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LEIDEN UNIVERSITY

POLITICS, CULTURE AND NATIONAL IDENTITIES SINCE 1789 TO THE PRESENT

DEPARTMENT OF HISTORY

A Historical Comparative Study of the Impact of Social Developments on the Evolution of Mental Healthcare in England & Ireland, 1950-2019

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Glossary of Abbreviations

UK	United Kingdom
MHA	Mental Health Act
NHS	National Health Service
HRB	Health Research Board
DHSS	Department of Health and Social Services
PFI	Private Finance Initiative
JRF	Joseph Rowntree Foundation
EHB	Eastern Health Board
EEC	European Economic Community
EU	European Union
HSE	Health Service Executive
CSO	Central Statistics Office
CMD	Common Mental Disorders

Introduction

The treatment of mental health problems has had limited success in both England and Ireland. Since the Percy Commission in 1957 in England, and the Commission of Inquiry into Mental Illness in 1966 in Ireland, both countries have strived to modernise and improve the quality of their mental healthcare systems. Despite this they have experienced several shortfalls surrounding funding, staffing and community care amongst other issues. As a result of these problems both countries have some of the highest rates of mental illness in Europe, with 18.5 percent of Irish people and 17.7 percent of English people experiencing at least one mental illness.[1]

While both England and Ireland inherited a similar system based around asylums and a focus on long-term institutionalisation the outcomes for the respective countries were vastly different. Additionally, both countries have move towards a community-based approach in the hope to rehabilitate and reintegrate patients into the community. Though, England has seen lower rates of hospitalisation and shorter hospital stays for mental illness than in Ireland as well as historically having lower rates of mental illness. However, since the 1990s English rates of mental illness have been increasing gradually. As a result, English rates of mental illness are nearly that of Ireland.[2] By discussing the historic developments in mental healthcare in the two countries and issues around welfare and healthcare the causes for this discrepancy as well as the recent increases in the rate of mental illness can hopefully be explained.

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[1] OECD/EU, *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, OECD Publishing, (Paris, 2018), p. 22, https://doi.org/10.1787/health_glance_eur-2018-en, (accessed 09/06/2023).

[2] Rachel Mullis, Julia Douglas-Mann, Emily Froud & Geeta Kerai, *Measuring national well-being: domains and measures*, Office of National Statistics, https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/measuringnationalwellbeingdomainsandmeasures, (accessed 13/02/2023).

English contemporary debate about mental health is universal in its criticisms of the current state of mental healthcare, however the reasons for these shortcomings vary as do the proposed solutions. Graham Scambler is highly critical of the rise of neoliberalism as he argued it atomises society, isolating people and making them more susceptible to mental illness. He also points to the cuts to the welfare and health-care systems at a time of increasing demand causing these systems to unravel at an alarming rate. Andrew Scull takes this a step further, effectively arguing that deinstitutionalisation was an error forced by the rise of neoliberalism. He points to the fact that while hospital numbers did decline from 1960 to the 1980s, they accelerated rapidly following the election of Margret Thatcher even though community services were severely underdeveloped. He, like Scambler, argued that, while these neoliberal policies promised to exclude the National Health Service (NHS), this has been far from the case and as the NHS deteriorated so did mental healthcare. He concludes that 'neglect has been the hallmark of the shift from the asylum to community care…'[3] George Szmukler and Lawrence Gostin instead focus on the role played by mental health law. Their argument is that, while the 1959 and 1983 *Mental Health* Act's (MHA) marked major steps forward during a time of major changes in psychiatric profession, the *Mental Health Act* (2007) (MHA 2007) was less well received as patient autonomy was rolled back as '"risk" replaces "need" as a core principle of public policy'[4]

The Irish sources, like their English peers are unanimous in their criticisms of the Irish mental healthcare systems, although they are slightly more optimistic. Dermot Walsh, a man who was unrivalled in his understanding of the issues the mental healthcare system faced as he

[3] Andrew Scull, UK Deinstitutionalisation: Neoliberal Values and Mental Health*, Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960–2010*, ed. George Ikkos and Nick Bouras, Cambridge University Press, (Cambridge, 2021), p. 311.

[4] George Szmukler and Lawrence O. Gostin, Mental Health Law: 'Legalism' and 'Medicalism' – 'Old' and 'New', *Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960–2010*, ed. George Ikkos and Nick Bouras, Cambridge University Press, (Cambridge, 2021), p. 77.

contributed to the three key Irish reports, is balanced in his critique of the healthcare services. Walsh points to a major decrease in mental hospital patients, that services have become more specialised to deal with the unique needs of certain groups (children and older people for example) and that the Mental Health Commission was established, which serves as a safeguard for patients' rights as feats worth celebrating. He was, however, critical of the large number of patients (1,500) who still reside in old hospitals which are no longer fit for purpose, the continuing lack of community care and major funding and staffing shortages. Brendan Kelly a professor of psychiatry, instead argued that, in the past (and to an extent still) those placed in asylums were there since the broader society failed 'to generate solutions to real human suffering (mental illness, disability, disease, poverty, [and] ill fortune)…'[5] However, like Walsh, Kelly speaks positively of the major steps the mental healthcare system has taken, most notably robust protections of the human rights of patients. He however concludes far too little has been done.

Historian Pat Thane's discussed the major developments in British society from 1900 till 2017, regarding a wide number of topics, of particular concern for this thesis around welfare provision, housing, and healthcare policy. Her overarching argument is that Britain was far more divided in 2017 than it was in 1900 in a variety of ways, but especially regarding wealth inequality. She argued that the socio-economic divides had continued and became more entrenched especially since the 1980s. She argued while conditions have improved with regards to poverty and homelessness between 1900 and 2017, it has not been eliminated and poverty and homelessness are continuing to rise unabated. Historian, Diarmaid Ferriter discussed nearly the same period from the Irish perspective (1900-2000). Ferriter details the radical shift Ireland has seen over the hundred years in nearly every facet of society. He

[5] Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland*, Irish Academic Press, (Newbridge, 2016), p. 305.

expresses alarm at the growing rates of wealth inequality from the 1980s onwards, as mismanagement of public services, such as welfare and healthcare provision, causes those who are poor to fall further behind. He argued that inadequate attention and funding has been given to social issues, while important reforms for centralisation have been prevented in favour of localism. Ferriter describes the situation as near circular, in nature with the mismanagement and misrule by the British, causing massive amounts of poverty being replaced by a native-born elite acting in much the same way.

There is clearly a connection between mental healthcare success and social issues and vice versa. Research has shown that those suffering from mental illness are more likely to live in poverty, experience homelessness and more health conditions.[6] Similarly, those who are in poverty, are homeless or have health conditions, are more likely to develop mental health conditions.[7] By extension poverty, homelessness and health inequalities all tend to compound on one another making existing issues complicated to resolve.

Therefore, this thesis will discuss changes occurring in society more broadly particularly regarding poverty, homelessness, and healthcare. These three areas are intrinsically tied to mental health and to each other, as shortcomings in one of these areas worsens the others. The general trajectory in these areas, especially following the 2008 Financial Crisis, has been negative. However, this thesis will investigate how certain decisions which were made decades earlier ultimately led to the failures which negatively impacted not only mental healthcare but also the broader welfare system. Both England and Ireland have seen major

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[6] Social Exclusion Unit, *Mental Health and Social Exclusion*, Office of the Deputy Prime Minister, (London, 2003).

[7] Shari McDaid & Antonis Kousoulis*, Tackling social inequalities to reduce mental health problems: How everyone can flourish equally*, Mental Health Foundation, (London, 2020), p. 10 also see Rebecca Murphy, Kate Mitchell & Shari McDaid, *Homelessness and Mental Health: Voices of Experience*, Mental Health Reform, (2017, Dublin), pp. 5-8, 18-20 and Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke & Bruce Guthrie, *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study*, Lancet, vol. 380, no. 9836, (2012), pp. 40-42, https://doi.org/10.1016/S0140-6736(12)60240-2, (accessed 20/06/2023).

societal and policy shifts since the 1950s by being able to track these trends and seeing how they interact with mental health policy our understanding of both will be enhanced. Thus, the question this thesis hopes to answer is:

> To what extent have changes in regard to welfare, housing and healthcare affected the effectiveness of changes in the manner in which mental healthcare was conducted in England and Ireland between 1950 and 2019?'

Discussion of this topic has largely been dominated by those from a medical background rather than a historic one. Many of those who write on this topic have directly contributed to it. While this offers a unique perspective when making their argument, some authors have recently expressed their frustration with this situation. The impact of this is while they do discuss the impact of societal factors (especially in the British case) on mental healthcare they often keep their analysis surface level. This thesis hopes to correct this by thoroughly discussing both mental healthcare and societal issues.

The issues around mental health are incredibly complex and multi-faceted thus the focus must be narrowed drastically. This thesis will look at the mental health reforms Ireland and England undertook from 1950 till 2019 and discuss how they impacted the treatment of those with mental illness. The two countries conducted mental health reform slightly differently from one another, to be reflected in the structure of this thesis. In the Irish case, reforms are driven by reports written by experts, notably the *Commission of Inquiry on Mental Illness 1966*,[8] *Planning for the Future 1984*,[9] *A Vision for Change 2006*.[10] The English system in

[8] Commission of Inquiry, *Commission of Inquiry on Mental Illness*, Stationery Office, (Dublin, 1966), https://www.lenus.ie/bitstream/handle/10147/45690/8634.pdf?sequence=1&isAllowed=y, (accessed 12/02/2023).
[9] Study Group on the Development of the Psychiatric Services, *The Psychiatric Services - Planning for the Future*, Stationery Office, (Dublin, 1984), https://www.lenus.ie/handle/10147/45556, (accessed 12/02/2023).
[10] Expert Group on Mental Health Policy, *A Vision for Change*, Stationery Office, (Dublin, 2006), https://www.lenus.ie/bitstream/handle/10147/43357/3327.pdf?sequence=1&isAllowed=y, (accessed 12/02/2023).

comparison is primarily impacted by legislation, thus this thesis will focus on the *Mental Health Act 1959*,[11] *Mental Health Act 1983*[12] and *Mental Health Act 2007*.[13]

This thesis is a continuation of and expansion on my BA dissertation which focused on tracking the evolution of mental health services in Ireland from the 1960s until the present by looking at three key reports. This was done by identifying the key recommendations, what the reports excelled at, and where they were lacking by how they impacted the rates of depressive disorders. Following this, I examined the way they were implemented and how these changes impacted mental healthcare by analysing how they affected the treatment of depressive disorders. The goal was by tracking these changes I would be able to explain why Ireland has some of the highest rates of mental illness in the European Union, which at the time included the UK.[14]

Sources and Methodology

In addition to the historiography of this topic an extensive collection of sources will be used in this thesis. The bulk of these sources are reports, be it governmental reports both for internally and external use, from NGO organisations such as charities and advocacy groups, or research groups such as the Irish Health Research Board (HRB). This offers a detailed account both from the perspective of the government regarding issues around poverty, homelessness, healthcare, and mental health, but also from external groups who are pressing for these governments to do more. These reports offer invaluable insight as some are

[11] House of Commons, *Mental Health Act, 1959*, http://www.legislation.gov.uk/ukpga/1959/72/pdfs/ukpga_19590072_en.pdf, (accessed 12/02/2023).
[12] House of Commons, *Mental Health Act, 1983*, https://www.legislation.gov.uk/ukpga/1983/20/contents, (accessed 12/02/2023).
[13] House of Commons, *Mental Health Act, 2007*, https://www.legislation.gov.uk/ukpga/2007/12/contents, (accessed 12/02/2023).
[14] Eurofound, *Inequalities in the access of young people to information and support services*, Publications Office of the European Union, (Luxembourg, 2019), p. 15, https://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef19041en.pdf, (accessed 16/04/2020).

templates for governmental reform. The goal is to draw from reports written by a diverse group of charities, universities, and governments over many years. By comparing these to one another, a more nuanced discussion can be had, despite how politically charged the discussion has become on all these topics. However, there are issues around standardisation, as different groups (including countries) use different criteria to measure similar phenomena. Additionally, some of the criteria by its nature changes. Both Ireland and England use 60 percent below the median earnings to determine if someone is living in poverty, however the figure applied changes over time and are different between the two countries.

This thesis will also draw upon newspapers as mental health and social issues become more prominent from the 1990s onwards. Some of these are drawn from *The National Archives* in London while others are drawn directly from both British and Irish news organisations. This offers insight into contemporary opinion, and how the media response to government action. As public awareness of issues increases so does the influence media has on government policy. Since public awareness of the issues discussed in this thesis have been increasing, so have news stories covering these issues increased in frequency, placing pressure on the government in both Britain and Ireland to act. However, newspapers their limitations. They are limited in scope and fervent media attention leads to an over emphasis on relatively minor issues. Having discussed the sources and methodology of this paper, the topic of the paper itself will be examined in the next section.

Structure

This thesis is composed of three main sections and seven chapters. The first section, composed of three chapters, discusses main English developments from the 1950s until 2019, with regards to mental health, housing, welfare, and healthcare policy.

The first chapter discusses the Percy Commission and the subsequent 1959 MHA which sought to overhaul the mental health services and challenges that arose, as highlighted by the convention to discusses the *White Paper on Better Services for the Mentally Ill (*1975). Additionally, this chapter discusses the creation of the English welfare state and NHS in the post-war period, as well as the "rediscovery" of poverty and healthcare inequalities. This chapter covers events from 1950 until 1980 with the publishing of the Black Report.

The second chapter continues this narrative from the 1980, following the election of Thatcher, to the election of Tony Blair in 1997 until 2007. This chapter discusses the 1983 MHA and how it reformed mental healthcare in England following major pressure from mental health advocates and how several high-profile homicides during the 1990s by psychiatric patients placed pressure on the government to reform the law. This period also saw a major shift in welfare policy, as major public housing schemes were ended, as were cuts to welfare. The NHS also experienced reforms during this time with mixed results.

The third chapter concludes the English section with a discussion of the MHA 2007, which was passed despite objections from mental health advocates. Following the 2008 crisis and the election of the Conservatives in 2010, rising mental illness rates worsened by the economic fallout. The response of austerity to these issues across the board has seen poverty and homelessness soar, as decades of neglect have caused the NHS to come under major strain.

The fourth chapter marks the beginning of the second section and looks at Ireland from the 1950s until 1984. Ireland was economically and socially behind, compared to England during this period. This chapter discusses the Commission of Inquiry (1966), which marked the beginning of Ireland's long road of mental health reform, the hope being to reduce the high number of patients in mental hospitals. It also discusses how, due to how relatively poor

Ireland was, welfare and healthcare spending remained far lower than in the rest of Europe. In addition, how Irish housing policy was not fit for purpose.

The fifth chapter discusses the *Planning for the Future* (1984) report and covers the period from 1984 until 2006. This report focused on continuing the decline of mental hospital patients and expanding community services, while being modest with its recommendations due to the economic climate. The financial downturn experienced in the 1980s gave way to the boom of the Celtic Tiger in the 1990s. While this period saw major increases in spending, in welfare and healthcare, as housing construction exploded, these improvements were not be experienced by the poorest in society. Homelessness increased and many people remained living in poverty.

The sixth chapter ends the Irish section and discusses the period from 2006 to 2019. The 2006 report *A Vision for Change*, while repeating many recommendations of 1966 and 1984 reports, called for sweeping reforms to the mental health services in Ireland. However, it was never fully implemented. The impacts of the 2008 crash caused many issues in Irish society. Both child poverty and homelessness increased to a concerning degree. Homelessness in general has continued to increase unabated, while the Irish healthcare system struggled to undergo reforms necessary to improve treatment.

The seventh and last chapter is a comparison between the two countries. As the number of hospital patients decreased entering the 1990s, the rate of mental illness became a more useful indicator of the mental health services. It shows that, while Ireland still has a greater degree of mental illness than the UK, the gap greatly narrowed. Both England and Ireland have seen increases in the poverty and homelessness rates, with children most impacted. In terms of healthcare spending, Ireland since the early 2000s, has spent more on-average than

the English and looking at doctors per 100,000 Ireland is rapidly approaching England regarding staff.

Section 1: The English Case 1950-2019

It is not well to sneer at political economy in its relations to the insane poor. Whether we think it right or not the question of cost has determined and will continue to determine their fate for weal or woe.

George Cook

The American Journal of Insanity (1866).[15]

[15] George Cook, *Provision for the Insane Poor in the State of New York*, American Journal of Insanity, ed. Medical Officers of the New York State Lunatic Asylum, (New York, 1866), p. 72.

