



Selected Findings and Policy Implications from 10 Years of HRB Mental Health Research

Introduction

Good mental health is central to our wellbeing. For more than 35 years the HRB has had a central role in collecting information about the level of use and users of the mental health services and, in more recent years, has been conducting research to understand more about a wide variety of mental health issues. The HRB Mental Health Research Programme was published in 2006 following consultation with stakeholders. The programme was based on a view of mental health as a continuum ranging from good mental health/psychological wellbeing to severe mental illness – one's position on this continuum varies depending on a range of intra and interpersonal, situational and socio-economic circumstances. The research programme addressed issues related to psychological wellbeing and distress, as well as issues related to mental health and mental illness.

The research carried out by the MHRU falls broadly into three main areas –health services research, psychosocial and environmental aspects of mental health/illness and epidemiology, with an emphasis on policy-relevant research. Furthermore *historical research* on mental health services has been carried out by Dr Dermot Walsh, a leading figure in mental health services research. This research has included reports on the establishment and development of the district lunatic asylums, the history of the lunatic asylum in Ennis, Co Clare and a historical review of suicide, attempted suicide and prevention. *Epidemiological research* has included the genetic basis of schizophrenia, the genetic basis of alcohol dependence and research based on data from our information systems. This research has been invaluable in the international context with the identification of important genes that may lead to susceptibility for schizophrenia and on trends in the use of Irish inpatient mental health services. Our *mental health services research* has included secondary analysis of database information and research studies assessing specific mental health service components. These studies included a review of the acute beds in psychiatric services, a review of the day hospitals and day centers and a review and evaluation of community residential services. Our mental health services research findings have provided information on service provision and delivery, service users' views and perceptions of services and service providers' views on services. These studies have been the primary source of evidence that feed into service planning and development and policy related issues in Ireland. Finally MHRU research in the area of *psycho-social and environmental aspects of mental health* examined how these factors impact on mental health in the Irish context. The research findings in this area throw light on individual, interpersonal and socioeconomic factors that facilitate or inhibit mental health and wellbeing. Of particular significance in this context is the HRB National Psychological Wellbeing and Distress Survey (HRB NPWDS) which was designed as a rolling survey to be carried out at regular [two yearly] intervals. The study provides much needed information on the prevalence of distress in the Irish adult population. Given the absence of a mental health morbidity study the HRB NPWDS is currently the only available information showing the current prevalence and one year prevalence of distress and associated health service use. To date two surveys have been completed, one of which included data from Northern Ireland. This data will provide a baseline going forward by which to monitor psychological distress and wellbeing in the population against which broader socioeconomic trends in society can be monitored. In addition, the survey explored the theoretical concept of distress disclosure showing the importance that the sharing of distressing information with others has on mental health and contributing to international theoretical work in the area. Important qualitative research has also been carried out which has included the Family Support Study and the Recovery Study. Findings from these studies have provided insights into the experience of families of those with mental illness and explored

what recovery means to those with enduring mental health problems. Both studies provide recommendations regarding service and community supports required for those with mental illness and their families.

The work carried out has provided essential evidence to inform mental health policy, evaluation of policy implementation and supported health service planning and delivery. In addition, it has thrown light on factors facilitating and inhibiting mental health and has contributed to theoretical development in a number of areas. Our mental health research evidence has been used widely by third party researchers working in diverse areas such as health geography to health economics. Our work programme has provided a great springboard for students training in the social sciences.

Following a strategic review at the HRB, from 2010 our role in mental health will focus on gathering, analyzing and researching (resources permitting) the information from our National Psychiatric Inpatient Reporting System (NPIRS) and related databases. Broader research concerns exploring psycho-social aspects of mental health, wellbeing and distress will no longer be addressed by the MHRU research team. It is hoped that other researchers will address these issues in the future and that the recommendations regarding mental health research in *A Vision for Change* will be implemented.

There is no doubt that the research to date has had an impact on policy and improving services for people with mental health problems. The present document captures some of the key outcomes and impacts of our work over the years and is the result of a radical culling of possible material from over 100 publications. We ask you to take some time to review these findings and to examine if and to what extent you do or can apply them in practice.

Our contribution to mental health research in Ireland has been the result of a wide variety of collaborations. The Mental Health research team would like to take this opportunity to thank: -

- Previous staff and collaborators for their valuable contribution to mental health research.
- People who were so willing to participate in our research, in many cases regardless of the problems they were experiencing.
- Staff throughout the mental health services for their support – their enthusiasm regarding findings has inspired us.
- HSE staff who make returns to the MHRU information systems.
- Department of Health and Children, for their continued support over the years.

