

2 ***KPIs should be supported by targets and associated timeframes for delivery which take account of existing gaps in progress, the constraints on public funding and the State's obligation to progressively realise the right to health.***
For indicators to be effective they should ideally be compared to performance targets or benchmarks. Such targets represent commitments made in advance to achieve a stated level of performance, usually within a pre-defined timescale and possibly also with associated milestones or intermediate targets.

Throughout the framework of KPIs selected in this report, a range of targets have been associated with each indicator. The majority of these targets – notably with respect to financial accountability, facilities and human resources – relate to the recommendations contained in *A Vision for Change*. In the case of the indicators presented on the scope and quality of mental health services and in relation to the outcomes of mental health service intervention, targets are recommended based on international best practice and assessment of the existing position in the mental health service in Ireland.

While explicit timescales have not been set for each indicator proposed in this assessment, to maximise effective application and incentivise performance, it is recommended that, if possible, a timescale should be associated with each indicator.

Targets and associated timescales should reflect the existing gaps in service development and, in particular, the extent of progress on implementation of the recommendations of *A Vision for Change*. They must also reflect the impacts of constraints on public funding while noting the State's obligation to use its available resources as effectively and efficiently as possible to realise the right to health.

3 **The proposed Mental Health Minimum Data Set should be implemented as a matter of priority in order to facilitate measurement of some of the Key Performance Indicators recommended in this report.**
The KPIs set out in this report are designed to form part of a wider framework of data/information and performance assessment metrics to be utilised by a range of stakeholders/user groups. These include policymakers and service management in the Department of Health and Children and the HSE, service practitioners and administration, political representatives, NGOs, as well as service users.

Notwithstanding the existing information systems in place which provide information on different aspects of the mental health service, this assessment has highlighted a number of weaknesses in terms of data/information and performance measures, particularly in the areas of mental health service funding, facilities and human resources inputs, service provision and quality, and outcomes for service users.

Full implementation of accountability for mental health service delivery will require the provision of a number of components of additional data/information. An important initiative in this context is the development of a National Minimum Data (NMD) set, which was recommended in *A Vision for Change*. Indecon understands from the HSE that the Mental Health Commission (MHC) and the Health Research Board have signed off on the NMD items required for their own purposes, and that the HSE and the Department intend to finalise the data set in the coming months.

Indecon recommends that urgent priority be given to finalising the preparation of the NMD with the objective of facilitating the inclusion of an appropriate set of KPIs designed to monitor and assess performance in relation to mental health service funding, facilities and human resources inputs, service provision and quality, and outcomes for service users, as set out in this report.

4 **Further exploration of outcome-based measures is required to develop a comprehensive set of indicators appropriate to assessing the outcomes for service users from mental health services**.
Considered by many practitioners internationally to be the most important indicator category, the development of appropriate outcome-based indicators designed to capture the overall effectiveness of mental health interventions is regarded as the most complex and challenging area of performance measurement.

This report has set out a small number of KPIs which are focussed on the monitoring of outcomes for service users and their families. However, a number of the outcome indicators evident from the review of international approaches may potentially be applicable in the Irish context.

Given the importance of outcomes indicators as a measure of the achievement of the human right to the highest attainable standard of mental health, Indecon recommends that further exploration be undertaken in this area to assess the operational feasibility of introducing a range of indicators appropriate to monitoring and assessing mental health service outcomes.

5 **The Assistant National Director for mental health should hold overall responsibility for the HSE's mental health budget to enable financial accountability at national level.**
Ensuring greater transparency and financial accountability in the funding and delivery of mental health services in Ireland will require a number of improvements in both governance and management systems. Specifically in relation to the role of management, while the mental health service is coordinated by the HSE through its Assistant National Director (AND), the scope of responsibility held by this office does not currently match that of the other ANDs within the HSE. In particular, the AND for mental health does not hold direct budgetary responsibility for the service. While this reflects the relatively recent establishment of this office, Indecon believes that to achieve

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accountability in the financial management of the mental health service, it will be important that decisions on development and operation do not take place in isolation from decisions on resource allocation.

Indecon recommends that HSE management structures for mental health should be re-examined with the objective of enabling full financial accountability for service funding and delivery. This should include the widening of responsibilities held by the AND for mental health to include budgetary control for mental health services.

6 **Executive Clinical Directors should assume responsibility for all resources allocated to mental health within their geographical and functional remits to enable accountability for the expenditure of mental health budgets.**
Ensuring financial accountability and effective implementation of service development plans will also require appropriate management and associated responsibilities at local/regional level within the mental health service.