Chapter 1: The Percy Commission and the 1958 Mental Health Act

This chapter focuses on the foundations of the modern mental healthcare system as well as the welfare and healthcare system between the 1950s and 1983. The 1957 Percy Commission and the subsequent *Mental Health Act* (MHA 1959) reformed nearly every facet of the mental healthcare system and was well received by psychiatrists. However, as shown by the convention on the White Paper *Better Services for the Mentally Ill* in 1975 issues continued to linger.

Additionally, this chapter looks at societal developments around welfare and healthcare to eliminate poverty, homelessness, and poor healthcare. Poverty was presumed non-existent until the 1960s with the publishing of the *Poor and the Poorest* (1965) and welfare spending increased into the 1970s until the election of Margret Thatcher in 1979. This period also saw a major public housing campaign which prevented homelessness from becoming an issue. The modern English healthcare system was created with the passing of the *National Health Service Act* (1946), which formed the NHS in 1948. While there were no major reforms to healthcare in this period the Black Report, published in 1980, highlighted that health issues were far higher amongst the poorer proportions of the population, and thus called for a major anti-poverty campaign.

The Percy Commission, Mental Health Act 1958, and the Aftermath

By the 1950s, there was widespread agreement amongst mental healthcare providers that mental healthcare law needed to be consolidated and updated. *The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (otherwise known as the Percy Commission after its chairman Baron Percy of Newcastle) noted in its opening section that, twenty Acts of Parliament were passed with regards to mental illness from 1808 to 1891. In this period, the laws were consolidated four times with the last being the *Lunacy Act* (1890).

Since 1891, there were only seven Acts that dealt with mental illness, and despite the major advances in medicine, the mental health laws had yet to be consolidated.[16]

The Percy Commission, published in 1957, was the first step in improving the effectiveness of the mental healthcare system in England by reducing the number of patients in mental hospitals. The Commission marked an important turning point for the mental health treatment in England and Wales, with an official turn away from institutionalisation and a pivot towards community treatment amongst its many sweeping recommendations. It also recommended the repealing of all previous legislation concerning mental health as they were 'seriously out of date and unnecessarily complicated.'[17] A cornerstone of the report was reduced restrictions on patients. It stated that 'the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty.'[18] The report also pushed for a focus on medical requirements, rather than legal criteria, of mental health treatment, meaning that for the first time since 1774 no judicial review was required for compulsory orders.[19]

The new system proposed focused on rehabilitation and reintegration. Assuming the patient was a severe case, they would attend the hospital handling in-patient and out-patient care for those who needed specialist treatment, or continual nursing until they were fit to live in the general community.[20] Local authorities were be responsible for community care and provided preventive services for all patients who were no longer required to be in the hospital's care and after care should be provided for as long as required. The Percy Commission went on to

[16] Royal Commission, *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957*, Her Majesty's Stationery Office, Cmnd. 169, (1957), p. 21.
[17] Ibid, p. 7.
[18] Ibid, pp. 3-4.
[19] Szmukler & Gostin, Mental Health Law, p. 70.
[20] Royal Commission, Royal Commission on Mental Illness, p. 17.

note that co-operation between medical staff and social workers of the hospitals and local authorities were vital for this system to work efficiently.[21]

These recommendations were used to create the *Mental Health Act* (1959). It repealed previous legislation and strengthened local authorities in order to provide community care. These reforms were well received by the medical profession. This feeling of enthusiasm for the reforms is perhaps best encapsulated by Eliot Slater, editor-in-chief of the *British Journal of Psychiatry* in 1963: 'Rehabilitation and new treatments are already reducing the bed numbers throughout the country, allowing many of the old "asylums" built in the last century to close within the next 10 to 15 years.'[22] The politicians were slightly more weary, as Enoch Powell, the Minster of Health, gave his famous 'Water Tower' Speech in 1961. Here he announced plans for reducing the number of mental health beds by 50 percent, going on to say:

'There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside – the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault.'[23]

Powell led this assault the following year, with large amounts of funding for the NHS Hospital Plan. This resulted in a slow but still drastic decline in psychiatric hospital beds, with hospital censuses detailing a decline from around 140,000 in 1960, to 107,000 in 1970 and to just over 79,000 by 1980.[24] The MHA 1959 also followed recommendations from the

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[21] Ibid, p. 18.
[22] Eliot Slater, *British psychiatry*, American Behavioral Scientist, 6, no. 9 (1963), p. 43.
[23] Enoch Powell, *Water Tower Speech*, Emerging Patterns for the Mental Health Services & the Public, 9th March, 1961, Church House, Westminster, London, p. 6.
[24] Andrew Scull, UK Deinstitutionalisation, p. 307.

Percy Commission regarding integrating the mental healthcare system into the rest of the NHS.

While these reforms were required, it became apparent that there were still issues. In 1975, during a convention on the White Paper *Better Services for the Mentally Ill*, economic slowdown was noted as a concern due to an increase in unemployment and homelessness that placed an increased demand on mental health services with a lack of new hospitals being built and a shortage of psychiatrists.[25] It is clear by this point that the earlier enthusiasm was more contained, despite the White Paper for the Mentally Ill proposing major advances in community care. There were issues in terms of community care as, Peter Townsend of the Disability Alliance notes: '18 [percent] of… ex-hospital patients were homeless or of no fixed address and 32 [percent] had only one meal a day…people who might have been in hospital in 1960 are not getting much support in the community in 1975.'[26] While in theory, social welfare and health services were supposed to work together to rehabilitate and integrate patients into society. This was simply not occurring, as Townsend went on to state, 'the evidence of repeated Government statements of priority over the last 15 years, we have failed to bring about a marked – not even a modest – shift in resources [to community care].'[27] The issue that Scull argued is that, rather than provide community care, the resources provided over-rely on psychoactive drugs to act as the spearhead of deinstitutionalisation. He argued that shutting down asylums allowed 'governments to save money while simultaneously giving their policy a humanitarian gloss.'[28] Scull also argued that

[25] Department of Health, *Long term plans for comprehensive care of the mentally ill: press notice, parliamentary question and answer; speech notes and background material for the Secretary of State's meeting with the All Party Mental Health Group 22 October 1975; press cutting*, London, The National Archives.
[26] Ibid, p. 12.
[27] Ibid, p. 13.
[28] Andrew Scull, *Decarceration, Community Treatment and the Deviant: A Radical View*, Prentice Hall, (Englewood Cliffs, 1977), p. 139.

'"community care" – was largely a figment of politicians' imaginations, a phrase that sought to obscure the fact that there was little in way of community to which most mental patients could return and still less in the way of care.'[29] Furthermore, akin to the MHA 1959, the 'White Paper embraced some high and rightful aims but did not back them with resources.'[30] Despite the original optimism for a revolution in care that the Percy Commission and MHA 1959 seemed to promise. Yet, by the mid-1970s this had largely dissipated as mental health services, despite gaining more resources, still were not adequately equipped.

The Welfare State, and the Black Report

During the 1950s it was assumed that poverty had nearly been eliminated, with the post-war period known as "The Affluent Society". This is likely due to a 1951 study, which found that in York only 1.5 percent of people lived in poverty in 1950 as opposed to 18 percent in 1936.[31] The contemporary belief was simply that Labour's policies were working: unemployment was kept at around 3 percent until the 1970s, growing wages and the welfare provisions had markedly improved the quality of life for the poorer citizens.[32][33] However, the 1960s also saw the "rediscovery of poverty" with the release of *The Poor and the Poorest,* which found that 7.5 million people were poor with nearly 63 percent of all retired people considered poor and 2 million children were living in poverty.[34] The beginning of an economic crisis in the later 1960s and the election of the Conservative government in 1970 saw the welfare spending cut as anti-poverty measures became means-tested.[35]

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[29] Scull, UK Deinstitutionalisation, p. 307.
[30] Department of Health, Long term plans for comprehensive care of the mentally ill.
[31] Ken Coates and Richard Silburn, *Poverty: The Forgotten Englishmen*, Penguin Books, (Harmondsworth, 1973), pp. 25-26.
[32] Ibid, p. 27.
[33] Pat Thane, *Divided Kingdom: A History of Britain, 1900 to the Present*, Cambridge University Press, (Cambridge, 2018), p. 192.
[34] Brian Abel-Smith and Peter Townsend, *The Poor and the Poorest*, G. Bell & Sons, (London, 1965), pp. 57-60.
[35] Thane, Divided Kingdom, p. 307.

Both Labour and Conservative governments oversaw major housing drives as a part of their social housing policy, that succeeded in building 1,192,000 houses by 1951.[36] This policy of housing construction continued under future administrations with mixed results. 1953 and 1954 marked the peak of housing construction for the Conservatives. building around 327,000 houses both years and Labour saw this peak at 426,000 houses in 1968.[37] Housing construction, however slowed as government support declined, it went from '378,000 in 1969, mostly public sector, to 280,000 in 1974, about 60 [percent] private sector.'[38]

The NHS remained largely unchanged with the major developments occurring alongside the changes with mental health. However, there persisted issues around health inequalities for poorer people. The Black Report (1980), officially the *Report of the Working Group on Inequalities in Health*, was commissioned in 1977 by the Department of Health and Social Services (DHSS).[39] The Black Report covered 20 years from the 1950s to the early 1970s and found that the wealthiest had seen a steady decrease in mortality while the poor saw no improvement or even a deterioration in their mortality rates.[40] The report acknowledged four potential explanations for inequality, but ultimately made clear their 'belief that it is in some form or forms of the "materialist" approach that the best answer lies.'[41] They proposed three key areas for DHSS to focus on: improve care for children so they have the best start possible, improve care for disabled people to improve their quality of life with less institutional care need, and finally improve preventive care and educational action to encourage good health.[42] The final chapter of the report listed a number of policies required

[36] Ibid, p. 196.
[37] Ibid, p. 224.
[38] Ibid, p. 308.
[39] Douglas Black, J. N. Morris, Cyril Smith, Peter Townsend, *The Black Report, Inequalities in Health*, ed. Peter Townsend, Nick Davidson, Penguin Books, (London, 1988), p. 1
[40] Ibid, pp. 2, 40.
[41] Black, Morris, Smith, Townsend, Black Report, p. 114.
[42] Ibid, p. 133.

to improve public health, nearly all of which focused on anti-poverty measures. Amongst the proposals, they suggest redirecting resources from the upper classes towards the poor (they suggest around 30 percent), the end of child poverty by 1990 via child benefit, infant care allowance, the provision of pre-school and day-care, free school meals. Finally, to tackle poverty in the wider community, they suggest disability allowance, safer workplace conditions and improvements around housing.[43]

Patrick Jenkin, the Conservative Secretary of State for Social Services, wrote in the report's foreword that 'additional expenditure on the scale which could result from the report's recommendations – the amount involved could be upward of £2 billion a year – is quite unrealistic in present or any foreseeable economic circumstances… I cannot, therefore endorse the Group's recommendations.'[44] The report was published in 1980 and barely circulated by the Conservative administration. with only 260 copies made available. Despite the DHSS's lack of interest, healthcare specialists and the media showed signifyingly more interest in the report's findings.[45] This report had strong implications considering how poverty, healthcare and mental healthcare interact and compound on one another. The issue was that, while improvements were occurring in terms of health, it was the poor who felt these improvements the least. Lord Kilmarnock perhaps described it best during a House of Lords debate in 1987,

> Just as the gap between the richest and the poorest has increased within an overall increased national income and the plight of the homeless has become worse within an overall pattern of increased home-ownership, so health inequalities have increased… It is all part of the same pattern.[46]

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[43] Ibid, pp. 164-191.
[44] Ibid, p. 31.
[45] Ibid, p. 3.
[46] Black, Morris, Smith, Townsend, Black Report, p. 9.

In summary, the post-war period was filled with both incredible hope and ambition to correct historical injustices. In terms of mental health, the Percy Commission, and the MHA (1959) in combination with medical advances lead to the hope that they could revolutionise mental healthcare and end the asylums in favour of community care. However, by the 1970s it was clear that this revolution failed to materialise, while the asylums had gradually been shut down this did not result in better care with former asylum patients receiving less care in the community than in the asylum. A similar situation unfolded with regards to the post-war welfare state which, while improving the lives of many, still failed the multitude of people it was initially set up to help the most. By the time of the Black Report, the previous measures were clearly not adequate and there was a need to reorganise and refocus resources towards areas of need. However, as shall be examined, this did not occur.

Chapter 2: The Mental Health Act 1983

This chapter will cover from 1980 to 2007. The MHA 1983 which was passed at the end of Thatcher's first premiership, repealed the MHA 1959. The MHA 1983 retained its general outline but played an important role in strengthening patient's rights in many areas. The passing of the act was seen as a major victory for mental health advocacy groups, most notably the National Association for Mental Health (now called Mind). As noted previously, the population in mental hospitals in 1980 was just over 79,000, down from just over 140,000 in 1960. By the time David Cameron became Prime Minster in 2010, this dropped to less than 23,000. [47] However, this progress was undercut by gradual increases in the rates of mental illness and mounting fear from the public towards patients with mental illness in the community.

Mental healthcare was improving. From the period from 1980 until the election of Labour in 1997, England saw a rapid decline in welfare spending with poverty rising as a result, in particular child poverty. The Tony Blair premiership saw child poverty targeted, and while falling short of their overall goals, succeeded in lifting millions of children out of poverty. Overall, poverty remained largely unchanged. Housing policy saw a titanic shift away from public to private housing, with the former only being available to the poorest people in society. Homelessness rose drastically however, during the Labour government this decreased. This period also saw the increasing role of the private sector in the NHS. Ranging from Thatcher inviting Roy Griffiths director of Sainsbury's[48] to make recommendations to reform the managerial system to John Major's Private Finance Initiative (PFI). The latter allowed the private sector to 'build, and own, hospitals and other health care facilities that

[47] Scull, Neoliberal Values and Mental Health, p. 307.
[48] A major British supermarket chain.

they then leased back to the NHS, often at exorbitant rents.'[49] This had long-term effects of undermining the healthcare system, as more money was required to pay the private sector. In-turn, cuts were made to services to make repayments.[50]

Mental Health Act 1983 and the Trajectory of Mental Healthcare

The MHA 1983 did not promise to be the sweeping revolution to mental healthcare treatment that the previous MHA 1953 had aspired to be. The MHA 1983 kept large parts of MHA 1953, but there was a shift away from clinical discretion and towards legalism, where decisions about treatment were made not by the medical professional but dictated by law.[51] The Civil Rights movement in the United States directed attention towards previously marginalised groups, one of which were those with mental illnesses in the now rapidly deteriorating mental hospitals and asylums. The period between 1959 and 1983 was marked by a number of highly publicised scandals and waning faith in the effectiveness of medication and trust in pharmaceutical companies.[52] In one example, Barbara Robb published a book called *Sans Everything: A Case to Answer* in 1967, detailing the conditions many elderly people were left to live in once deinstitutionalisation began, she stated that the elderly were left 'to vegetate in utter loneliness and idleness.'[53] The consequences of this revelation resulted in the Ely Inquiry and resulted in major reforms for long-stay patients.[54] This created a situation where mental hospitals were no longer in adequate condition to properly tend to their needs, pushing them into a community care model that did not have the required resources to provide for those exiting the asylums. The growing public awareness of the

[49] Graham Scambler, Liberty's Command: Liberal Ideology, the Mixed Economic and the British Welfare State, *Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960–2010*, ed. George Ikkos and Nick Bouras, Cambridge University Press, (Cambridge, 2021), pp, 25-26.
[50] Ibid, p. 26.
[51] Szmukler and Gostin, Mental Health Law, p. 72.
[52] Ibid, pp. 72-73.
[53] Barbara Robb, *Sans Everything: A Case to Answer*, Nelson, (London, 1967), p. xiii.
[54] Claire Hilton, *A Tale of Two Inquiries: Sans Everything and Ely*, The Political Quarterly, 90, (2019), p. 185.

plight of the mentally ill saw the growth in prominence of organisations like Mind, Larry Gostin, an American law professor who specialises in public health law, essentially wrote Mind's proposal for reform, arguing,

> The [MHA 1959] is largely founded upon the judgment of doctors; legal examination has ceased at the barrier of medical expertise, and the liberty of prospective patients is left exclusively under the control of medical judgments which have often shown in the literature to lack reliability and validity.[55]

Despite this victory, by the mid-1990s there were clearly serious issues in terms of mental health care. *The Independent* newspaper wrote in 1995 'For every 122 patients who needed care, only 100 beds were available…' and on the same day *The Times* reported 'Crowded mental wards "turned into battles zones."'[56] In a report on the crisis in inner city mental health, it noted a number of serious issues placing large amounts of pressure on acute wards. Additionally occupancy levels were as high as 140 percent, increasing number of assaults on staff, and poor aftercare co-ordination, amongst other issues.[57] Community care was also noted to be in poor condition with high demand and funding restrictions placing constraints on services as well as 'conflicting drives between different agencies and primary care leading to potential for increasing fragmentation of services!'[58] This is despite improvements to community care for when patients were able to start receiving treatment. However, there were still gaps in this care 'such as twenty-four-hour crisis services, high support