The current MHRU research team

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Selected Important Findings: Psycho-social and Environmental Aspects of Mental Health

Key findings from the *HRB National Psychological Wellbeing and Distress Surveys* carried out in 2005/2006 and 2007

1. A survey of the adult Irish population showed that the majority of the sample reported good or very good mental health. However a total of 12% of the sample were currently experiencing significant psychological distress as measured by the General Health Questionnaire. Extrapolating these figures to the population would suggest that as many as 389,258 Irish adults are experiencing psychological distress at any given time in Ireland.^{1,2}
2. Approximately 10% of people had spoken to a GP specifically about a mental health problem in the previous year with an average of four visits per person. The projected figures suggest that as many as 320,381 people will contact their GP in a given year for mental health problems resulting in 1,281,524 GP consultations for mental health problems.^{1,2}
3. Interestingly the main factors that influenced attendance at the GP specifically for mental health problems were not cost but rather factors related to 'need' e.g. how one felt, limitations in physical activities due to poor mental health and use of psychotropic medication. In contrast attendance at the GP for physical health problems was influenced by non-need factors such as employment status and income.³
4. Respondents of the survey who were unemployed were four times more likely to exhibit high levels of distress than people who were employed.²
5. A total of 6% of the Irish population surveyed took psychotropic medication in the previous year while as many as 31% who reported mental health problems had used psychotropic medication.¹
6. Family and friends and the GP were the most preferred sources of support in the face of psychological distress.^{1,3}
7. The better ones mental health the more willing one is to disclose distressing information to others. Males and older people were the least willing to disclose distressing information to others.⁴
8. More than one in four Irish adults had used the Internet to search for information on health and 60% of Internet users with mental health problems had used the Internet to search for health information. These findings highlight the potential of the Internet as a source of information on general health and mental health in particular.⁵

Key findings from qualitative studies in the psycho-social research area

9. Carers of those with enduring mental health problems reported that having access to information about mental illness, treatment and recovery helped them cope and provided them with hope for the future.⁶
10. A qualitative study of recovery explored what recovery means to those with enduring mental health problems. The findings revealed that recovery involved an active effort to establish and maintain self acceptance and to connect with others. This study will facilitate understanding, of the recovery ethos within the Irish mental health care.⁷
11. One of the key factors that facilitated recovery was making the decision to fight to get better.

This included finding one's own motivation for recovery, and learning new ways of coping with negative emotions.⁸

Policy Implications

- Health promotion policy and programmes need to address the stigma surrounding mental health problems and encourage people to seek support when under distress. Furthermore there is a need to target those who are less likely to disclose distressing information such as males and older people.
- There is a need to recognize and acknowledge the extent of distress in the general population. Public attitudes to mental health need to be refocused from a division into 'us' and 'them' to acknowledgement that mental health problems can effect anyone at difficult times.
- There is a need to acknowledge the factors shown to influence levels of distress such as unemployment to ensure that support is provided to those most vulnerable to distress.
- It is important to build resilience at the individual, family and community levels to help people cope with adversity and change. Intersectoral planning can help build individual and social capital to support and improve mental health and wellbeing.
- The GP and primary care team are important for the treatment and care of mental health problems. As such there is a need to develop training for primary care staff, to increase the range of mental health professionals (e.g. counselors and psychologists) and community supports that primary care staff can access and to explore the benefits of implementing different models of primary mental health care in Ireland.
- There is a need to review Irish health websites to assess the quality of the information provided on these sites. The potential of the Internet as a mechanism for the delivery of mental health treatment and care should be examined.
- Families caring for those with enduring mental health problems will benefit from a range of services such as family education, individual and family counseling and family psycho-education.
- The study of recovery identified competencies and principles which can guide recovery oriented person-centered care.

Selected Important Research Findings: MHRU Health Services Research

Acute hospitals, day hospitals, day centres and community residences

1. A study examining the availability and use of psychiatric beds in 1996 found that nearly half of all acute beds were being used for non-acute purposes. Thus the problem with the availability of psychiatric beds was largely due to inappropriate occupancy rather than inappropriate admissions, a situation not changed greatly today.⁹
2. Contrary to intended purposes many day hospitals are not providing a service for acutely ill patients with 94% of the patients attending experiencing relatively mild mental illness.¹⁰
3. Quite a high proportion (31%) of professionals did not understand the role of a day hospital while 51% were unsure as to what type of illness could be treated there.¹⁰