Indecon understands that 14 new Executive Clinical Director (ECD) posts have been appointed within the mental health service. This includes 13 geographic posts in addition to one post covering the National Forensic Mental Health Service, with the geographic directors having responsibility with the Executive Management Team for Mental Health for all aspects of service delivery at the level of the new super catchment areas. Previously the work involved in implementation of *A Vision for Change* at local level resided with Local Health Managers, who were not necessarily equipped to the level required to support this process.

To enable the envisaged delegation of responsibilities to take place and to ensure financial accountability, Indecon recommends that the responsibilities of the new ECDs include accountability for all financial and human resources allocated to mental health within the directors' geographical and functional remits. It will also be critical that the ECDs work closely with the Executive Management Team within the HSE to ensure that resource allocation takes place in line with functional and geographic requirements.

We understand from the HSE that all Regional Directors now have two new performance indicators in their contracts, namely (a) the number of beds and (b) the average number of staff per CMHT. We understand that this is intended to drive bed reductions while also ensuring that overall resources are not diverted elsewhere but rather are used to develop community-based services. We also understand that the Regional Directors can impose these obligations on the Local Health Managers in each region. Indecon is very supportive of this process.

7 **The HSE's Service Plan needs improved transparency in relation to the level of detail provided on actual and planned mental health service expenditures. This should include a breakdown of annual mental health funding allocations by service area and mental health catchment area.**
This report highlighted a number of weaknesses in the existing channels of information and data available in the public domain about the funding of, and expenditures on, mental health services in Ireland. In particular, the assessment highlighted some specific weaknesses in the information published as part of the HSE's annual National Service Plan, including:
The high-level, aggregate nature of existing data published in relation to funding of, and expenditure on, mental health services; and
The absence of transparency in relation to actual versus planned levels of annual funding allocated to mental health by service area and on a geographic basis.

It is essential, if accountability is to be ensured, that there is full transparency in relation to budgeted and actual levels of expenditure taking place within the mental health services. This requires comprehensive reporting of budgets and expenditures on a regular basis, with associated reconciliation of actual versus planned expenditure not only at national level across the mental health care programme, but also at a more micro level,

in terms of expenditures across the mental health service areas and at a regional level.

Indecon recommends that, in the interests of ensuring full financial accountability, future HSE reporting includes a full breakdown of budgeted and actual outturn expenditures for mental health by service area (including General Adult, Child and Adolescent, Older People, Intellectual Disability, Rehabilitation and by specialist service area) and by mental health super catchment area.

8 **There is a need to ensure consistency between the figures presented on actual and planned mental health expenditures in the annual Revised Estimates published by the Department of Finance and the HSE's annual Service Plan.**
Indecon's assessment has also highlighted a number of weaknesses in relation to the consistency of data/information published in relation to mental health service funding and expenditures. This includes the evident significant variations in budgetary figures presented in different annual National Service Plans published by the HSE and the existence of substantial variations in funding and expenditures on mental health presented in the HSE Vote within the Revised Estimates and the National Service Plan.

This is an important issue in the context of ensuring accountability in the funding of, and expenditure on, mental health services; and Indecon recommends that closer scrutiny should take place in relation to the process of funding allocation and reporting to ensure full integration and consistency between funding and expenditure figures published by the HSE and the detail published in the Revised Estimates. Given that the primary purpose of the National Service Plan, in particular, is to demonstrate how the HSE intends to meets it legislative and other obligations to provide health services within the level of funding voted by the Oireachtas in the Estimates, it is important that consistency is evident between the two publications.

9 **The implications of any recruitment moratorium on the implementation of *A Vision for Change* should be shown in the HSE's annual Service Plans.**
Reflecting the economic and financial climate and the implications for government finances, there is currently a moratorium in operation on public service recruitment. The timescale over which this moratorium will operate is uncertain. However, it is important in planning for the transformation and development of the mental health service that the implications of this constraint are made transparent in the HSE's annual service planning. In particular, Indecon recommends that the HSE's annual National Service Plan should set out the implications of the current recruitment freeze for the development of the service, including in relation to the reconfiguration of existing staffing and the provision of human resources required to support the development of multi-disciplinary community mental health teams.

10 **The funding model for the mental health service upon which the HSE's implementation plans are based should be published.**
At present, there is insufficent clarity regarding the approach to funding of the mental health service. This includes, in particular, the funding model applied by the HSE to support the transformation and development of services in line with the recommendations of *A Vision for Change*. The HSE's Implementation Plan for *A Vision for Change* notes that a resource allocation model should be agreed and implemented. However, detail on this is currently not in the public domain. Indecon's 2009 review for Amnesty recommended that a number of changes in resource allocation would be required to support reconfiguration of the mental health service in line with the goals set out in *A Vision for Change*. Currently, it would appear that implementation is taking place in an incremental, piecemeal fashion, with insufficient clarity on how resource allocation is aligned with the recommendations of the policy.