[55] Larry Gostin, *A Human Condition: The Mental Health Act from 1959 to 1975: Observations, Analysis and Proposals for Reform*, Vol. 1, Mind, (London, 1975), p. 35.
[56] David Roy, Paul Lelliot, Hilary Guite, *Inner City Mental Health: A report to the Council of the NHS Trust Federation*, February 1996, London, The National Archives, p. 1.
[57] Ibid, p. 4.
[58] Ibid, p. 6.

accommodation and the increase in the number of trained workers with appropriate case loads' as well as staff shortages of every role from nurses to consultant psychiatrists.[59]

The 1990s witnessed growing public anxiety directed towards patients in the community. A 1996 report to the Minister of Health, stated 'Although the [Confidential Inquiry into Homicides and Suicides by Mentally Ill People] also reported on 240 suicides, it was its conclusions on 39 cases of homicide between July 1992 and March 1995 that were given by far the higher profile [by the media].'[60] One such example cited in the report being from *The Guardian*, which in 1996, ran the headline 'Spotting a killer'. It discussed how to identify potentially dangerous mentally ill patients.[61] Another notable example was *The Falling Shadow* written by Louis Blom-Cooper and published in 1995. It sensationalised fears around mental illness by detailing a homicide by a patient in community care. Thus, by the late 1990s, the government was in the process of drafting an update of the MHA 1983 which took the form of the MHA 2007.[62]

Thatcher, Major, Blair, and the Welfare State

In the 1979 election, the UK elected a Conservative government, and Prime Minister Margaret Thatcher promptly launched a major effort in dismantling the welfare state. As a result, during her premiership, poverty, wealth and income inequality grew dramatically.[63] Thatcher believed that 'inequality was the natural and desirable state of society', and to that end she was incredibly successful.[64] By the time she resigned in 1990, child poverty had nearly doubled to 28 percent (from 1.7 million to 3.3 million) and from 1979 to 1992

[59] Roy, Lelliot, Guite, Inner City Mental Health, pp. 6-7.
[60] Department of Health, Mental Health 1995-1998, Flag E2, The National Archives, London.
[61] Referenced within ibid.
[62] Louis Blom-Cooper, *The Falling Shadow: One Patient's Mental Health Care, 1978-93*, Bloomsbury, (London, 1995).
[63] Thane, Divided Kingdom, p. 346.
[64] Ibid, p. 346.

homelessness grew from 70,000 to 180,000.[65] While real incomes increased 37 percent between 1979 and 1992 the richest 10 percent saw their incomes grow by 61 percent, meanwhile the poorest 10 percent saw their incomes drop by 18 percent.[66]

Tony Blair and "New" Labour were elected in 1997, but "third way socialism" proved to appear remarkably similar to Thatcherism. Blair, like Thatcher strongly believed in social responsibility and saw the welfare state as encouraging dependency, resulting in some referring to him as the "son of Thatcher".[67] This title is perhaps unearned, as while poverty and inequality largely remained at their previous levels, they did not increase to the same degree that they had during the 1980s. Despite this shortcoming, Labour planned to halve child poverty by 2010 and eliminate it by 2020, and while they fell short of these goals, they did lift 1.1 million children out of poverty.[68] Children and pensioner poverty declined drastically under Blair and unemployment dropped below 1 million, Kitty Stewart argued that 'Overall Britain is a fairer and more equal society in 2007 than it was in 1997…'[69]

Regarding housing, Thatcher passed the *Housing Act* (1980) allowing tenants to buy their council house at a heavily discounted price, with the buyers often being middle-aged, skilled working class which only increased regional and social inequality.[70] By 1995 1.7 million houses, or a quarter of the 1980 stock, had been bought by tenants. Meanwhile, councils were forbidden from using the sales to build more housing, thus 'council housing fell from almost one-third to one-fifth of total housing between 1979 and 1994.'[71] This eroded local

[65] Scull, UK Deinstitutionalisation, p. 309 and John Hills and Beverley Mullings, 'Housing. A Decent Home for All at a Price Within their Means?', *The State of Welfare: The Welfare State in Britain since 1974*, ed. John Hills, Oxford University Press, (Oxford, 1990), p. 149.
[66] Eric Evans, Thatcher and Thatcherism, Routledge, (London 1997), p. 118.
[67] Thane, Divided Kingdom, p. 426.
[68] Ibid, p. 449.
[69] Kitty Stewart, *Equality and Social Justice, Blair's Britain*, 1997–2007, ed. Anthony Seldon, Cambridge University Press, (Cambridge, 2007), p. 435.
[70] Thane, Divided Kingdom, p. 353.
[71] Thane, Divided Kingdom.

authorities' revenue streams as payments from council housing fell from £1,258 million to £520 million between 1979 and 1989.[72] The Conservative government expected this shortfall to be made up by raising the rents of remaining tenants, which ultimately rose by 50% on average. As real incomes fell and unemployment rose, a means-tested housing benefit was introduced.[73] This effectively ended the previous goal of socially mixed housing. Those in council housing increasingly becoming lower income households, as the divide between those who were prospering and those who were left behind widened. *The Housing Act* (1988) reduced the power of local authorities even more, in favour of housing associations and landlords to fill the void.[74] John Major continued to implement Thatcherite policies to deregulate the housing market, avoiding building public housing. During Labour's term, homelessness remained high in comparison to other European countries. Of particular concern was homelessness amongst the mentally ill, with 30 to 50 percent of rough sleepers having mental illness'.[75] This created a cycle of exclusion in-which the longer it persisted, the harder it became to break.[76]

Unlike welfare or public housing, the NHS escaped relatively unharmed in Thatcher's first term. Nigel Lawson, the Chancellor of the Exchequer, in 1983 aspired for the privatisation of the NHS but other Treasury officials argued that the NHS was cost-effective, with quality comparable to that of other countries.[77] The Griffith's reforms were introduced in 1983 which 'greatly [increased] central supervision and management costs with no obvious increase in efficiency or quality of service.'[78] In 1989, Thatcher's government published the white paper *Working for Patients* which was then implemented via the *National Health Service and*

[72] Ibid, p. 354.
[73] Ibid, p. 354.
[74] Ibid, p. 378.
[75] Social Exclusion Unit, Mental Health and Social Exclusion, p. 18.
[76] Ibid, p. 20.
[77] Thane, Divided Kingdom, p. 367.
[78] Thane, Divided Kingdom.

Community Care Act (1990).[79] These reforms sought to create an internal market between the bodies that provided care and those who bought it, with the hope being an increase in patient choice and satisfaction.[80] These reforms required a much larger bureaucracy to run and thus the salaries of administrators and managers increased from £158.8 million in 1990 to £609.6 million in 1994 as 'it sat on the spectrum somewhere between a bureaucratic command and control economy and a private free market.'[81] Major introduced PFIs, which were rarely used, and the 1991 Patients' Charter, but otherwise the NHS was largely left alone.

Unlike Major, Blair and his Chancellor of the Exchequer and eventual successor, Gordon Brown embraced PFIs which acted as a Trojan horse for privatisation in the NHS. While in the short term these costs did not appear on government books, in the long run cost the NHS far more.[82] Allyson Pollock thoroughly discusses the shortcomings of the PFI from it costing too much, to providing buildings that did not meet the needs of the area and then absorbing the entirety of the NHS budget for the area. She went on to argue that 'they are leading to more and more uneven levels of service provision, as trusts with expensive PFI hospitals struggle to balance their books by cutting services to divert funds to meet their PFI payments.'[83]

In conclusion, while the MHA 1983 marked a step in the right direction it was ultimately overshadowed by the subsequent events of the Thatcher, Major and Blair administrations. As a reaction to several criminal actions by mentally ill patients saw a government response in the form of the MHA 2007. Regarding welfare policy Thatcher shattered the post-war system, a project subsequent conservative governments continued. While Blair stalled the

[79] Ibid, p. 281.
[80] Department of Health, *Working for patients*, Her Majesty's Stationery Office, CM 555, (London, 1989).
[81] Thane, Divided Kingdom, p. 381 and Scambler, Liberty's Command, p. 25.
[82] Allyson Pollock, *NHS Plc: The Privatisation of our Health Care*, Verso, (London, 2005), pp. 27-28.
[83] Ibid, p. 61.

erosion of the welfare state, he did not reverse it, the effects of which will be seen in the next chapter.

Chapter 3: The Mental Health Act 2007

This chapter will discuss the period from 2007 to 2019. The New Labour government attempted to pass reforms to the MHA 1983 in 2002, 2004 before succeeding in 2007. , The UK had run afoul of the European Convention on Human Rights, making a review of previous legislation necessary. This was the first full scale review since the MHA 1959. However, as member of the House of Lords, Baronness Barker argued 'the Bill is not the step forward for people with mental health problems that we all wanted, it is not the Bill that we needed and it will not be the legislation that we need.'[84]

The 2007 MHA marked a return to strengthened physiatrists discretion, like the MHA 1959, rather than a legal process which was present in MHA 1983. However, John Fanning, professor of law, argued unlike the MHA 1959, where the focus was on making decisions according to clinical need. The MHA 2007 emphasised prevention of risk, adding 'a covert political dimension to mental health decision making...'[85] This period saw rising rates of mental illness in the population at a time when mental health services were being cut due to lack of funding.

The welfare system following the 2010 election, saw further cuts to spending and poverty continuing to rise. By the end of 2019, the social security payments were the lowest they had been since the foundation of the welfare state.[86] Similarly homelessness had also greatly increased, as by 2019 it was nearly twice as high as in 2009. Meanwhile, the NHS struggled to pay back the PFIs approved by Labour and the Conservatives, resulting in cut services to make repayments. These developments contributed to increases in both mental illness and worsening conditions for those with mental illness.

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[84] Hansard, House of Lords, 2 July 2007, Col. 817.

[85] John Fanning, *Risk and the Mental Health Act 2007: Jeopardising liberty, facilitating control?*, PhD thesis, University of Liverpool, (Liverpool, 2013), pp. 39-40.

[86] Scambler, Liberty's Command, p. 27.

Mental Health Act 2007 and the State of Mental Healthcare pre-Covid

As previously mentioned, the MHA 2007 was created as a reaction to a number of negative news stories. This created an issue as what was necessary for patients' wellbeing was placed second to that of "public safety". The government began reviewing the MHA 1983, as Frank Dobson, the then Secretary of State for Health stated, to 'ensure that patients who might otherwise be in danger to themselves and others are no longer allowed to refuse to comply with the treatment they need. We will be changing the law to permit the detention of a small group of people who have not committed a crime but whose untreatable psychiatric disorder makes them dangerous.'[87]

The Mental Health Alliance formed in 1999 as a response to these developments with Rowena Daw becoming the chair of the coalition 'of 80 organisations, [it] was a unique alliance of: service users; psychiatrists; social workers; nurses; psychologists; lawyers; voluntary associations; charities; religious organisations; research bodies; and carers' groups.'[88] The government in response to this opposition appointed an Expert Committee chaired by Ginevra Richardson which produced a well-received report which emphasised non-discrimination towards mentally ill people, patient autonomy and their right to care and treatment, with a preference for voluntary treatment.[89] However, as Daw argued,

> [The] Government, on the other hand, had different priorities. It was driven to legislate by its need to deal with breaches of the European Convention on Human Rights; its wish to give flexibility in delivery of mental health services through compulsory treatment in the community; and its fear of 'loopholes' through which otherwise treatable patients might slip. In its general approach, the government

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[87] Szmukler and Gostin, Mental Health Law, p. 76.

[88] Rowena Daw, *The Mental Health Act 2007: The Defeat of an Ideal*, Journal of Mental Health Law, no. 16, (2007), p. 131.

[89] Ibid, p. 132.

> followed a populist agenda fueled by homicide inquiries into the deaths caused by mental health patients. Public concern and media frenzy went hand in hand to demand better public protection against those who were mentally ill and dangerous...[90]

While the Act by and large stripped patients' rights in favour of public safety, it is worth noting that it did strengthen patients' rights regarding electroconvulsive treatment.[91] The results of these reforms can be seen in the increase of involuntary admissions in England from 1964 to 2014. Involuntary admissions slowly declined from just over 12,000 admissions to about 10,000 in 1984 before rising sharply until 1998. It then stabilized at just over 25,000 until 2007 where it increased rapidly towards 50,000 admissions.[92] While the changes to the legislation may be the most obvious explanation for these rates of change with spikes after both the 1983 and 2007 Acts it ignores the stabilization between 1998 and 2008, 'a period [that] was characterised by a substantial investment in community mental health services, suggesting that resources are a major determinant of the rate of involuntary admissions. Consistent with a resource contribution is the steep rise from 2009, a period of austerity'[93]

The election of the Conservatives saw a quick reversal of any improvements in mental healthcare as David Cameron announced, 'The age of irresponsibility is giving away to an age of austerity.'[94] The Conservatives and their Liberal Democrat allies cut funding for local authorities by 60 percent. Additionally, they placed caps on council taxes, which placed them under great financial strain with amongst their responsibilities included community care for the mentally ill.[95] This combined with suicide rates increasing during periods of economic recession with a 'rise in unemployment appear[ing] to account for less than half of the

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[90] Daw, The Defeat of an Ideal, p. 132.
[91] Szmukler and Gostin, Mental Health Law, p. 77,
[92] Ibid, p. 81
[93] Szmukler and Gostin, Mental Health Law, p. 81.
[94] Paul Barltrop, *The Age of Austerity*, BBC, 2010, http://news.bbc.co.uk/2/hi/programmes/politics_show/regions/west/8711855.stm, (accessed 02/05/2023).
[95] Scull, UK Deinstitutionalisation, p. 310.

increase in suicide deaths during recessions,' as well as 'the people most vulnerable to job loss and debt are individuals with pre-existing mental health problems or past psychiatric illness.'[96] The impacted of the rising rates of mental illness was severe as the Mental Health Foundation published a report that found that the UK economy lost at least £117.9 billion in 2019 (or 5 percent of GDP) with 'mental health conditions… account[ing] for 7% of all ill health in the UK.'

Equally problematic is the rise of the "gig economy" (employed people in work but looking for additional hours, an extra job or a job with more hours) which strips workers of their security, leading to increases in underemployment and working poor (those who are employed but who are below the poverty line). [97] Meta analysis found that the 'rates of depression, anxiety, and suicide correlate negatively with income and employment, with those with the lowest incomes in a community suffering 1.5 to 3 times more frequently from depression, anxiety and other common mental illnesses than those with the highest incomes.'[98] This combined with the fact that these cuts have also pushed those with mental illness into poverty, the Joseph Rowntree Foundation (JRF) found that 'Nearly half of those who are disabled and living in poverty have a mental disability[99] – around 2.1 million people. The poverty rate among those who are mentally disabled is 39%, 9 percentage points higher

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[96] David Gunnell, Jenny Donovan, Maria Barnes, Rosie Davies, Keith Hawton, Nav Kapur, Will Hollingworth and Chris Metcalfe, *The 2008 Global Financial Crisis: Effects on Mental Health and Suicide*, Policy Report No. 3, University of Bristol, (2015), pp. 2-3.

[97] The Health Foundation, *Trends in unemployment and underemployment*, The Health Foundation, (2022), https://www.health.org.uk/evidence-hub/work/employment-and-underemployment/trends-in-unemployment-and-underemployment, (accessed 02/05/2023) and Phillip Inman, *Number of people in poverty in working families hits record high*, The Guardian, https://www.theguardian.com/business/2020/feb/07/uk-live-poverty-charity-joseph-rowntree-foundation, (accessed 02/05/2023).

[98] Matthew Ridley, Gautam Rao, Frank Schilbach & Vikram Patel, *Poverty, Depression, and Anxiety: Causal Evidence and Mechanisms*, Science (American Association for the Advancement of Science) 370, no. 6522 (2020), p. 2.