4. Many patients spent up to four hours travelling to and from day hospital or and day centre services , although 80% of patients interviewed expressed satisfaction with their treatment. A comprehensive range of treatments was not available in day hospitals and there was a lack of activity in some. ¹⁰
5. Most day hospitals were not served by a multidisciplinary team including psychologists, occupational therapists and social workers, while consultant psychiatrists spent limited time there. ¹⁰
6. A study evaluating the nature and quality of community residential accommodation showed that the functions of the residences was aimed more at continuing care rather than rehabilitation, the internal environment was less than ideal with a high number of residents sharing bedrooms and a high ratio of residents to bathrooms was typical. ¹¹
7. The majority of residents in community residential facilities showed mild symptoms and few impairments with no difference between those in low, medium or high support facilities, suggesting that, for many, needs were over-provided for in some instances, yet under-provided for in others - such as independent living and rehabilitation. ¹¹
8. In 2006 there were 1,412 people resident in 113 high support community residences, an average rate of 46.6 per 100,000 population aged 16 years and over. The number of high support places exceeded the 30 per 100,000 population recommended in *A Vision for Change*, indicating reform of the sector is required. ¹²

Re-admissions and the revolving door phenomenon

9. A study examining first admissions to psychiatric units and hospitals in 2001 found that as many as 37% of individuals had one or more re-admissions during the period 2001–2005, while 7% were categorised as 'frequent users', having 4 or more re-admissions during that time. ¹³
10. Patients diagnosed with alcoholic disorders accounted for one-fifth of patients who were readmitted during the period 2001–2005 despite recommendations to treat this disorder in community based settings. ¹³
11. Examination of inpatient re-admissions in catchment areas where home care teams have been in operation for some time have shown considerable reductions in re-admissions over a ten-year period; inpatient re-admissions in Cavan/Monaghan declined by 70%, while those in Tallaght/St Loman's declined by 49%. In contrast the decline in re-admissions for all other services for the same period was much less at 23%. ¹⁴
12. Scientific evaluation of the efficacy and usefulness of community treatment orders has been inconclusive. Thus for this reason and because of ethical considerations, the research does not recommend their introduction in Ireland. ¹⁵

Policy Implications

- Services are not operating at the level envisaged by successive policy documents. The nature, deployment and efficacy of community based services need to be examined given the findings of inappropriate occupancy of beds, day hospitals operating more like day centres rather than substituting for inpatient care, the continued re-admission of patients with illnesses that could be more suitably treated in the community and community residences more reflective of 'mini-institutions' than home like environments.

- The expansion of community-based services has not diminished the need for inpatient treatment for those with enduring illnesses and thus re-admissions will continue to be a feature of inpatient activity. However, the suitability of inpatient psychiatric care for the continuing care of those with an organic mental disorder without accompanying behaviour disorder and those with a primary diagnosis of intellectual disability needs further examination.
- More progress on the treatment of alcoholic disorders on a community-treatment basis needs to be made to end the 'revolving' door process for those with alcoholic disorders and to enable the recommendations of successive policy documents to be fully implemented. *A Vision for Change* recommended that responsibility for uncomplicated substance abuse lay outside the mental health system and rested with the Primary and Continuing Community Care Programme.
- All staff working in each component of the mental health service should be fully aware of the role and functions of, and the policies regarding admission and discharge to, that component.
- There should be access to adequate and appropriate out-of-hours assessment/crisis intervention/home-based and early intervention services to reduce the cycle of re-admissions to inpatient facilities.
- In line with *A Vision for Change*, all staff in mental health services should be trained in the principles of recovery and a recovery ethos incorporated into services as a matter of urgency.

Selected Important Research Findings: from MHRU Information Systems and Epidemiology

Census data for psychiatric inpatient services

1. The number of people in psychiatric hospitals in Ireland reached a peak of 21,075 at the end of 1961, representing a hospitalisation rate of 7.3 per 1,000 population, reportedly one of the highest rates of psychiatric hospitalisation in the world at the time.¹⁶
2. In line with successive policy documents the numbers of persons resident in Irish psychiatric units and hospitals has declined by 83%, from 19,801 in 1963 to 3,389 in 2006.¹⁷
3. Schizophrenia has accounted for the largest proportion of psychiatric inpatients in each successive inpatient census, although the proportion has declined from 53% in 1963 to 34% in 2006.¹⁷
4. The proportion of inpatients with a shorter length of stay has increased over the years with a corresponding decrease in those with a length of stay of 5 years or more (old long stay patients), from 61% in 1963 to 29% in 2006.¹⁷
5. A follow-up of 450 new long stay patients identified in the 2006 inpatient census revealed that two-thirds remained in hospital one year later. Eighty-six per cent of those still in hospital at one year follow-up were resident in 19th century psychiatric hospitals, 2% were in general hospital psychiatric units and 12% were in other psychiatric services.¹⁸
6. The proportion of patients hospitalised in general hospital psychiatric units has increased from 3% in 1981 to 23% in 2006, while the proportion of patients in older psychiatric hospitals decreased from 90% in 1981 to 52% in 2006.¹⁷