Indecon recommends that to ensure financial accountability and progress on achievement of the goals set out in *A Vision for Change*, a funding allocation model should be finalised and published by the HSE which details the mechanisms by which funding is allocated on a service area level and geographic basis.

11 **The HSE should publish its implementation plan for *A Vision for Change* on its website and report on an annual basis on progress achieved relative to measurable targets.**
While the HSE has prepared an Implementation Plan for *A Vision for Change* (covering the period 2009-2013), this plan is currently not in published form. A copy of the plan provided to Indecon for the purposes of this report indicates that the document is primarily high-level in focus and addresses the organisational capacity required to implement the 82% of the more than 200 recommendations for which the HSE has responsibility (with other Government Departments and agencies having responsibility for the remaining recommendations).

It is important in the interests of transparency and accountability that the HSE Implementation Plan for *A Vision for Change* is fully published. The HSE should also report on an annual basis on progress achieved relative to pre-defined targets and should reflect the proposed indicator framework set out in this report.

12 **Government should consider the feasibility of introducing an appropriately designed legal framework to underpin the provision of comprehensive and community-based mental health services, and to ensure transparent planning and reporting on the funding and delivery of mental health services by the HSE.**
This report has highlighted a number of weaknesses in the current accountability of the HSE for mental health service expenditure and service delivery. The report has identified inconsistencies in published financial information and a lack of detailed information on planned service developments and progress on these. In light of these findings, Indecon believes that consideration should be given by Government to examining the feasibility of introducing an appropriately designed and targeted legal framework that would underpin a set of specific obligations on the HSE for the progressive provision of specific community-based services in line with *A Vision for Change*. In addition, such legislation could include a detailed planning and reporting obligation on the HSE. This obligation would increase transparency of both expenditure on and implementation of Government's mental health policy.

13 **The powers of the Mental Health Commission should be extended to include the registration and approval of all mental health services (not just inpatient units) and the Inspector of Mental Health Services should inspect all mental health services on a regular basis.**
The MHC and the Inspectorate of Mental Health Services play a vital role in relation to the promotion of high standards in the delivery of mental health services, and regulation and approval of mental health facilities. Among the functions conferred on the MHC under the Mental Health Act 2001 is the approval and registration of hospitals and other inpatient facilities for the care and treatment of persons under section 64 (Approved Centres). Other mental health services (such as community-based services) are not subject to such approval by the MHC.

Each approved centre is inspected on an annual basis by the Inspector, with detailed reports compiled under a number of headings, including

in relation to Quality of Care and Treatment, and Evidence of Compliance with Regulations, Rules and Codes of Practice. These reports provide the most comprehensive current source of information concerning the degree of compliance with regulations, rules and codes of practice governing the relevant aspects of the mental health legislation within approved inpatient units.

The existing inspections regime does not, however, cover all community-based facilities. While the Inspector of Mental Health Services has the power to inspect community-based mental health services and in 2009, the Inspectorate inspected 13, 24-hour staffed community residences and 10 day hospitals, there is currently no statutory requirement for inspection of such services. Indecon understand that the Inspectorate intends to expand the scope of the inspection process in order to increase the inspection of community services in the future.

In relation to the role of the Inspector regarding data/information collection, we understand that the Inspectorate of Mental Health Services is now requiring that all services provide information on their facilities and staffing, by super catchment area. This will essentially provide an annual audit and Indecon is very supportive of this process.

In order to protect the interests of service users across the mental health service, Indecon would recommend that the existing powers of the MHC be extended to include the approval of all mental health facilities and that the Inspector's duty to regularly inspect services be extended to all mental health services. This reflects the transformation of the mental health service and the greater emphasis in the future on community-based rather than inpatient provision, as recommended in *A Vision for Change*, and the implied requirement to ensure that regulatory and quality monitoring systems are aligned with the evolving structure of services and facilities.

7.3 Key Performance Indicator Sub-Set

While all of the KPIs recommended in this report have been chosen for their specific contribution to demonstrating performance or financial accountability in the mental health services, it may be useful to select a set of high-level indicators that can provide an overview of progress. For this reason, Indecon proposes the below sub-set of KPIs that could provide such an overview. These indicators have been selected on the basis that, firstly, they focus on the transformation of services (proportion of staff in community mental health teams, balance of funding in community-based services and the overall investment in mental health). Secondly, two of these indicators provide high-level evidence of trends on least restrictive treatment (first admission and involuntary committal rates). Thirdly, two of these indicators provide a snapshot of trends in quality and scope of service (recovery plans, availability of psychological therapy). Finally, the indicator on quality of life provides a service user assessed measure of the extent that services are achieving valued outcomes.