[99] Mental disability in this context includes mental illness as well as learning, memory, and social and behavioural difficulties.

than those who have a physical disability.'[100] Scull, described the current situation for many patients in need of care in stark terms,

> Many psychotic patients are thus left to shuffle between flop-houses, homelessness, and short periods in jail, when their illness and dependency cause them to commit what are usually minor offences. Misery and poverty remain their lot, till most of them succumb to an early death. Given the thrust of public policy for the past sixty years, it should come as no surprise to learn that those afflicted with serious mental illness have a life expectancy of between fifteen and twenty-five years less than the rest of us. It is, nonetheless, a disgrace.[101]

Decline of the Welfare State and the Privatisation of the NHS

The Conservative government in 2010 cut many of the remaining welfare payments leading to increases in poverty, homelessness and in turn mental illness while weakening the institutions that could counter or mitigate these issues. Despite this, welfare had been cut repeatedly by Conservative governments as when the 'unemployment benefit was first introduced in 1948, it was equivalent to 20 [percent] of average weekly earnings. Since then, the real value of today's equivalent – the universal credit standard allowance – has fallen to 12.5 [percent] of average earnings.'[102]

The homeless charity Crisis published a report in 2015 that showed rehousing a homeless person, regardless of how long the individual was homeless, costed less than to leave the problem grow worse.[103] They proposed vignettes one with early intervention which sees the average costs £2,317, and one where homelessness persists for 12 months before

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[100] Joseph Rowntree Foundation, *UK Poverty 2019/20*, Joseph Rowntree Foundation, (York, 2020), p. 56.
[101] Scull, UK Deinstitutionalisation, p. 312.
[102] Clare McNeil, Dean Hochlaf & Harry Quilter-Pinner, *Social (in)security: Reforming the UK's Social Safety Net*, Institute for Public Policy Research, (2019), p. 2, 18-19.
[103] Nicholas Pleace, *At What Cost?*, Crisis, (London, 2015), p. vi.

intervention, with an average cost of £12,327.[104] These are figures that hold true internationally, and that is ignoring the human cost of being homeless.[105] Homelessness, while slightly declining in 2019, remains 42 percent above its 2009 low point with 200,000 homeless people living in temporary accommodation and rough sleepers remaining an issue for many local authorities.[106]

The English healthcare system following the 2008 crisis has been placed under extreme pressure. In 2022, The King's Fund chief executive Richard Murray reported on the state of the NHS that 'though Covid certainly exacerbated the crisis in the NHS and social care, we are ultimately paying the price for a decade of neglect.'[107] While stagnating funding has contributed to this decline, the increasing privatisation of the NHS cannot be overlooked either. Initially, the Conservatives argued against the PFI, however once elected they quickly adopted them. In their first year they approved 61 PFIs worth £6.9 billion (as opposed to 32 in 2008 and 38 in 2009 under Labour). Mark Hellowell, from the University of Edinburgh argued 'the government is very concerned to keep the headline rates of deficit and debt down, so it's looking to use an increasingly expensive form of borrowing through an intermediary knowing the investment costs won't immediately show up on their budgets.'[108] In 2018, following the collapse of a major PFI provider, the government announced the end of their usage of PFI but 'Existing PFI [...] contracts will not end because of this announcement – the

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[104] Ibid.
[105] Dennis Culhane, *The Costs of Homelessness: A Perspective from the United States*, European Journal of Homelessness, 2.1, (2008), pp. 97-114.
[106] Suzanne Fitzpatrick, Hal Pawson, Glen Bramley, Jenny Wood, Beth Watts, Mark Stephens & Janice Blenkinsopp, *The homelessness monitor: England 2019*, Crisis, (London, 2019), pp. xii-xiii.
[107] Denis Campbell, *Decade of neglect means NHS unable to tackle care backlog, report say*s, The Guardian, (2022), https://www.theguardian.com/society/2022/dec/12/decade-of-neglect-means-nhs-unable-to-tackle-care-backlog-report-says, (accessed 05/05/2023).
[108] Andrew Sparrow, *George Osborne backs 61 PFI projects despite earlier doubts over costing*, The Guardian, (2011), https://www.theguardian.com/politics/2011/apr/18/george-osborne-backs-pfi-projects, (accessed 06/05/2023).

Government will honour its commitments.[109] This is despite the fact the damage has already been severe to the NHS finances in 2022, as NHS trusts were required to pay just under £50 billion or a third of the NHS England budget for 2019-2020 for PFI payments.[110] As a result of the increasing use of PFIs has caused the NHS to place the PFIs and private interests payments ahead of caring for patients.[111]

In conclusion, the post 2007 period regarding both the welfare state and mental illness has been one marked by defeat, errors, and steps backward. Despite the minor improvements the 2007 MHA offered, it was overall not needed nor wanted by many involved in treating mental illness. This was compounded by successive Conservative governments (sometimes in coalition with the Liberal Democrats or the Democratic Unionist Party) cutting much of what remained of the welfare state. The result has been homelessness, poverty and mental illness rising in unison. Meanwhile, the NHS, an institution many English people take great pride in, is on the brink of collapse with Richard Murray saying that 'In my (quite long) career I do not think I have ever seen such widespread and deep problems and the signs of stress are everywhere.'[112]

[109] HM Treasury, *Budget 2018: Private Finance Initiative (PFI) and Private Finance 2 (PF2)*, (2018), https://www.gov.uk/government/publications/private-finance-initiative-pfi-and-private-finance-2-pf2-budget-2018-brief, (accessed 06/05/2023).
[110] Michael Goodier, *NHS hospital trusts paying hundreds of millions in interest to private firms*, The Guardian, (2022), https://www.theguardian.com/politics/2022/oct/25/nhs-hospital-trusts-paying-hundreds-of-millions-in-interest-to-private-firms, (accessed 06/05/2023).
[111] Kamran Abbasi, *The BMJ's Commission on the Future of the NHS*, BMJ, 381, (2023), p. 1.
[112] Richard Murray, *The health and care system is in crisis: what should (and shouldn't) be done?*, The King's Fund, (2022), https://www.kingsfund.org.uk/blog/2022/08/health-and-care-system-crisis-what-should-and-shouldnt-be-done, (accessed 06/05/2023).

Section 2: The Irish Case 1950-2019

Thanks to this indifference of the public, our asylums are in a bad way. They are over- crowded. They are both understaffed and inefficiently staffed. Curable and incurable cases are herded together. There is practically no treatment. The percentage of cures remains at a very low figure. Public money is wasted. The asylums are unsuitable for their purpose in almost every respect.

Edward Boyd Barrett,

Modern psycho-therapy and our asylums (1924)[113]

[113] E. Boyd Barrett, 'Modern psycho-therapy and our asylums', *Studies*, vol. 13, No. 49, (March 1924), p. 29.

Chapter 4: The 1966 Commission of Inquiry on Mental Illness

This chapter discusses the period from 1950 until 1984. It will look at early attempts to reform the Irish mental healthcare system through the 1966 report the Commission of Inquiry. The Irish mental healthcare system in this period struggled, with the 1950s witnessing overcrowding in district and auxiliary hospitals. The report *The Commission of Inquiry on Mental Illness*, published in 1966 formed the foundation of future reports most notably *Planning for the Future* and *A Vision for Change.* As Walsh argued, 'In its understanding of the defect of the services of the time the Commission was particularly acute and its recommendations so visionary that they are hardly bettered in principle or in spirit by its successors, *Planning for the Future* in 1984 and *A Vision for Change* in 2006.'[114] Implementation was slow, with changes occurring incrementally, or in some cases not at all. With some, recommendations being repeated in the 2006 report, some forty years later.

This chapter will also look at the state of welfare provision, housing and healthcare in this time period. The Irish welfare spending wasfar lower than England, or the rest of Europe. For much of this period. economic conditions largely prevented major increases in welfare spending until the 1980s. Housing was also a major issue, with poor housing policy resulting in tens of thousands of houses being unfit for human habitation. The healthcare systems gradual reform, from a highly decentralised system, to one group by region reflected Irish society's slow progress towards modernisation.

[114] Dermot Walsh, Mental Health Services in Ireland, 1959-2010, Asylums, Mental Health Care and the Irish 1800-2010, ed. Pauline Prior, Irish Academic Press, (Newbridge, 2012), p. 78.

1966 Commission of Inquiry on Mental Illness: The First Step to Reform

During the period of 1950 to 1960 the Irish population had declined by approximately 200,000 due to emigration. [115] Despite this, the patients' numbers in mental hospitals remained unaffected. There were 19,950 patients in Irish district and auxiliary hospitals on 31 December 1959.[116] This meant that the number of patients had remained at around 20,000 as in 1950 there was 20,079.[117] The Commission recommended a number of progressive reforms, many of which were taken directly from the Percy Commission. This was due to the fact the Commission of Inquiry had members working in England and had inquired with the British Ministry of Health (amongst other institutions) in which they had dealt with an 'analogous situation in England and Wales.'[118] Additionally, the Commission was spurred on by the Irish White Paper on *The Health Services and their Further Development* (1966) which was used by the Commission as a framework in which to structure their recommendations around.[119]

The picture painted by the Commission of the mental healthcare services was extremely bleak, with Ireland reportedly having the highest rate of mental illness in the world with 'approximately 7.3 psychiatric beds… provided in 1961 per 1,000 of the population'.[120] As a result of this exceptionally high rate of mental illness, the Commission eventually concluded that more research was required urgently. This was done following this report, by the

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[115] Central Statistics Office, *Census of the Population of Ireland 1961*, Stationary Office, (Dublin, 1963), p.2, https://www.cso.ie/en/media/csoie/census/census1961results/volume1/C_1961_Vol_1.pdf, (accessed 10/04/2023).
[116] DH, *Report of the Inspector of Mental Hospitals for the year 1959*, Stationery Office, (Dublin, 1959), p.5, https://www.lenus.ie/bitstream/handle/10147/249838/ReportOfTheInspectorOfMentalHospitalsForTheYear1959.pdf?sequence=1&isAllowed=y, (accessed 10/04/2023).
[117] DH, *Report of the Inspector for Mental Hospitals for the year 1950*, Stationery Office, (Dublin, 1950), p.7, https://www.lenus.ie/bitstream/handle/10147/251923/ReportOfTheInspectorOfMentalHospitalsForTheYear1950.pdf?sequence=1&isAllowed=y, (accessed 10/04/2023).
[118] Walsh, Mental Health Care and the Irish, p. 78.
[119] Commission of Inquiry, Commission on Mental Illness, pp. xvi-xvii.
[120] Ibid, xiii.

Medico-social Research Board, found that mental illness was no worse in Ireland than anywhere else.[121] Issues were worsened by the fact that hospitals were simply outdated with the Commission writing, 'There are still too many barrack-like structures characterised by large wards, gloomy corridors and stone stairways. Too many also have inadequate facilities and services and lack the purposeful activity and therapeutic atmosphere.'[122] Concluding that 'in Ireland mental illness poses a health problem of the first magnitude.'[123]

The Commission's recommendations could be summarised as 'community services and short-term and long-term hospital treatment,' which mirrored the Percy Commission's recommendations of community services provided by local authorities and in-patient hospital care.[124] The hope was to establish short-term units close to or in hospitals and, while the Commission notes that 0.5 beds per 1,000 is adequate in Britain they recommend 0.5-1 per 1,000 to accommodate the 'exceptionally high admission rate in this country.'[125] The Commission emphasised that it was 'just as essential to develop facilities for long-term residential treatment as it is to provide short-term psychiatric units', as if either half failed to function, the entire system failed.[126] Central to the Commission's recommendations were measures designed to increase patients' liberty and preserve their individuality in order to help with rehabilitation and reintegration. These ranged from reducing long-term unit sizes to a max of 750 beds, to more simple improvements such as allowing patients to keep personal items and wear clothes of a variety of colours.[127] The Commission believed if these reforms could be implemented that the number of individuals in long term care could be rapidly reduced stating, 'the advent of drug therapy and increased understanding of mental illness has

[121] Walsh, Mental Health Care and the Irish, p. 117.
[122] Commission of Inquiry, Commission on Mental Illness, p. xiii.
[123] Ibid.
[124] Ibid, xv.
[125] Ibid, pp. 34-35.
[126] Ibid, p. 40.
[127] Ibid, pp. 48-49.

facilitated the care and treatment in the community of many persons who, in the past, was cared for in hospital.'[128]

Despite the sweeping recommendations the Commission made, actual implementation proved to be a far more difficult task, with Dermot Walsh concluding that, 'it is difficult to evaluate the impact it had on mental health services.'[129] Walsh is perhaps understating it. Many recommendations were either ignored, or were simply not sufficient to remedy the situation. There were multiple possible reasons for this. Walsh suggests that it was due to the fact that 'no mechanism of implementation was broached and no costing was attempted.'[130] The Chief Psychiatrist Ivor Browne grew increasingly frustrated in his reports, with his report to the Eastern Health Board (EHB) on the evolution of mental health services in 1977, expressing annoyance at the fact that despite raising concerns around admission and discharge procedures to the EHB and the government repeatedly, no action had been taken.[131] By the late 1970s discussion of reform ceased entirely as it was clear that a new report was required to breathe life back into the reform movement.

The Church, State, and the Welfare State

Ireland experienced economic malaise through the 1950s with the writer Anthony Cronin described the stagnation that had crept into Irish society as a whole in 1954 as, 'here, if ever was, is a climate for the death wish.'[132] In the period of 1949 to 1956, Ireland fell increasingly far behind the rest of Europe with 'real national income [rising] by only 8 [percent], at a time when the average increase in Europe was about 40 [percent]' with

[128] Commission of Inquiry, Commission on Mental Illness, p. 55.
[129] Walsh, Mental Health Care and the Irish, p. 118.
[130] Walsh, Mental Health Care and the Irish, p. 118.
[131] Ivor Browne, *Development of community mental health services: planned evolution*, Eastern Health Board, (1977), p. 29, http://hdl.handle.net/10147/45611, (accessed 22/05/2023).
[132] Anthony Cronin, *This time, this place*, The Bell, vol. XIX, no. 8, (1954), pp. 5-7.

attempts to reform facing 'significant barriers and a stubborn refusal to face reality.'[133] The 1950s saw extremely high unemployment with as many 100,000 being unemployed, with unemployment benefit being '50 shillings (even for a family of up to ten), which obliged those on welfare to live on a diet of bread and margarine, milk and tea… while Erskine Childers of Fianna Fáil[134] suggested that unemployment could be solved only under a dictatorship.'[135] The 1960s saw a period of major economic growth. This economic growth in turn paved the way for the expansion of the welfare state, as means tests were relaxed and payments grew larger with per capita spending on social welfare in real terms rising by 55 percent between 1966 and 1973.[136] However, Ireland's welfare system still lagged behind other EEC nations (Ireland officially joined the EEC, now the EU in 1973), including Britain by the turn of the 1970s.[137] This improvement was short-lived as the economic chaos that dominated the 1970s in Britain had an equally strong effect in Ireland with the situation worsening well into the 1980s with political parties being accused of 'being prepared to risk national bankruptcy in order to buy votes.'[138]

In the 1960s there was a growing recognition that the provision of social services was lagging behind economic development. Housing became a particularly contentious issue in this period when a tenement house collapsed in Dublin resulting in the death of four people sparking widespread outrage.[139] A local authority survey nationwide in 1963 suggested up to 60,000 houses were unfit for human habitation.[140] A White Paper from 1964 notes that 98,000 new homes needed to be built from 1964 – 1970 in order to meet demand or 14,000

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[133] Diarmaid Ferriter, *The Transformation of Ireland, 1900-2000*, Profile Books, (London, 2004, p. 463.
[134] Irish meaning "Soldiers of Destiny", traditionally the largest party in Ireland
[135] Ferriter, The Transformation of Ireland, p. 491.
[136] Mary Daly, Sixties Ireland: Reshaping the Economy, State and Society, 1957–1973, Cambridge University Press, (Cambridge, 2016), pp. 250-252.
[137] Ibid.
[138] Ferriter, The Transformation of Ireland, pp. 669.
[139] *Collapse of Tenements 1963*, Dublin City Council, (2019), https://www.dublincity.ie/library/blog/collapse-tenements-1963, (accessed 23/05/2023).
[140] Ferriter, The Transformation of Ireland, pp. 591.

houses per year.[141] While this did result in increases in the supply of housing, it proved to be insufficient to meet demand. With little to no government intervention, a new class began to grow in dominance during the 1980s as Ferriter notes, ‘it was ironic that a hundred years after the end of the Irish Land War[142], a native class of landowner and speculators aped many of the traits of the worst landlords of the nineteenth century.’[143]

The effort to reform the Irish healthcare system began in earnest in the early 1950s with Dr. Noël Browne’s Mother and Child Scheme, which granted free healthcare to mothers and children up to the age of sixteen.[144] Browne faced fierce criticism from the Church and healthcare providers, in the subsequent political crisis the Scheme was defeated and the government collapsed shortly after the resignation of Browne.[145] The traditional view of this clash is of the state opposing the church. However, as a contemporary, Liam O’Bríain a professor of languages wrote in a letter to Michael Hayes of Fine Gael[146] in 1951, ‘I and many can’t resist the feeling that the bishops were pulled by the doctors who wanted to remain gentlemen and not let officials near them or their tax returns.’[147] The importance of this defeat would have drastic ramifications later as it would fundamentally shape the health services and the welfare state as a whole in Ireland with, ‘the premise on which the welfare state is based, was settled in the controversy. It was settled against a universal non-means test system and in favour of a neo-liberal model.’[148] The Fianna Fáil government that replaced it instead passed a much-reduced version of the Mother and Child Scheme in the 1953 Health

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[141] Fred Powell, *The Political Economy of the Irish Welfare State: Church, State and Capital*, Policy Press, (Bristol, 2017), p. 160.
[142] The Irish Land War occurred between 1879-1882 and was marked by agrarian agitation against landlordism in Ireland.
[143] Ferriter, The Transformation of Ireland, pp. 675.
[144] Noël Browne, *Against the Tide*, Gill and Macmillan, (Dublin, 1986), pp. 150-151.
[145] John Cooney, *John Charles McQuaid: Ruler of Catholic Ireland*, O'Brien Press, (Dublin, 1999), pp. 252-276.
[146] Irish meaning Family of the Irish, traditionally the second largest party in Ireland
[147] Ferriter, The Transformation of Ireland, p. 503.
[148] Lindsey Earner-Byrne, *Mother and Child Scheme Controversy*, History Hub, http://historyhub.ie/mother-and-child-scheme-controversy, (accessed 21/05/2023).