Admissions to psychiatric inpatient services

7. While admission numbers to Irish psychiatric units and hospitals have increased over a 43-year

period from 15,440 in 1965 to 20,752 in 2008, overall admission rates have declined from 535.4 per 100,000 population in 1965 to 489.5 in 2008.¹⁹

8. Re-admissions to psychiatric units and hospitals continue to account for 70% of all admissions to these services.¹⁹
9. Depressive disorders, schizophrenia and alcoholic disorders have consistently accounted for almost two-thirds of all admissions over the last number of years.¹⁹
10. Depressive disorders account for the highest proportion of all and first admissions. There has been no reduction in admissions for depressive disorders to coincide with the introduction of antidepressant medication.^{16, 19}
11. There has been a 59% reduction in the admission rate for schizophrenia from 227.9 per 100,000 population in 1971 to 93.1 in 2008. Schizophrenia accounted for 19% of all admissions to psychiatric units and hospitals in 2008.^{16, 19}
12. In 2008, alcoholic disorders accounted for 12% of all admissions. Alcohol has been estimated to be responsible for at least 6% of suicide deaths.^{16, 20}
13. Of all occupational groups, the unskilled group has had the highest rate of admission for the last thirty years, considerably higher than rates for employers and managers, pointing to clear differences between socio-economic groups.¹⁹
14. The rate of non-voluntary admissions has decreased from 130.0/100,000 in 1971 to 37.3/100,000 in 2008.¹⁹
15. Contrary to good practice, children continue to be admitted to adult psychiatric units and hospitals with almost two-thirds (65%) of all admissions aged under 18 years in 2008 going to adult services. Over a ten-year period over half of all those aged under 18 years with a psychiatric diagnosis were treated in general hospitals.^{19, 21}
16. There are remarkable differences in admission and diagnostic rates between catchment areas, requiring further investigation.¹⁹
17. In line with policy, the length of stay for admissions to inpatient services have become shorter over the years with 70% of discharges occurring within one month of admission and 94% occurring within three months of admission.¹⁹

Discharges from psychiatric services and general hospitals

18. A total of 283,020 discharges with a principal psychiatric diagnosis were returned for psychiatric and general hospitals combined for the period 1997–2006 and surprisingly, 17% were from general hospitals.²¹
19. Of discharges from general hospitals given a principal psychiatric diagnosis, the majority (42.6%) were classified as either alcohol dependence or abuse, while schizophrenia and mania were the almost exclusive preserve of psychiatric units and hospitals.²¹
20. Comparative data on psychiatric admissions, discharges and residents in Ireland and Scotland show broadly similar rates of all and first admissions for all ages in both countries with the exception of the very much higher rates for the 75 year and over age group in Scotland. In keeping with the higher rate for the 75 and older age group in Scotland, dementia rates were many times higher in Scotland than in Ireland.²²

Genetic epidemiology of schizophrenia and alcohol dependence

21. Studies on the genetic epidemiology of schizophrenia have identified a gene that appears to play a significant role in susceptibility to this condition.²³
22. Field studies have now been completed on the genetic basis to alcohol dependence and the process of the analysis of materials resulting from this work is now proceeding.²³

Policy implications

- The pace of development of community-based services for mental health as advocated by successive policy documents including *A Vision for Change*, does not appear to have progressed at the level recommended by such policies, with the result that patients continue to be re-admitted on an inpatient basis when they could be more appropriately treated in the community.
- *A Vision for Change* recommended that all public psychiatric hospitals should close. However in 2006, 52% of all persons resident in psychiatric inpatient facilities were resident in public psychiatric hospitals (as opposed to general hospital psychiatric units or private psychiatric hospitals).
- Because schizophrenia accounts for a sizeable proportion of all admissions to inpatient facilities in Ireland and despite the recommendation by *A Vision for Change* to establish a second Early Intervention Service (EIS) pilot project with a view to establishing the efficacy of EIS for the Irish mental health service, it is notable that this has not taken place.
- Alcoholic disorders still account for a sizeable proportion of all admissions despite recommendations to treat this disorder in community-based settings.
- The burden placed on general hospitals for the treatment of alcohol disorders is quite significant.
- The need for improved under-graduate and post-graduate education in the recognition of psychiatric disorders is vital. This is all the more relevant now that liaison psychiatry has an acknowledged role in general hospital practice.
- Despite recommendations in *A Vision for Change* for the expansion of child and adolescent mental health services the number of admissions for persons under 18 years of age to adult psychiatric units or hospitals remains high. It remains to be seen how this will be accommodated from 1 July 2009 given the Addendum to the Code of Practice relating to the Admission of Children under the Mental Health Act 2001 which states that no child under 16 years is to be admitted to an adult unit in an approved centre except in exceptional circumstances.

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See www.hrb.ie for full list of references for Schizophrenia and Alcohol Dependency Studies