The Key Performance Indicator Sub-Set is presented overleaf:

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Proposed Key Performance Indicator Sub-Set

	Indicator No. and Description	KPI Objective	Indicator Target Setting and Timeframe	Indicator Data Frequency and Method of Collection
1	*Recurrent Expenditure* on MHS - € million and % breakdown by Hospital/Inpatient and Community-based MHS and by service area and MHCA*	mprove transparency in and accountability for expenditure of allocated recurrent funding by service area and geographically	Level and breakdown of recurrent expenditure to align with optimal configuration based on population need and resource requirements	Annual via DoHC and HSE mental health budget planning and expenditure controls
2	*AVfC Development Expenditure* - € million and % breakdown by Service Area** and MHCA*	Improved transparency in and accountability for expenditure of allocated AVfC Development Funding	Annual expenditure to reconcile with allocated funding by service area and catchment area	Monthly and Annual data via HSE
3	Overall national ratio of staff in Community Mental Health Teams to total no. of MHS staff	Monitoring of progress in reducing current over-staffing of adult inpatient services and reconfiguring resources to increase staffing of CMHTs across MHS	National ratio to target 39% of MHS staff employed in CMHTs	Annual data based on Mental Health Commission census of CMHT staffing
4	First-time admission rate per 100,000 population	Incentivise shift in service provision to least restrictive community care settings	Reduce ratio to align with best practice benchmarks internationally within a pre-defined timescale	(Data already collected by HSE and reported annually by HRB)
5	% of service users in receipt of an individual care and recovery plan	Incentivise application of a 'recovery' approach to MHS provision in line with MHC Quality Framework Standard 1.1	Target to have all MHS service users to be in receipt of individual care and recovery programme within a pre-defined timescale	Annual data via NMD/WISDOM database
6	% of service users offered a psychological therapy	Incentivise development of Holistic MHS	Target to make available some form of counselling, family or psychological therapy service available through all CMHTs within a pre-defined timescale	Annual data via NMD/WISDOM database
7	No. Of Involuntary Committals per 100,000 of Population	ncentivise minimisation of involuntary committals and un-necessary detention, and incentivisation of appropriate treatment	Target to reduce involuntary committal rate to align with best practice benchmarks internationally	Annual rate monitored via Mental Health Commission annual reports
8	% of service users rating their quality of life as good or better	Demonstration of impacts and outcomes from MHS interventions on quality of life of service users	Target appropriate annual increase in satisfaction rating over pre-defined timescale	Annual survey

** Service area refers to area of community-based MHS, i.e. General Adult, Child & Adolescent, Older People, Rehabilitation, Intellectual Disability and Forensic and other Specialist Services.*
*** Mental Health Catchment Area (MHCA) refers to super-catchment areas*
Source: *Indecon*

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Annex 2 Additional KPIs for Specialist MHS

Summary of Proposed Key Performance Indicators – *Mental Health Service Human Resources – Specialist Services*

Proposed KPI	KPI Objective	Organisational Responsibility for Implementation and Delivery	Indicator Target Setting and Timeframe	Indicator Data Frequency and Method of Collection
Overall No. of Specialist CMHTs with full multi-disciplinary staff complements	Monitoring of progress in development of Special Category MHS CMHTs in line with no. of teams and staff functional mix recommended in *A Vision for Change*	HSE	Overall target of 44 multi-disciplinary teams, broken down as per specialist services below Overall timeframe of 5-7 years in each case, with annual intermediate targets/ milestones*	Annual data based on Mental Health Commission census of CMHT staffing
Of which:				
Eating Disorder	As above	As above	1 team per HSE region	As above
Early Intervention	As above	As above	2 teams	As above
Liaison	As above	As above	13 teams	As above
Neuropsychiatry	As above	As above	2 teams	As above
Perinatal Psychiatry	As above	As above	1 teams	As above
Substance Misuse	As above	As above	13 teams	As above
Intensive Care Rehabilitation	As above	As above	4 teams	As above
Forensic	As above	As above	4 teams	As above
Forensic ID	As above	As above	1 teams	As above

** Note: targets may be attainable over shorter time periods in the case of teams that are currently relatively well resourced*
Source: *Indecon*

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