Act, set the overall trend for both health and welfare provision in Ireland, with reforms being slow and incremental.[149]

The Irish healthcare system remained extremely decentralised and dominated by localism, until the creation of the Health Boards following the 1970 Health Act.[150] The system that was created, while still decentralised, grouped a number of counties and cities together in eight Health Boards, as opposed to the old system in which every county and city council was responsible for its locality.[151] The Act replaced funding for health services from the local rates to the central government, however a key source of many hospitals funding remained the Hospital Sweepstakes (a lottery) until 1986.[152] The healthcare system still required a massive overhaul. Hospital consultants in particular formed an obstacle to any reform. Their demands to be able to perform unlimited private practice while still receiving pensionable public employment caused particular issues for Labour's attempts to reform the healthcare system in the 1970s and 1980s under Brendan Corish and Barry Desmond.[153]

The period from 1948 to the 1980s was crucial for the new republic. The country threatened to fall further behind the rest of Europe without drastic steps. This did not happen, but enough was done to prevent further stagnation that dominated the 1950s. The mental healthcare system saw the first attempts to reform it via the 1966 Commission of Inquiry, enthused by the optimism from England, and positive overtures from the government recommended sweeping changes to the mental healthcare system. The number of patients declined in this period, but the extent of which this can be attributed to the efforts of the Commission remains questionable at best. However, it formed a solid foundation for future reform. Similarly,

[149] Brian Harvey, Evolution of Health Services and Health Policy in Ireland, Combat Poverty Agency, p. 4, http://hdl.handle.net/10147/296776, (accessed 15/05/2023).
[150] Powell, The Political Economy of the Irish Welfare State, pp. 148-149.
[151] Ibid.
[152] Ibid, pp. 146-147.
[153] Diarmaid Ferriter, The Transformation of Ireland, 1900-2000, pp. 707-709.

while no major reforms came regarding social welfare, housing, or healthcare, like with mental health, enough was done to offer a foundation however incremental changes were insufficient in the long term without reforms to all of these areas.

Chapter 5: 1984 Planning for the Future

The 1980s saw fresh attempts to reform the mental healthcare system in Ireland. With systemic issues, by 1981, having become increasingly noticeable.[154] The Commission of Inquiry had hoped to reduce demand for beds to 8,000 from about 20,000. Instead, by the end of March 1981, there were still 13,984 inpatients in hospitals.[155] *The Psychiatric Services – Planning for the Future* (1984) reaffirmed and expanded on the conclusions of the 1966 Commission. This report was well received despite the relatively modest scope of its recommendations.

The 1980s and 1990s saw Ireland transformed by the Celtic Tiger, with the economy expanding rapidly from the mid-1990s until the 2008 Financial Crisis. The 1990s marked near unrivalled economic growth as Fintan O'Toole later said, 'in its rise and fall, Ireland made Icarus look boringly stable.'[156] This growth was not experienced equally as income inequality soared and many of those who languished in poverty found their conditions improve little. Welfare was expanded, housing was being built but affordability remained a major issue. Between 1996 and 2006, the average price of new homes increased by 250 percent, despite for example, the construction of 80,000 new homes in 2004 in a period where the UK built 160,000 despite the UK having fifteen times the population.[157] The Health Service Executive (HSE) was formed in 2005 to replace the Health Boards and marked further centralisation of healthcare in Ireland as the ten Health Boards were replaced by five HSE regions.

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[154] Kelly, Hearing Voices, p. 224.
[155] Walsh, Mental Health Care and the Irish, p. 81.
[156] Fintan O'Toole, *Ship of Fools: How Stupidity and Corruption Sank the Celtic Tiger*, Faber & Faber, (London, 2009), p. 9.
[157] Ray O'Neill, *Tá Súil Agam: Deadly Visions of History in Ireland*, ABEI Journal, vol. 21, no. 1, (2019), p. 44.

Planning for the Future and Correcting the Past

As briefly noted in the previous chapter, the 1980s was a period of economic recession which dampened more radical calls for reform. The Study Group instead turned their attention to issues that required urgent attention, such as hospitals reaching the end of their service life and implementing parts of the 1966 report that had still not been put in place. In the key findings of the 1984 report, it found that services were still below acceptable levels with rehabilitation and community services remaining of poor quality.[158] Overcrowding remained an issue for many hospitals despite the overall decline, partially due to the admittance of destitute individuals who should not have been there.[159] The report described a damming situation, 'The [mental] hospitals were designed to isolate the mentally ill from society and this isolation still persists.'[160]

The report lowered the guideline of hospital beds from the 1966 report to 0.5 beds per 1000 for acute to medium stay patients, with an additional 0.5 beds per 1000 for long term care.[161] The report called for reforms to the organisation of care with it pushing for it to be community orientated with inpatient services being based in psychiatric units in hospitals. A key difference between the 1966 and 1984 report is the emphasis the former placed on community services, with it offering an in-depth review of community services and how to implement them. The hope, as it was in England, was to avoid disrupting the patients' life as much as possible and avoid the patients deteriorating to the point where they required hospital treatment.[162] The report also expressed the need to create supports and resources for relatives caring for family members with mental illness in the community like day care, crisis support and temporary care units.[163] To prevent the inappropriate admissions to psychiatric

[158] Study Group, Planning for the Future, p. 7-8.
[159] Ibid.
[160] Ibid, p. xi.
[161] Ibid, p. 127.
[162] Ibid, p. 11-12.
[163] Ibid, p. 13.

hospitals previously mentioned, the report recommends reforming the admission process to avoid the recurrent scenario of admitting those who were destitute rather than those who were exclusively mentally ill.[164] This shows that the welfare provisions were still not adequate for many people considering the state of many of these hospitals. Amongst other recommendations.[165]

The report emphasised that the costs of implementation are high, but they stressed that not implementing changes would cost more in the long run and harmed some of the most vulnerable members in society.[166] The Study Group unlike the Commission attempted to cost their reforms, unfortunately their figures were incorrect as Walsh noted 'somewhat confusingly the report estimated cost of its recommendations as coming to fifty millions [Irish Pounds], despite the total from the component parts, as itemised, totalling sixty-seven million.'[167] Using the correct figure of £67 million it can be seen that the report hoped for an additional £4.5 million over a fifteen year period. The report expresses the hope of avoiding spending more than the £145 million that was being spent. They believed that the additional spending would come from the shutting down of mental institutions that, 'date from the middle of the last century and are now approaching the end of their lifespan.'[168] This was easier in theory than in practice, as due to lack of funding the last of the nineteenth century hospitals are not forecast to close until 2030.[169]

Unlike the 1966 Commission, the government was far more willing to support the 1984 report (rhetorically at least, funding continued to be an issue) with the Department of Health

[164] Study Group, Planning for the Future, p. xiii, 7.
[165] Ibid, xv.
[166] Ibid, p. ix.
[167] Walsh, Mental Health Care and the Irish, p. 82.
[168] Study Group, Planning for the Future, pp. 126-130, 129.
[169] Antoinette Daly & Dermot Walsh, *Irish Psychiatric Units and Hospitals Census 2010*, HRB, (Dublin, 2011), p.14,
https://www.lenus.ie/bitstream/handle/10147/138375/PsycUnitsHosp2010.pdf?sequence=3&isAllowed=y, (accessed 12/02/2023).

following up the report with the Green Paper on Mental Health in 1992. Ultimately however, many of the measures of the 1984 report, which were as previously mentioned relatively modest in scope, were not adopted as the norm as the Green Paper noted.[170] While hospitalisation for mental illness declined from 3.4 per 1000 in 1984 to 2 per 1000 in 1990, Irish rates were still twice as high as Denmark, France, Wales and of particular note England.[171] The reforms resulted in the decline of inpatient numbers until 2001 which saw the number stabilise at ~4,500 patients.[172] The 2000s promised to be an exciting period for mental healthcare with the passing of the Mental Health Act 2001, the HSE being established in 2005 and A Vision for Change being published in 2006, which hoped to remedy these shortcomings.

The discussion of a new *Mental Health Act* had been ongoing since the 1960s, when the 1966 Commission had suggested that the Act needed amendments in a number of areas including but not limited to the manner in which involuntary admissions was conducted.[173] However, discussions did not begin in earnest until the 1990s with a Green Paper published by the Department of Health in 1992 which reviewed existing legislation (1945 Act) and a White Paper which proposed a 'new Mental Health Act' and conceded that Ireland did 'not fully comply with [its] obligations under international law'.[174] The government passed the Mental Health Act 2001 through the Oireachtas[175] the following year and it was to be fully

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[170] DH, *Green Paper on Mental Health*, Stationery Office, (Dublin, 1992), p.14, https://www.lenus.ie/bitstream/handle/10147/46355/1296.pdf?sequence=1&isAllowed=y, (accessed 20/05/2023).
[171] Ibid.
[172] Antoinette Daly & Dermot Walsh, Irish psychiatric hospitals and units census 2001, HRB, (Dublin, 2002), pp.21-22, https://www.lenus.ie/bitstream/handle/10147/335740/psychiatriccensus2001.pdf?sequence=1&isAllowed=y, (accessed 12/02/2023).
[173] Commission of Inquiry, Commission on Mental Illness, pp. xxxviii-xxxix.
[174] Department of Health, White Paper: A New Mental Health Act, Stationery Office, (Dublin, 1995), p. 13, http://hdl.handle.net/10147/77441, (accessed 29/05/2023).
[175] The Irish Parliament

implemented by 2006.[176] The 2001 Act drew on a number of elements from the English 1983 MHA rather than the 2007 MHA and primarily focused on involuntary detentions and mechanisms to maintain high standards of care in institutions.[177]

The Celtic Tiger Roars

While the rest of Ireland ended the twentieth century richer than it ever could have imagined. The Celtic Tiger saw Ireland have 'the fastest growing economy in the world'.[178] This growth was not spread equally. The United Nations Development Programme report published in 2002 found that, 'Ireland had the highest level of poverty in the Western world outside of the United States and was one of the most unequal among Western countries, with the richest 10 [percent] of the population 11 times wealthier than the poorest 10 [percent]… It was estimated that 15.3 [percent] of Irish people were living in poverty…'[179] Gøsta Esping-Andersen described the welfare system in Ireland and the UK as, 'like the American, seeks actively to sponsor market solutions. It pursues this via the double strategy of encouraging private welfare provision as the norm, and by limiting public responsibilities to acute market failures…'[180] These issues and the rapid changes were too much for some to bear the consequences described starkly by Irish historian Dermot Keogh,

> In 1999, there were 455 suicides recorded in Ireland… Confronted with this alarming situation, the health authorities commissioned a national study on suicide. Published in 2001, it found a number of worrying trends in relation to the population generally and young males particularly. It found that almost five times more men died from suicide than women, and that suicide is the principal cause of death for men aged 15-35 years. Alcohol and unemployment, particularly long-term unemployment, were

[176] Kelly, Hearing voices, p. 245.
[177] Ibid, pp. 245-246.
[178] Ferriter, The Transformation of Ireland, p. 662.
[179] Ibid, p. 663.
[180] Gøsta Esping-Andersen, *Why We Need a New Welfare State*, Oxford Academic, (Oxford, 2002), p. 15.

> factors associated with young male suicide. While no relationship with the Celtic Tiger was cited in the report, one could read between the lines. The implications were obvious: as Irish society becomes more competitive and more work oriented and moves at an ever faster pace, the pressures on young males in particular become more unbearable.[181]

For context, the period from 1990 to 2009 saw suicide increase from around 1.2 percent of total deaths to a peak of 2.1 percent. During this increase other European countries (including England) saw a decrease.[182]

The 1980s saw Ireland continue to struggle with both poverty and housing, 1980 the Dublin Corporation was forced to declare a housing emergency following protests by community leaders.[183] While the 1990s and 2000s saw a major housing boom, this did little to reduce the cost of housing or alleviate the housing crisis, as Keogh noted; 'The capital city, unable to cope with the housing crisis, had been deformed by a boom in property speculation which replaced landmark buildings with ugly office blocks… the modernisation of Dublin had been good for some people. A number of new entrepreneurs had done very nicely out of the building boom and they had every reason to feel grateful.'[184] The result of these shortcomings is that according to Focus Ireland the estimated number of homeless increased from 1,500 in 1989 to almost 5,600 in 2002, meanwhile, in the same period those waiting on housing lists increased from under 20,000 to 48,500.[185]

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[181] Dermot Keogh, *Twentieth Century Ireland: Revolution and State Building*, Gill & Macmillan, (Dublin, 2005), p. 462.
[182] Global Burden of Disease Collaborative Network. *Global Burden of Disease Study 2019*, https://vizhub.healthdata.org/gbd-results?params=gbd-api-2019-permalink/4eac9e695039dae117ac177d0558a2bc, (accessed 25/06/2023).
[183] Ferriter, The Transformation of Ireland, p. 704.
[184] Powell, The Political Economy of the Irish Welfare State, p. 161.
[185] Keogh, Twentieth Century Ireland, p. 462.

Debates and controversies around the Irish healthcare system raged in the 1980s and 1990s and largely have continued. Barry Desmond, Minster of Health from 1982 – 1987, described the challenges he faced in his memoirs,

> I had faced down the cynical Fianna Fail dominated health boards whose accounts were often submitted to the department years out of date. I had challenged the proliferation of private beds in publicly funded hospitals which were a licence to print money for some very well paid consultants under the extremely generous common contract given to them by Charles Haughey when he was Minister for Health.[186]

The cutbacks during the 1980s in healthcare spending reached its nadir in 1989, which saw spending reduced 'to 57 [percent] of the EU per capita average.'[187] This period solidified a two-tier system in Irish hospital care, where those who could afford private care could be treated immediately. Meanwhile, those who could not afford it were forced to wait for treatment.[188] Tom Garvin a political scientist and historian described the two-tier system as 'the child of history and the survival of the interest group veto, as are so many other irrationalities and anomalies in Irish public service systems, ranging from transportation to town planning.'[189] The HSE was founded in 2005 as an attempt to centralise healthcare and thus reduce costs and increase efficiency following the Hanley,[190] Prospectus[191] and Brennan[192] reports all published in 2003 which criticised the Health Boards and called for a more centralised system.

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[186] Barry Desmond, *Finally and in Conclusion: A Political Memoir*, New Island, (Dublin, 2000), p. 312.
[187] Ferriter, The Transformation of Ireland, p. 708.
[188] Ibid, p. 710.
[189] Ibid, p. 709.
[190] National Task Force Medical Staffing, *Report of the National Task Force on Medical Staffing*, Department of Health and Children, (Dublin, 2003), http://hdl.handle.net/10147/46569, (accessed 30/05/2023).
[191] Watson Wyatt Worldwide, *Audit of Structures and Functions in the Health System*, Stationary Office, (Dublin, 2003), http://hdl.handle.net/10147/42913, (accessed 30/05/2023).
[192] Commission on Financial Management and Control Systems in the Health Service, *Report of the Commission on Financial Management and Control Systems in the Health Service*, Stationary Office, (Dublin, 2003), http://hdl.handle.net/10147/46721, (accessed 30/05/2023).

The 1980s saw more slow steps towards modernisation of Ireland, although this accelerated rapidly in the 1990s and 2000s with the Celtic Tiger. In terms of mental health, the 1984 report was modest in its requests for funding however it was only partially implemented. The 1980s saw Ireland continue to struggle financially which damaged its ability to provide housing, which changed in the 1990s and 2000s with sufficient housing being built however it was unaffordable for many resulting increases in homelessness. The transition into the Celtic Tiger resulted in many being left behind as wealth inequality and poverty increased rapidly. The pressures of these changes led to increases in suicide rates particularly amongst young men. Following major cuts in healthcare in the 1980s, spending increased in the 1990s and 2000s.

