

Comments on

## “Changing Our Mindset” Labour’s Approach to Mental Health, January 2005.

The Irish College of Psychiatrists welcomes this policy on Mental Health. We, however would like to make a number of comments on the content of the document as follows;

- Stigma – We agree that stigma continues to be a barrier to service development, access to services and better mental health for all and welcome any measures to reduce it.
- Funding. The document refers to increasing mental health funding to 10%. We recommend that this should be 12-13% in line with what it previously was in 1988. It is quite true to say that change to a community based service can be initially more expensive than the original institutionally based one, therefore funding levels should have risen and not decreased since 1984.
- In reference to equitable funding, we do not agree with ‘redistribution’ of funds to provide equitable services. Services should not be taken from one area in order to provide services elsewhere. No service is above average. Even in areas that are highly funded, the services are not adequate. Priority should be to improve the funding in under-resourced areas.
- It is not necessarily true that long-term temporary consultants are only in underdeveloped areas. In general we advocate that consultants in temporary posts should be made permanent, provided they are eligible to be on the Specialist Register.
- Staffing
  1. A wide range of skills are required to provide a comprehensive MHS. These are usually provided via the Consultant led multidisciplinary team. Many of these teams are not in place or only recently appointed. Barriers to development include funding deficits, recruitment and retention problems, lack of manpower and training strategies, failure to adequately recognise and remunerate particular skills (e.g. Psychotherapy: Many different professionals may be trained in the various psychotherapies yet there is no register or definition of what a psychotherapist is!), WTE recruitment ceilings also prevent any increase in staffing and development of services.
  2. Specialist Services :We agree with the broad statement that these are inadequately developed but would add to your list other recognised specialties – **Liaison Psychiatry**, which deals with the link between Mental and Physical health ( theme of World mental Health Day 2004, and further developed in the 2005 theme) – **Perinatal Psychiatry**, which deals with mental health of both mother and child and the development of crucial early relationships – **Rehabilitation Psychiatry** ,which encompasses the goal of full recovery.
  3. There is a need for a national manpower and training strategy for mental health.
- Primary Care; We agree that Primary Care teams should be resourced to diagnose and treat those milder mental health disorders that are appropriately treated in that situation. However there are many disorders that will still require the expertise of a Specialist service.
- Move from Psychiatric Institutions; We agree with Labour’s view on the move from the psychiatric institutions; however there is a problem in that there are not enough in-patient beds for those who need them.
- Poverty and Inequality; People cannot return to work following an illness because they can lose their benefits. Community Employment schemes are very important.
- Children and Adolescents; We agree that services for children and adolescents are not adequate. Funding for these services represents only about 7% of the total mental health spend (for 25% of the population!!!). Valuable opportunities are lost for early identification and treatment of childhood disorders. The principle of Early Intervention must be a central part of any new mental health policy. There is a serious crisis situation at present in that inpatient and day hospital services are almost non existent.
- Prisons; There is a major concern about levels of psychiatric illness in prisons. Diversion from the prison system is hampered by the lack of community forensic psychiatry services, psychiatric intensive care units and Regional Secure Units. Once prisoners are discharged, they tend to go back to local general service. The comment on solitary confinement is unclear. Is seclusion, which may be an appropriate therapeutic intervention, being confused with solitary confinement? A National Strategy on the development of Forensic Psychiatry needs to be instituted, involving both the Departments of Health and Children and Justice.
- Mental Health Courts – This is a welcome and positive statement and political support would be welcome. In particular we would request that provision be given for facilities for court diversion at the new courts complex which is planned for the Phoenix Park. However, resources must be put in

place for the development of locked ward facilities which would be necessary to ensure the success of the court diversion scheme.

- In the whole document, there is no mention of the Mental Health Commission or the Mental Health Act 2001. There is a serious concern about the failure of the Department of Health and Children to provide any extra funding for increased numbers of Consultants to cope with the extra duties required by the new Act, and treating consultants will be taken away from their already overstretched clinics to comply with the Act e.g. to attend tribunals etc. Any Government funding for this Act has solely been allocated to the Mental Health Commission and not to Services.
- Suicide; When patients present at A&E, it is inaccurate to say there is no service to refer to. All adult psychiatric units have a 24/7 emergency service. There are very few liaison nurses and they decide if a patient needs to be seen by the local catchment area service. There should be a Liaison Psychiatry Service to every General and Paediatric Hospital where children, adolescents and adults who have attempted suicide may present. At a minimum these should consist of Consultant Psychiatrist, Liaison Nurse and NCHD. They could triage referrals and provide follow up for defaulters. People who have attempted suicide and do not present to A&E need to be targeted.
- Eating Disorders. All psychiatric services should have the competencies, expertise and personnel to treat eating disorders. Tertiary referral services for difficult/complex cases are required.
- Recovery – we support the concept of a service that aims for psychosocial recovery which is the central tenet of the Specialty of Rehabilitation Psychiatry.
- Psychiatry of Intellectual Disability. There is no reference to this specialty at all in the document. Mental health services for people with intellectual disability fall well below acceptable standards, are patchy in location with some counties having no psychiatric services at all for this population. There are no designated multi-disciplinary teams in psychiatry of intellectual disability. (Ref: A proposed model for the delivery of a mental health service to people with intellectual disability. Irish College of Psychiatrists, OP58, July 2004).
- Advocacy –
  1. Agree that there is a need for a national register re what constitutes a psychotherapist/counsellor – define the difference between counselling and psychotherapy.
  2. Advocacy Network Services to the HSE should have standard guidelines and operational policies. They should also have a formal contract with the HSE. Advocates should have formal standardised training, undergo security clearance and have standardised role definitions and operational procedures. There should also be a complaints procedure and outcome measurement.
- We agree that there should be a single Mental Health Management structure.

## Legislation

The impact of recent legislation on Psychiatric services must also be taken into consideration. Much of the proposed legislation will place extra demands on already overstretched services and no financial plans have been made to incorporate these. This can only result in a reduction of direct service provision to patients

- Mental Health Act 2001
- Amendments to the Medical Practitioners Act
- Criminal Law (Insanity) Bill 2003