Chapter 6: A Vision for Change

A Vision for Change (2006) was written at a time of major reform of the healthcare system. The 2001 Mental Health Act had called for a review of Mental Healthcare policy, which led to the establishment of the Expert Group in 2003.[193] Tim O'Malley, the Minister of State for Disability and Mental Health, outlined the goals of the group was, 'to review long-standing policy in this area and to formulate a blueprint for a modern, comprehensive, world-class service to meet the mental health challenges facing our society - not least of which is our significant suicide rate, particularly among young people.'[194] The report repeated many of the recommendations laid out in 1966 and 1984 as well as offer an in-depth review of mental healthcare services as a whole.

In 2008 Great Recession had a devastating impact on Ireland. Historian Thomas Bartlett compared the economic fallout to that of the Great Famine.[195] This overstated the impact of the crash, as the Famine was so devastating that Ireland's population still has not recovered. This period saw poverty rise and welfare cut. A Central Statistics Office (CSO) report from 2016, *Measuring Ireland's progress 2014* highlights this by showing 49.3 percent of the population was at risk of poverty before social transfers were accounted for, the second highest rate in the EU and when transfers were accounted this rate dropped to 17.2 percent.[196] Homelessness, meanwhile, has been increasing seemingly unchecked. Additionally, the HSE struggled with issues such as lack of staffing, lack of funding, and mismanagement that continued to plague the organisation while attempts at reforming it were largely scuttled.

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[193] MHC, *Mental Health Act*, MHC, (2001), p.2, https://www.lenus.ie/bitstream/handle/10147/80913/MentalHealthAct01.pdf?sequence=1&isAllowed=y, (accessed 03/03/2020).
[194] Expert Group, A Vision for Change, p. 4.
[195] Thomas Bartlett, *Ireland: A History*, Cambridge University Press, (Cambridge, 2010), p. 552.
[196] CSO, *Measuring Ireland's Progress 2014*, CSO, (Cork, 2016), https://www.cso.ie/en/releasesandpublications/ep/p-mip/mip2014/introduction/, (accessed 03/06/2023).

A Vision for the Future: A Gloomy View

The push for Irish mental health reform continued with A Vision for Change 2006 and while it too fell short of its goals such as in 1966 and 1984, it was still a positive development. One of the main issues the Expert Group had to address was that many of the recommendations from previous reports had yet to be fully implemented.[197] The last Report of the Inspector of Mental Health Services in 2004 outlined several issues that the Expert group had to address.

> The development of new management systems at expanded catchment and national level are essential to allow the necessary development of specialty services and facilities and to ensure proper planning and funding of services nationally. The development of functioning community mental health teams is necessary to allow the provision of community-based care programmes in all specialties, including home-based and assertive outreach care as alternatives to in-patient care.[198]

The report echoed much of what was laid out in 1966 and 1984 with the goal being to 'work with service users and their families towards recovery and reintegration by the provision of accessible, comprehensive and community-based services.'[199] However, unlike the previous reports, the Expert Group sought to account for the shortcomings of their predecessors by creating a monitoring group to oversee the implementation of reforms as well as clearly outlining the cost, and staffing requirements of each feature. Funding was a key area of discussion for the report as it outlined the requirements for an increase in spending. The

[197] Expert Group, A Vision for Change, p. 52.

[198] MHC, *Annual Report 2004 Including the Report of the Inspector of Mental Health Services*, MHC, (Dublin, 2005), p. 125, https://www.lenus.ie/bitstream/handle/10147/42816/2300.pdf?sequence=1&isAllowed=y, (accessed 10/04/2020).

[199] Expert Group, A Vision for Change, pp. 63-69.

report discusses how the British mental health service received 12-13 percent of the healthcare budget, while Irish mental health services only had 7.3 percent allocated for it.[200]

Unfortunately, the implementation of the report was conducted poorly. The report had called for the creation of a Monitoring Group to oversee implementation and this group was extremely critical of the HSE's implementation of the report, as was the College of Psychiatry. Lack of funding, equipment shortages and in particular staffing shortages become reoccurring themes in the reports by the Monitoring Group and College of Psychiatry. A report from the College of Psychiatry called *A Gloomy View* found that 52 percent of teams suffered from personnel shortages while only 16 percent of teams had the required equipment and personnel to function efficiently.[201] Staffing shortages continued to be a problem as by 2017 staffing was at 76 percent of what had been requested in 2006.[202] These issues were worsened by the fact that Ireland had underfunded its mental health services proportionally in comparison to other countries. The 2006 report called for increased spending to 8.24 percent of total healthcare spending. However by 2017, only 6 percent was being spent on mental health services.[203] Absolute funding had increased from €612 million in 2003 to €853.7 million in 2017, however this was a far cry from what was requested by the report amounting to just over €1,172 million in 2017.[204] Additionally, 47 percent of the money that was designated for mental health spending was being siphoned by the HSE for other purposes.[205] The Monitoring Group also criticised the slow rate of implementation stating,

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[200] Ibid, pp. 177-184.
[201] Siobhán Barry & Patrice Murphy, *A Gloomy View: Rhetoric or reality in relation to the advancement of A Vision for Change*, College of Psychiatry of Ireland, (2009), p. 9, https://www.irishpsychiatry.ie/wp-content/uploads/2016/12/A-Gloomy-View.pdf, (accessed 12/02/2023).
[202] Mental Health Reform, *Mental Health Reform submission on review of A Vision for Change*, Mental Health Reform, (Dublin, 2017), p. 156, https://www.mentalhealthreform.ie/wp-content/uploads/2017/09/Submission-on-review-of-A-Vision-for-Change.pdf, (accessed 12/02/2023).
[203] Ibid, p. 155.
[204] Barry & Murphy, A Gloomy View, p. 7.
[205] Ibid.

> Three years into implementation a comprehensive implementation plan is still not in place and the Group is very disappointed with the slow rate of progress. The Group recognises the difficulties facing the HSE in the current economic climate, but this does not in any way diminish the HSE's responsibility to implement *A Vision for Change*.[206]

Despite the strengths of *A Vision for Change,* the report's failure to significantly reform the mental healthcare system was ultimately due to 'the absence of an implementation plan… and the failure by Government to implement a national mental health information system.'[207] The impact of a lack of community facilities and crisis teams had increasingly become obvious. The OECD found readmissions to the same hospital for schizophrenia was 21.6 per 100 in Ireland. Meanwhile, it was 8.1 per 100 in the UK with the rate being similar for other mental illnesses.[208] The high rate of readmission is most likely due to the fact that '94% of patients who commenced day hospital treatment…were found to be suffering from, a relatively mild level of illness despite the fact that day hospitals are supposed to cater for patients with acute psychiatric illnesses.'[209] Ultimately the Chief Executive of the Mental Health Commission described it best, stating that ''Vision for Change' was a "very good document", the problem is that it still has not been implemented 14 years later.'[210]

Austerity, Sláintecare and Those Left Behind

The 2008 crash had a devastating effect on Irish society as private debts were to be shouldered by the public. An infamous example being the Anglo-Irish Bank and Irish

[206] Monitoring Group, Third Annual Report, p. 2.
[207] Mental Health Reform, Review of A Vision for Change, p. 160.
[208] Ibid, p. 90.
[209] Antoinette Daly, Donna Doherty & Dermot Walsh, *Reducing the Revolving Door Phenomenon*, Irish Journal of Psychological Medicine, 21(10), (2010), pp. 27-31.
[210] Fergal Bowers, *'Almost total absence' of community mental health services – report*, RTÉ News, (2020), https://www.rte.ie/news/health/2020/0219/1116170-mental-health-commission-review/, (accessed 12/02/2023).

Nationwide Building Society bailout which ultimately cost the Irish Government around €36.4 billion to stabilise the banks, as a part of a larger €400 billion scheme to protect the banking sector.[211] This effectively tied the fate of Ireland to that of the banks and culminated with a IMF/EU bailout.[212] The Irish welfare state, which was never particularly large, began to shrink rapidly, healthcare spending was cut and poverty rose, particularly child poverty. The Irish Times wrote in an editorial in 2016,

> The biggest burden of the austerity years that followed the great crash of 2008 was placed on those least able to bear it. In 2013, Eurostat reported that Ireland ranked 23rd out of 27 EU countries in tackling child poverty. A study published by UNICEF in 2014 placed Ireland 37th out of 41 developed countries in the protection of children from poverty during the global financial crash. The child poverty rate in Ireland rose by more than 10% between 2008 and 2012-18 other states recorded a reduction.[213]

The economic collapse proved to be catastrophic to Irelands housing market which had seen prices soar from 1990s to the late 2000s, however by 2013 prices had fallen back to late 1990 levels.[214] This created pressure on not only the banks, but on the home-owners as well as their mortgage was suddenly wildly inflated which almost immediately triggered a housing crisis with Focus Ireland finding that there were 89,872 people on the social housing waiting list in 2013.[215] By 2016 'official homelessness' (due to the large amount of hidden homelessness) had risen drastically to 6,525 people, including 2,177 children, which was a 40 percent increase from 2015. With the collapse of the construction industry, housing construction declined drastically and failed to keep up with demand, with younger people in particular

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[211] Ciarán Hancock, *Was it worth paying €41.7bn to bail out Irish banks?*, The Irish Times, (2019), https://www.irishtimes.com/business/financial-services/was-it-worth-paying-41-7bn-to-bail-out-irish-banks-1.4036792, (accessed 07/06/2023).
[212] Powell, The Political Economy of the Irish Welfare State, p. 253.
[213] Ibid, p. 254.
[214] Powell, The Political Economy of the Irish Welfare State, p. 257.
[215] Ibid.

finding it increasingly difficult to purchase a home. These issues with housing not only affect the mental health of the population, but it also directly impacts the provision of mental healthcare as in 2022 beds reserved for emergency mental health treatment had to be closed because of lack of staff due to the cost of living in Dublin.[216]

By the end of the 2010s the HSE its struggles were apparent. The cuts to healthcare spending undermined much of the HSEs potential for change as spending that had increased from 6.6 percent of gross national income in 2004 to 9.7 percent in 2009 dropped to 8.7 percent in 2013.[217] Staff shortages for doctors and nurses quickly became a chronic issue as graduates emigrated to other countries due to the better working conditions and pay, which was compounded by the HSEs recruitment embargo.[218] In 2017, the government announced plans to end the two tier health system with the Sláintecare[219] plan which aimed to implement 'an affordable, universal, single-tier healthcare system, in which patients are treated promptly on the basis of need, rather than ability to pay.'[220] By 2021 it was clear that reforms were occurring incredibly slowly with key members responsible for its implementation resigning.[221] Once again the shortcomings in reform directly impacted mental health treatment, an investigation was launched into a Child and Adolescent Mental Health Service (CAMHS) in south Kerry due to mismanagement and the inappropriate actions of one doctor in particular which had resulted in 46 children suffering significant harm and 227 children

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[216] *Health staff shortages due to soaring property costs - HSE manager*, RTÉ, (2022), https://www.rte.ie/news/politics/2022/0628/1307318-linn-dara/, (accessed 11/06/2023).
[217] Ibid, p. 254.
[218] Ciara Kenny, *Why has Ireland lost so many doctors and nurses?*, The Irish Times, (2015), https://www.irishtimes.com/news/health/why-has-ireland-lost-so-many-doctors-and-nurses-1.2343477, (accessed 10/06/2023).
[219] Sláinte being the Irish word for health.
[220] Committee on the Future of Healthcare, *Sláintecare Report*, House of the Oireachtas, (Dublin, 2017), p. 4.
[221] Sara Burke, *Whatever happened to Sláintecare?*, The Irish Times, (2022), https://www.irishtimes.com/opinion/whatever-happened-to-slaintecare-1.4792060, (accessed 11/06/2023).

being exposed to the risk of serious harm from 2016 to 2021.[222] Sara Burke, a professor in Health Policy and Management, argued that since 'neither the Taoiseach[223] nor the Minister for Health [had] done much to progress [Sláintecare]…' and the poor condition of the health services generally that 'it is a miracle is [sic] that there are not many more scandals unearthed, on a much more frequent basis.'[224]

The impact that these events in the welfare system and the drastic increase in homelessness had on mental illness, especially amongst young people, has been noticeable. Using 2016 figures, a report found that the 'prevalence of mental health disorders [to be] highest in Finland, the Netherlands, France and Ireland (with rates of 18.5% or more of the population with at least one disorder)'[225] A Eurofound report found that 'the highest proportion of young people [15-24 year olds] reporting chronic depression was found in Ireland (12%)…' while the EU average was only 4 percent.[226] In 2019 there were 524 suicides down from a peak of 585 in 2012.[227] The CSO concluded that in 2019 suicide remained the number one cause of death for young men under the age of 25 and third highest among young women, with young men accounting for 13.7 percent of all male suicides and young women making up 18.1 percent of all female suicides.[228] Given the degree of failure to support those in need, particularly young people, in regards to mental health treatment, healthcare, poverty and homelessness it is perhaps little wonder that mental illness has become so prevalent especially with looming international and domestic crisis' on the horizon.

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[222] Sean Maske, R*eport On The Look-Back Review Into Child & Adolescent Mental Health Services County MHS Area A*, HSE, (2022), https://www.hse.ie/eng/services/news/newsfeatures/south-kerry-camhs-review/, (accessed 11/06/2023).
[223] Taoiseach is Irish for Chief or leader and acts as the Prime Minister.
[224] Sara Burke, Whatever happened to Sláintecare?.
[225] OECD/EU, Health at a Glance, p. 22.
[226] Eurofound, Inequalities in the access of young people p. 15.
[227] CSO, *Suicide Statistics 2019*, CSO, (Cork, 2022), https://www.cso.ie/en/releasesandpublications/ep/p-ss/suicidestatistics2019/, (accessed 03/09/2023).
[228] Ibid.

Section 3: Comparison

An era of considerable hope has arrived. Old ideas are being discarded or challenged. Doctors, nurses and public alike display a greater interest than ever before. Mental health has taken a leading part on the world stage.

Commission of Inquiry on Mental Illness (1966)[229]

[229] Commission of Inquiry, Commission on Mental Illness, p. 14.

Chapter 7: Comparing the Anglo and Irish Cases

Even by simply looking at the Irish and English cases it quickly becomes apparent that, regarding the treatment of mental illness, the Irish system appears almost as an ersatz version of the English system. Irish reports continuously look at the developments occurring in England and tend to mimic the English recommendations a few years later. While the English system had faults and shortcomings, as highlighted by Townsend in 1977, it never suffered to the same degree that the Irish system did in terms of lack of funding and staff shortages until perhaps around the 2000s. The rates of mental illness in England have nearly caught up to Ireland. In 2014 as previously stated, 18.5 percent of Irish people were estimated to have at least one disorder.[230] However, in England, 17 percent of English people were estimated to have at least one disorder according to the NHS with this marking a slow but steady increase since the 1990s.[231]

While the manner in which the mental health services operate and the laws that govern them is obviously important, equally important are the wider societal changes around welfare provision and healthcare. This chapter will look at poverty, homelessness and at healthcare spending and see if changes in these statistics reflect the changes in the rate of mental illness.

Mental Healthcare

It is obvious that the Irish 1966 Commission of Inquiry took a large degree of inspiration from the 1957 British Percy Commission. Both reports had the same goal, namely to push for deinstitutionalisation in favour of community care and sought to fundamentally restructure mental health services. However, the Percy Commission surpassed its Irish counterpart in almost every metric. With the main goals of both reports being to reduce the population in

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[230] OECD/EU, Health at a Glance, p. 21.
[231] Sally McManus, Paul Bebbington, Rachel Jenkins & Traolach Brugha, (eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014, NHS Digital (2016, Leeds), pp. 10-11.

mental hospitals, their success can be seen quite simply by looking at the number of patients in mental hospitals from 1959 to 1981. In 1959, there were 693.8 patients per 100,000 in psychiatric hospitals in Ireland, while in England and Wales there was 306.4 patients per 100,000.[232][233] By 1981, there was 406 patients per 100,000 in Irish psychiatric hospitals. Meanwhile, in England there was 176 per 100,000.[234] It is worth noting Wales is present in the 1959 statistics but excluded in the 1981 count. While the decrease is greater in Ireland (287.8 per 100,000 as opposed to 130.4 per 100,000), the percentage decrease slightly favours England (42.6 percent decrease as opposed to 41.5 percent). This is worsened by the fact that as, previously mentioned, the Irish rates had stabilised by the 1980s while the English rates continued to decline.

The key issue appears to be community care and preventive methods. with community care helping to keep hospital patient numbers low and preventive care (which includes socio-economic conditions) preventing admissions in the first place. While the Irish case saw the implementation of community care continually frustrated or spread unequally, community care in the English case despite being underfunded and not operating as intended, at least existed in some form, with the Expert Group (1984) pointing to the English Hospital Plan in 1962 and Better Services for the Mentally Ill in 1975 as templates for in-patient and community care systems.[235] The lack of preventive measures is visible in the rate of first admissions, with 251.5 per 100,000 in Ireland as opposed to England's 112 per 100,000, regardless of gender or age, with 'the lower the social class the higher the rate of admission.'[236]

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[232] Department of Health, Inspector of Mental Hospitals 1959, p. 5.
[233] Ministry of Health, *Some Factors affecting the Demand for Beds in Psychiatric Hospitals*, 1962, London, The National Archives, p. 1.
[234] Study Group, Planning for the Future, pp. 143-144.
[235] Ibid, p. 4.
[236] Ibid, pp. 146-147.

The period from the 1980s to the early 2000s continues the trend of reduction, but with Irish rates remaining higher than their English counterparts. In terms of hospitalisation, Irish rates dropped drastically from 406 patients per 100,000 in 1981 to 119.2 per 100,000 in 2001, nearly a 71 percent decrease.[237] However, English rates remained lower than Ireland's with England going from 176 per 100,000 in 1981 to 62 per 1000 in 2001, marking a 64 percent decrease.[238] While it is difficult to find data on first time admissions in England, an increase can be seen in the prevalence of severe Common Mental Disorders (CMD) from 6.9 percent in 1993 to 7.9 percent in 2000.[239] What can be confidently stated that more individuals were making first contact with mental health services. Unfortunately, the exact extent of this is unclear. The fact that more moderate forms of CMD also saw increases, indicates that first time admissions to inpatient care most likely increased.[240] Fortunately, stats for first time admission date for Ireland are available and they show a moderate decrease from 251.1 per 100,000 in 1980 to 202.4 per 100,000 in 2000, however the bulk of this decrease occurred between 1985 and 1990 (245.1 per 100,000 to 214.1 per 100,000).[241]

By 2010, Ireland's rates of hospitalisation were nearly comparable to that of England, with resident numbers in psychiatric hospitals being 66.3 per 100,000 in the former in comparison to 60.1 per 100,000 in the latter.[242] The greatest decline occurred between 2006 and 2010, however, this achievement is undercut by the fact that this decrease was being driven primarily by older patients dying. This can be seen this with Irish patients being both significantly older, with 33.1 percent being 65+ years old as opposed to 26.1 percent in

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[237] Antoinette Daly & Dermot Walsh, *Irish psychiatric hospitals and units census, 2001*, HRB, (2002, Dublin), p. 22, http://hdl.handle.net/10147/335740, (accessed 12/06/2023).
[238] Ibid.
[239] McManus, Bebbington, Jenkins & Brugha, Mental health and wellbeing in England 2014, p. 11.
[240] Ibid
[241] Antoinette Daly & Dermot Walsh, *Mental illness in Ireland 1750 - 2002: Reflections on the Rise and Fall of Institutional Care*, HRB, (2004, Dublin), p. 39, http://hdl.handle.net/10147/42553, (accessed 22/05/2023).
[242] Antoinette Daly & Dermot Walsh, *Irish Psychiatric Units and Hospitals Census 2010*, HRB, (2011, Dublin), p. 17, http://hdl.handle.net/10147/138375, (accessed 10/06/2023).

England, and having more long stay patients (being in hospital for over five years), 24.6 percent in Ireland in comparison to 8 percent in England.[243] This indicates there were ongoing issues with the community services in 2010. Further highlighted by the fact that in England 28.9 percent of patients were under care in a hospital for over a year while in Ireland this was 42.2 percent.[244] By 2019, there were 2,308 patients in Irish psychiatric hospitals with 37 percent being under continuous care for over a year with 53 percent of patients being 65+, strongly indicating that the issue of getting patients out of hospitals and into community care had not been resolved.[245] It is also unlikely that patients in England are being released prematurely as the MHA 2007 primarily functions to detain individuals if necessary to prevent a repeat of the homicides committed in the 1990s, while this was never the main focus for Ireland. While the situation is by no means as dire as in Ireland, there has been a noticeable increase in mental illness in England since the 2000s, the severe CMD rate has increased from 7.9 percent to 9.3 percent in 2014, while moderate CMD has increased by 20 percent from 1993 to 2014.[246] Quite concerningly, while in England's mental illness rates had been increasing, rates of suicidal thoughts and self-harm have been increasing at a far more rapid rate, indicating that people of all ages are finding it increasingly difficult to cope with their mental health problems.[247] This is only worsened by the fact this figure excludes a large number of people, it excludes people in prison or homeless amongst other groups thus the real figure is most likely higher.[248] The rising rates of Irish suicides suggests the same issues are occurring in Ireland. This strongly indicates that there was a lack of societal supports,

[243] Daly & Walsh, Hospital Census 2010, p. 41-42.
[244] Ibid, p. 42.
[245] Antoinette Daly and Sarah Craig, *Irish Psychiatric Units and Hospitals Census 2019 Main Findings*, HRB, (Dublin, 2019), pp. 8, 14, http://hdl.handle.net/10147/635905, (accessed 15/04/2023).
[246] McManus, Bebbington, Jenkins & Brugha, Mental health and wellbeing in England 2014, p. 11.
[247] Ibid, pp. 303-307.
[248] *Mental health facts and statistics*, MIND, https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#References, (accessed 15/06/2023).

from the government and by extension the public, regarding community care and wider social supports such as welfare and healthcare.

This raises the question about the state of community care and if it is adequate to deal with these health challenges which are worsening. In their current state almost certainly not, but even if they were widespread and available for every individual to access the services as needed and receive the treatment required (an unlikely feat under any government) it further resulted in treating the symptoms and not the root cause. Compounding issues, those under treatment of mental illness in both Ireland and England were predominantly lower economic status a group that has been growing in size. [249] Thus, the cuts to the welfare system and worsening economic conditions disproportionately affects them.[250]

As mentioned, Andrew Scull argued against the use of community care as he focused on the way that politicians 'regard [patients] as little more than a drain on the public purse'.[251] While in Ireland, community care had only received proper support since *A Vision for Change,* in England it has had a much longer time to take root. The term "community care", however 'has come to be mocked in, for example, TV comedies and public attitudes and has been associated with public homelessness and inquiries into homicides.'[252] This was compounded by the fact that due to deinstitutionalisation, more violent individuals have been incarcerated instead resulting in 'the doubling of the prison population over the last forty years' since they can't be kept in the community nor the hospitals.[253]

[249] Study Group, Planning for the Future, p. 147 also see Daly & Walsh, Hospital Census 2010, pp. 31-32.
[250] McDaid & Kousoulis, Tackling social inequalities to reduce mental health problems, p. 10.
[251] Scull, UK Deinstitutionalisation, p. 307.
[252] Trevor Turner, Changing Services I: Clinical Psychiatric Perspectives on Community and Primary Care Psychiatry and Mental Health Services, *Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960–2010*, ed. George Ikkos and Nick Bouras, Cambridge University Press, (Cambridge, 2021), pp. 222-223.
[253] Ibid, p. 223.

Poverty

Poverty, as like mental health, has become an increasingly pressing issue in both England and Ireland, especially following the 2008 crisis. The relationship between these factors has been restated in multiple studies. There were two different experiences with poverty in England and Ireland. In England, poverty was thought to have been irradicated much like in the U.S. in the post war period. In the 1960s it was "rediscovered" as previously mentioned in 1966, following the publication of *The Poor and the Poorest* which was co-written by Townsend. This showed that poverty had increased from 7.8 percent in 1953 to 14.2 percent in 1960, amounting to around 7.5 million people.[254] However, poverty dropped drastically across the island of Britain (figures for just England are unavailable) from the 1970s to the 1980s, with the core poor[255] dropping from 14.4 percent to 9.8 percent and the breadline poor[256] from 23.1 to 17.1 percent.[257] Ireland had a similar issue with 56 percent saying that: 'they did not think there were any poor people, or they did not know any.'[258] However, the works by Townsend greatly influenced Ireland.[259] While the exact numbers are difficult to gauge reliably as, akin to mental health, poverty was heavily stigmatised, with a study from 1982 finding 25 percent of Irish people believing poverty was due to personal misfortune and 30 percent believing it was due to laziness.[260] However, rough estimates, place the number

[254] Coates & Silurn, Poverty, the Forgotten Englishman, p. 32.
[255] Core poor being individuals who are simultaneously income poor, necessities/deprivation poor and subjectively poor with deprivation poor has much the same meaning as in Ireland and subjective poor means less than 70 percent of the median income.
[256] Breadline poor are relatively poor and thus cannot participate the norms of society.
[257] Daniel Dorling, Jan Rigby, Ben Wheeler, Dimitris Ballas, Bethan Thomas, Eldin Fahmy, David Gordon & Ruth Lupton, *Poverty, wealth and place in Britain, 1968 to 2005*, The Policy Press, (2007, Bristol), p. 16.
[258] Frank Sammon, *The Problem of Poverty in Ireland: Lessons from the Combat Poverty Programme*, *Studies: An Irish Quarterly Review*, Vol. 71, No. 281, (1982), p. 9, https://www.jstor.org/stable/30090401, (accessed 16/06/2023).
[259] Ibid, p. 2.
[260] Ibid, p. 9.

around 20 to 30 percent of Irish in poverty in 1975 with a 1971 study putting the figure at 24 percent.[261]

The 1980s saw Irish poverty rates remain high, remaining stubbornly at around 20 percent.[262] This continued going into the 2000s at around 20.9 percent.[263] By 1989/90, it was clear Ireland was doing far worse in comparison to other EC countries from the period with income poverty being 22.9 percent while in the UK in comparison it was 12 percent.[264] This does not mean Britain was doing well in this period as between 1980 and 1990 poverty rates essentially returned to their 1970 levels: 14.3 percent for core poor in 1990 in contrast to 14.4 in 1970 and 21.3 percent breadline poor as opposed to 23.1 in 1970.[265] The 2000s saw Britain reduce the core poor from 14.3 to 11.2 but, the breadline poor increased from 21.3 to 27 percent in 2000.[266] This showed that Thatcher's policies effectively reversed the effects of the anti-poverty measures implemented in the 1970s. Meanwhile, Blair's policies while effective at helping the poorest in society often failed to help those who were still living in poverty even if it wasn't abject poverty.

On the lead up to 2008, with Ireland nearly approaching comparable spending in welfare to other EU countries, Irish poverty dropped to 15.8 percent in 2007 with this rising and peaking in 2013 due to the crisis at around 16.9 percent.[267] Social Justice Ireland found that while the

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[261] Ibid.
[262] Tim Callan & Brian Nolan, *Income Inequality and Poverty in Ireland in the 1970s and 1980s*, ESRI, p. 15, (Dublin, 1993), https://www.esri.ie/publications/income-inequality-and-poverty-in-ireland-in-the-1970s-and-1980s, (accessed 17/06/2023).
[263] Brian Nolan, Brenda Gannon, Richard Layte, Dorothy Watson, Christopher Whelan & James Williams, *Monitoring Poverty Trends in Ireland: Results from the 2000 Living in Ireland Survey*, ESRI, (Dublin, 2002), p. 18.
[264] Callan & Nolan, Poverty in Ireland in the 1970s and 1980s, p. 20.
[265] Dorling, Rigby, Wheeler, Ballas, Thomas, Fahmy, Gordon & Lupton, Poverty, in Britain, 1968 to 2005, p. 16.
[266] Ibid.
[267] *Policy Briefing on Poverty 2009*, Social Justice Ireland, (Dublin 2009), p. 3, https://www.socialjustice.ie/content/publications/policy-briefing-poverty-2009, (accessed 18/06/2023) and *Poverty Focus 2019*, Social Justice Ireland, (Dublin 2019), p. 7, https://www.socialjustice.ie/content/publications/poverty-focus-2019, (accessed 17/06/2023).

overall rate was reduced to 12.8 percent in 2019 with 629,952 in poverty.[268] This marks a step in the right direction in tackling Ireland's stubbornly high poverty rate, but the composition of poverty was also a concern with 12.3 percent being ill or disabled and most concerningly, 26.1 percent being children under the age of 16, forming the largest group living in poverty.[269] England and the UK as a whole had seen poverty rates largely stabilised at around 22 percent since 2010.[270] Also, like Ireland, child poverty is worryingly high of the 14 million people in poverty 4 million are children or around 28.6 percent which is an improvement from the late 1990s where it nearly reached 35 percent.[271]

There has been a noticeable discrepancy in poverty between England and Ireland from the 1950s until the 2000s Britain had a lower rate of poverty than Ireland. However, since the 1980s poverty had been slowly increasing in Britain while Ireland poverty rate remained at around 20 percent. During the 2000s Irelands poverty rate began to decline and while it did increase following 2008 it quickly began to decrease again. In comparison Britain has seen poverty gradually increase before stabilising at around 22 percent following 2010. A key difference being welfare spending in 2019 Ireland spent €4,269 per capita on social welfare while the UK spent around €3,762.[272] While this alone does not entirely account for the rise in poverty it undoubtedly contributes to it and when combined with other factors contributes to rising rates of mental illness in England. This is due to the fact that there are numerous

[268] *Poverty Focus 2021*, Social Justice Ireland, Dublin 2021), p. 3, 7, https://www.socialjustice.ie/content/publications/poverty-focus-2021, (accessed 18/06/2023).
[269] Ibid, p. 7.
[270] UK Poverty 2019/20, JRF, (York, 2020), pp. 5, 21.
[271] Ibid, pp. 12, 19.
[272] *Minister Humphreys publishes Social Welfare Statistics Annual Report 2019*, Department of Social Protection, https://www.gov.ie/en/press-release/7d11c-minister-humphreys-publishes-social-welfare-statistics-annual-report-2019/, (accessed 24/06/2023) and Welfare trends report, Office for Budget Responsibility, (London, 2019), p. 8.

studies on the impact that income level has on mental health, put simply: the poorer the individual the more likely they are to develop mental illness.[273]

Homelessness

Homelessness figures are notoriously difficult to find reliable statistics of at any point in time due to the stigma attached with it in addition to the large number of "hidden homeless" as well as homelessness highly politicised nature.[274] Adding to the difficultly, Ireland had no official definition of homelessness until 1988, and more detailed counts (such as children) don't start until after 2008.[275] Therefore, both England and Ireland have seen homelessness rise drastically since the 1990s, especially following the 2008 crash. In Ireland, estimates from the 1990s vary from 2,500 to 5,000 to as high as 10,000.[276] In England, these estimates range from around 50,000 to 70,000. Depending on the group conducting the count the number varies.[277] This figure saw a decrease to 47,715 in 2010 with rough sleepers in London seeing a minor increase of 2,807 in 2006 to 3,673 in 2010.[278]

Official Irish figures from 2000-2010 paint a more positive picture with the count peaking at 5,581, although this declined before increasing again following the 2008 crisis.[279] In 2011 the CSO published a special report as a part of the 2011 census that showed 3,808 were either in emergency accommodation or rough sleeping.[280] In 2014, Ireland reformed the way

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[273] Some examples include; *Surviving or Thriving: The State of the UK's Mental Health*, Mental Health Foundation, (London, 2017), p. 13, Daly & Walsh, Hospital Census 2010, p. 31 and OECD/EU, Health at a Glance, p. 24.
[274] Kieran McKeown, *Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions*, Disability Federation of Ireland, (Dublin, 1999), p. 11, http://hdl.handle.net/10147/282458, (accessed 16/06/2023).
[275] Cormac Fitzgerald, *FactCheck: Are there more homeless people in Ireland now than at any time since the Famine?*, The Journal, (2017), https://www.thejournal.ie/fact-check-homeless-3370182-May2017/, (accessed 18/09/2023).
[276] Ibid, p. 10.
[277] Molly Warrington, Running to Stand Still: Housing the Homeless in the 1990s, *Area*, Vol. 28, No. 4, (1996), pp. 471, 473, https://www.jstor.org/stable/20003732, (19/06/2023).
[278] Anwen Jones & Nicholas Pleace, *A Review of Single Homelessness in the UK 2000 – 2010*, University of York/Crisis, (London, 2010), pp. 14, 25.
[279] Fitzgerald, Are there more homeless people in Ireland now?.
[280] *Homeless persons in Ireland: A special Census report*, CSO, (Cork, 2012), p. 1.

homelessness was counted to be at set intervals and more frequently instead of it's more ad hoc manner in the past.[281] Ireland saw its homelessness population increase to 7,148, with 2,505 being children at the end of 2016.[282] By 2019, this increased to 9,731 or with 3,422 being children and this trend has continued until the present.[283] England, too, has seen an increase as in 2019, the charity Shelter, stated that there were 320,000 homeless people in the UK although this number is dubious.[284] The charity Crisis proposes this number is instead 153,000 of which around 4,600 were rough sleepers.[285]

While the precise numbers might be unreliable the overall trend points towards an increase in homelessness in both England and Ireland and that this increase is a sizable one. This had a devastating impact on homeless individuals as they are more likely to develop mental illness as well as other health complications, while those who have mental illness are more likely to become homeless.[286] In light of this issue the NHS has announced in 2023 that they will deploy mental health teams in England to assist rough sleepers.[287] This most certainly will help many people. However, its impact will be limited by the fact that so long as rough sleepers are homeless, they will still be at higher risk of developing mental illness and a number of homeless charities have expressed concern that other homeless supports have been

[281] Fitzgerald, Are there more homeless people in Ireland now?.
[282] *Homeless Report - December 2016*, Department of Housing, Local Government and Heritage, (2020), https://www.gov.ie/en/publication/0edf1-homeless-report-december-2016/, (accessed 18/06/2023).
[283] *Homeless Report - December 2019, Department of Housing*, Local Government and Heritage, (2020), https://www.gov.ie/en/publication/b2312-homeless-report-december-2019/, (accessed 18/06/2023).
[284] Mattha Busby, *Number of households in temporary residence highest since 2007*, The Guardian, (2019), https://www.theguardian.com/society/2019/sep/12/sharp-rise-in-number-of-homeless-households-in-england, (accessed 18/06/2023).
[285] Fitzpatrick, Pawson, Bramley, Wood, Watts, Stephens & Blenkinsopp, The homelessness monitor: England 2019, pp. 62, 69.
[286] Murphy, Mitchell & McDaid, Homelessness and Mental Health, pp. 5-8, 18-20 also see Stefan Gutwinski, Stefanie Schreiter, Karl Deutscher & Seena Faze, *The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and meta-regression analysis*, PLoS Med, vol. 18, no. 8, (2021), p. 12-15, https://doi.org/10.1371/journal.pmed.1003750, (accessed 19/06/2023).
[287] Robert Booth, *NHS to deploy street mental health teams to help England's rough sleepers*, The Guardian, (2023), https://www.theguardian.com/society/2023/jun/09/nhs-to-deploy-street-mental-health-teams-to-help-rough-sleepers-england?bingParse, (accessed 19/06/2023).

cut by various councils.[288] Essentially since homelessness is rising since 2010, so are the rates of mental illness with this increasing the demand for mental health services. The figures however point to housing not being a key point of difference as both countries are doing poorly in this regard with homelessness undoubtedly worsening rates of mental illness in both countries.

Healthcare

Mental healthcare is by its very nature embedded and dependent on the wider healthcare system to function as intended. Without adequate funding for healthcare systems the mental healthcare systems will in turn suffer as well. If the structures of the health system are not operating correctly this will impact the mental healthcare system as they don't receive requested resources and mismanagement leads to poor care. Ireland perhaps best highlights all these issues as discussed in chapter 6 lack of funding weakens not only the mental healthcare system but the HSE as a whole and mismanagement resulted in a number of children being harmed. Additionally, physical illness and mental illness can impact one another with chronic physical illness often leading to mental illness and those who are poorer are more likely to develop physical ailments (in addition to mental health issues).[289] Finally, there's the fact that by increasing healthcare funding, even if the proportions don't change, the mental health care budget will also increase.

Unfortunately, there is not really a viable metric to use consistently over the period covered but spending per capita should show the general trend. Although, this has its own issues, as in Ireland healthcare was largely paid by local rates and sweepstakes until the formation of the Health Boards in the late 1970s. English specific data is largely unavailable until 2014, the

[288] Ibid.
[289] Barnett, Mercer, Norbury, Watt, Wyke & Guthrie, Epidemiology of multimorbidity and implications for health care, pp. 40-42.

latter is a lesser issue since spending per capita appears relatively similar even in the devolved system.[290] Healthcare spending per capita will offer a general idea of how well funded the healthcare system is in comparison to one another.

This subsection uses per capita spending in euros using 2018 prices.[291] Most of the discussion uses data for the UK however where available English specific data is used. The UK spent an estimate approximately €282 per capita in 1955.[292] This increased significantly, as by 1985 spending reached an approximate €797 per capita.[293] This means that there was a 7 percent increase in spending per year (for context in 2018 the UK government promised to increase the budget by 3.4 percent per year).[294] However, by 1995 it had surpassed approximately €1,166 per capita resulting in just over a 10 percent increase per year in spending.[295] Ireland from 1980 to 1990 saw spending increase from approximately €274 to €574 per capita marking a 10 percent increase over that period.[296] Irish healthcare spending nevertheless was still extremely low, especially in a European context as 'during the 1970s, 1980s, and 1990s, the Netherlands spent on average 54% more than did Ireland [sic] annually on a per capita basis, while Germany spent over double the Irish figures. Only since the turn of the century has Ireland closed this gap.'[297]

The 1990s and 2000s saw funding for both nations soar rapidly as both countries experienced an economic upswing. The UK, in particular under Blair and Brown saw funding increase to

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[290] Rachael Harker, *NHS Funding and Expenditure*, House of Commons Library, (London, 2019), p. 8.
[291] Conversion calculations done with figures from the Bank of England from the 01/12/2018, https://www.bankofengland.co.uk/boeapps/database/Rates.asp?TD=30&TM=Nov&TY=2018&into=GBP&rateview=D, (19/06/2023).
[292] George Stoye & Ben Zaranko, *UK health spending*, Institute of Fiscal Studies, (London, 2020), p. 4.
[293] Ibid.
[294] Stoye & Zaranko, *UK health spending*, p. 4 and Chris Ham, *The rise and decline of the NHS in England 2000–20: How political failure led to the crisis in the NHS and social care*, The King's Fund, (London, 2023), p. 12.
[295] Stoye & Zaranko, UK health Spending, p. 4.
[296] Miriam Wiley, The Irish health system: developments in strategy, structure, funding and delivery since 1980, *Health Economics*, vol. 14, (2005), pp. S171-S172, https://doi-org.ucd.idm.oclc.org/10.1002/hec.1034, (accessed 19/06/2023).
[297] Brian Turner, Putting Ireland's health spending into perspective, *The Lancet*, vol. 391, no. 10123, (2018), https://doi.org/10.1016/S0140-6736(18)30461-6, (accessed 20/06/2023).

6 percent per year (1997-2010), in comparison to the 3.3 percent under Thatcher and Major (1979-1997), and the 3.6 percent average increase overall (1950-2019).[298] As a result healthcare spending soared from approximately €1,257 per capita in 1997, to €2,231 per capita in 2010, with 2000 to 2005 seeing an unprecedented 8.7 percent yearly increase.[299] In this period Ireland poured money into its healthcare system from 1990 to 2000 spending increased from €573 per capita to €1,486.[300] By 2009 it reached €2,919 per capita, with the annual average growth rate in real health expenditure per capita from 1997 to 2007 being 6.7 percent while the OECD average was 4.1 percent and the UK was 4.8 percent.[301] However, the past of underfunding healthcare resulted in Ireland having far fewer healthcare professionals than other OECD nations (except for nurses).[302] In comparison to the UK, Ireland lagged behind in terms of doctors per 100,000 with the UK having 192.81 doctors per 100,000 in 2009, as opposed to Irelands 141.6 doctors per 100,000.[303] In the coming decade this gap narrowed.

The 2008 crisis negatively affected both England and Ireland, yet the impact on the healthcare system in the UK and by extension England had been far worse than in Ireland. The average annual growth rate for healthcare spending as mentioned averages at 3.6 percent however, the Coalition government (Conservatives and Liberal Democrats) from 2010 to 2015 saw 1 percent increase in spending, and the Conservative government from 2015 to 2019 saw a 1.6 percent increase.[304] By 2019 healthcare spending grew modestly to

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[298] Stoye & Zaranko, UK health Spending, p. 5.
[299] Harker, NHS Funding and Expenditure, p. 3.
[300] Wiley, The Irish health system, p. S172.
[301] Oireachtas Library & Research Service, *Benchmarking Ireland's Health System*, Houses of the Oireachtas, no. 7, (2010), pp. 4-5.
[302] Ibid, p. 11.
[303] *Annual, Medical doctors, Head count per hundred thousand inhabitants (1980-2021)*, Eurostat, (2022), https://ec.europa.eu/eurostat/databrowser/view/HLTH_RS_PRSHP1__custom_6603358/default/line?lang=en, (accessed 19/06/2023).
[304] Stoye & Zaranko, UK health Spending, p. 5.

approximately €2,347 per capita.[305] England specifically spent €2,315 per capita in 2014 increasing to €2,556 per capita in 2018, the least per capita out of the devolved nations (although not by much).[306] Ireland also saw spending stagnate until 2015 when it surpassed the 2009 peak (€2,964 per capita in 2015 as opposed to €2,919 per capita in 2009).[307] By 2019 this had grown to €3,655 per capita, resulting in an approximate 6.35 percent increase in funding per year.[308] This shift can be seen in doctors numbers as Ireland began to catch up to the UK in terms of doctors per 100,000 with the UK seeing very little growth having 207.12 doctors per 100,000, while Ireland had 177.06 per 100,000 in 2018.[309]

The general trajectory of the two countries' health services is clearly outlined as Ireland had consistently failed to adequately fund its healthcare system going into the 1990s whereas the UK had, especially in comparison to other European countries. Both countries increased healthcare spending astronomically from the late 1990s to 2010, most notably in the early 2000s. However, Ireland overtook the UK in per capita spending in this period. Once again both countries either largely froze increases to healthcare spending or cut it slightly but by 2015 Ireland was once again able to increase funding at a higher rate than in the UK. This has manifested itself with UK doctor numbers largely stagnating while Ireland slowly increases.

There are two main points of deviation, the period before 1990 where Ireland had failed to fund its healthcare system sufficiently and the period between 2015 and 2019, with Ireland increasing its healthcare funding to a far greater degree than the UK. With this trend being similar to that of poverty. The former saw Ireland in a period where it struggled greatly with high rates of poverty and mental illness and while a lack of funding for healthcare services

[305] Ibid, p. 4.
[306] Harker, NHS Funding and Expenditure, p. 8.
[307] *Measuring Ireland's Progress 2021*, CSO, (Cork, 2021), Measuring Ireland's Progress 2021, https://www.cso.ie/en/releasesandpublications/ep/p-mip/measuringirelandsprogress2021/health/, (20/06/2023).
[308] Ibid.
[309] Medical doctors, Head count, Eurostat.

did not cause these issues it almost certainly worsened them. As previously mentioned, physical and mental health are intrinsically linked to one another and if Ireland only spends around half of what the UK or another European country can per person then that care is almost certainly going to be worse in one way or another indirectly impacting one's mental health. Additionally, since those who are poor are more likely to develop both physical and mental health issues, the fact such a large portion of the country was living in poverty only increases the demands on the healthcare and mental healthcare systems. While the full impact for the lack of funding from 2015-2019 for the UK healthcare system is yet to be seen, the reports, particularly from The King's Trust on this matter, paint a concerning picture.

Conclusion

Both English and Irish mental health services have changed drastically to a near unrecognisable degree from what they were in the 1950s. The old mental asylums have for the most part been completely replaced with hospital care and community care, with the goal being to rehabilitate and reintegrate rather than simply remove individuals from society.

England successfully underwent a major shift from asylum-based care to community care, however this shift has been far from perfect. Community care has repeatedly found itself lacking the resources required to provide adequate care for patients, as highlighted in 1975 during the convention on the White Paper for Better Services for the Mentally Ill and in 1995. Additionally in 2015 with a decreasing mental health budget, 2,100 mental health beds were forced to close at a time when mental illness was increasing. These pressures on community care and hospital care undoubtedly contribute to the increased use of compulsory orders, as people do not receive the care they need until they are a danger to themselves and others and even then, too many end up in prison. While the goals of deinstitutionalisation are pure over time, they have become warped by politicians seeking to reduce costs rather than improve mental health patients' quality of life. This is perhaps best seen through mental health law as, while both the 1959 and 1983 MHAs had faults, they were at least written with the goal of improving the wellbeing of patients. The 2007 MHA was however made in part to soothe public fears about the potential "dangers" of the mentally ill, who were only in the situation they were in because of the shortages of mental health services.

Ireland adopted a near identical approach to England, however it had far less resources to implement community care and at least initially saw far less political support. The 1966 Commission of Inquiry, much like the Percy Commission (1957) recommended sweeping recommendations, but unlike the Percy Commission it saw next to no financial or political support. It was nearly twenty years before the next report 1984 Planning for the Future was

published, which saw far more political support, but it still struggled to see mental health services receive the funding they needed to operate effectively. In *A Vision for Change* (2006) was published and repeated many of the recommendations made in 1966 and 1984 and while implementation proved to be a major issue, it had been more successful than its predecessors. While like in England, the shortages of community care have repeatedly proved to be a major issue, the general trajectory has at least been somewhat continuously positive, unlike in England.

The mental health systems in both countries, however, do not exist in a vacuum and we have seen repeatedly that mental illness, poverty, homelessness, and health inequalities overlap with one another and compound on each other. Poverty has been a major issue in England and Ireland, however, since the 2008 crisis, it has become a far greater issue in England. Historically, England had a far more expansive and generous welfare system than Ireland and as a result saw lower rates of poverty. Since the 1980s, English poverty had been gradually increasing, while the Irish saw a slight decline until 2008. Following the 2008 crisis poverty increased in both countries however, in Ireland this has decreased slowly to around 13 percent, while in England it has remained at around 22 percent.

Like poverty, homelessness has been a major issue in both countries, but it has been a far greater issue in Ireland than in England. Until the 1980s, England experienced a very effective public housing scheme which ensured that most people lived in good homes. Ireland, in contrast, struggled to provide both sufficient housing and good quality, particularly housing in Dublin. The 1980s, however, saw the effective end of England's public housing scheme and it is perhaps unsurprising that homelessness promptly began to increase before declining in the late 2000s. In Ireland, the 1990s marked the beginning of a construction boom which, while providing many houses, did not decrease their costs as prices soared until 2008. Following the 2008 crisis, both countries have seen continuous increases in

homelessness, with rising numbers of rough sleepers being the most visible symptom of the ongoing housing crisis.

As with the previous areas, England had a far more robust healthcare system than Ireland until the 1980s, which saw the NHS become a major source of pride for many English people, despite health inequalities remaining an issue as highlighted by the Black Report. In comparison, Ireland continually underfunded its healthcare and it remained a decentralised system until the formation of the Health Boards in 1977. While the NHS underwent a number of reforms in the 1980s that hindered its ability to operate effectively, it wasn't until the Blair administration began to use private funds to keep public expenditure low from 1997 to 2010 that the NHS began to seriously struggle, despite the increase in funding. Ireland too saw a massive surge in spending from the 1990s, with the HSE being formed in 2005 further centralising healthcare, but it's two-tiered healthcare system continued to cause issues. Following the 2008 crisis, the NHS has come under increasing pressure as funding stabilised but private funds were still used. As a result, the NHS was eroded internally by rising interest costs. In Ireland, the HSE struggled to find its footing as health spending stabilised until 2015 when it began to increase at a steady pace. However, the Sláintecare reform which sought to remove the two-tiered system stalled quickly and mismanagement has harmed patients, as seen in CAMHS in south Kerry.

In my dissertation on the Irish mental healthcare system, I concluded that due to lack of funds and staff the Irish mental health system failed to tackle Irelands stubbornly high rates of mental illness. This thesis largely refutes that claim: while these failures indeed worsened the situation, it did not cause the high rates of mental illness. Instead, the arguments of Graham Scambler, Andrew Scull and Brendan Kelly hold true to at least some degree. In England the rise of neoliberalism has had a negative effect in every area discussed in this thesis, there is a noticeable increase in poverty, homelessness and issues with the healthcare system following

the 1980s. This appears to be less of an issue in Ireland, since the situation was so dire and spending was so low that, once the economy began to improve in the 1990s, it led to improvements in all these areas or at least it did not get worse. While the case could be made that Ireland's situation only improved due to the embracing of neoliberal policies, it seems unlikely considering the economic growth in the 1960s. Kelly is also largely correct in stating that those in mental hospitals in Ireland were placed there and forgotten, and this trend has continued to a certain degree. This also applies to England however, instead of in mental hospitals they are put in prison as mentioned by Scull. One issue with these arguments is that, while they correctly identify poorer people as those who suffer the most, they miss the fact that a sizeable proportion of those with mental illness, living in poverty, dealing with homelessness, and experiencing health inequalities are children. Due to failed policies and inaction in past and present, the lives of so many children have been seriously negatively affected which can cause more issues in the future.

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