



Irish College of Psychiatrists

Presentation to the Joint Committee on Health and Children

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We wish to thank the Chairman and Members of the Joint Committee on Health and Children for agreeing to meet with us, affording us the opportunity to share the Irish College of Psychiatrists' concerns about the deficits in the Mental Health Services.

We propose to show you the deplorable state of these services. This year only one area in psychiatry received an increase in budget, that was the much needed funding for the development of forensic services at the Central Mental Hospital. No other service received an increase, this is in comparison to other specialties in acute hospital settings.

Funding for the mental health service has dropped from **11%** of the total health budget in 1997 to **6.6%** in 2003. The level of increase in funding of psychiatry is the lowest of all the medical specialties.

Why is this happening when each of the Mental Health Inspector's reports clearly show major deficits in the service, with recommendations for the development of community services and the full establishment of multi-disciplinary teams.

Mental Health is a serious public health issue.

Mental ill health affects **1 in 4** of us during our lifetime causing even more disability than lung problems, and yet development of services are neglected year after year.

You may not be aware that of the 10 major causes of all disability, 4 are due to psychiatric conditions;

- Unipolar depression
- Bipolar Disorder
- Schizophrenia
- Obsessive Compulsive Disorder

also on this list is alcohol use.

(Leading Causes of Disability: Global Burden of Disease Study, WHO 1990)

The burden of psychiatric illness has for too long been underestimated.

Psychiatric conditions account for 19% of total disability.

10% of people with a severe mental illness die by suicide.

These are WHO figures.

Planning for the Future, was published in 1984, and has not yet been implemented in terms of the development of multi-disciplinary teams. We have called for the Higher Education Authority to develop the postgraduate training of clinical psychologists. At present only over 20 places are available, yet it is recognised that at least 50 are needed to keep services at the present level, never mind produce a sufficient number of trained clinical psychologists. About 100 places are required annually so ensuring their skills are present on each clinical team.

We have also requested the Department of Health and Children to develop psychotherapy with the establishment of Consultant Psychotherapists, no such posts exist in Ireland. The Inspector of Mental Hospitals, the Irish Psychiatric Training Committee and the Irish College are all agreed that psychotherapy services and training are of paramount importance. This training is now mandatory for Basic General Training, as well as Higher Training but almost all areas of the country are unable to meet the required standard.

Adult Psychiatry

Recent research (Browne et al) on a questionnaire sent to all Consultant Psychiatrists demonstrates that;

- a) There is a strong negative correlation between the team size and the rate of psychiatric admission in any of the Health Board areas;

- b) There is a significant correlation between the size of the clinical team and the number of non drug treatments provided to patients;
- c) The size of the clinical team differed significantly between Health Boards;
- d) There is a four fold difference in personnel numbers between the most and the least resourced team;
- e) There is an inequality in the development of multi-disciplinary teams between Health Board areas.

Psychiatric services are under-resourced. The above evidence shows that the size of psychiatric team influences outcome; whether the patient is admitted to hospital and whether they are offered a full range of treatments. 83% of Consultants have no access to a Psychotherapist and 76% have no access to a Family Therapist, 33% have no access to an Occupational Therapist.

There is also inequality in funding of mental health services across Health Boards. Urban areas have on average half the funding per capita of rural areas, but urban areas have twice the rate of severe mental illness compared to rural areas. An example is in **an urban area we have €100 per head for 100 ill people, while in a rural area, we have €200 per head for 50 ill people**. We need to be clear that we are not saying that rural areas are adequately funded, but just not as badly funded as those in urban areas.

Amnesty International's series of reports 'Mental Illness: The Neglected Quarter', highlights the long-term neglect by the Department and politicians of the mental health services. While there have been reports such as 'We Have No Beds', very little has been done to implement the numerous recommendations, which have emerged. These patients are a vulnerable, marginalised group, and are stigmatised within society, such inactivity further compounds this. The Review of Acute Bed Capacity specifically excluded psychiatric beds so that the agreed 3,000 extra beds does not include one psychiatric bed. The Department of Health study shows that 45% of acute psychiatric beds in the ERHA region are blocked. In some cases these beds are provided in facilities that are poorly maintained, badly lit, cold, damp and out-dated. I can assure you that if you were to visit any of these facilities you would be shocked.

Again there are inequalities between Health Boards.

- In the Eastern Region, there are 50% less beds per capita than the rest of the country.
- There are 2.4 times as many community residences in non-ERHA areas as there are in the ERHA.

Child and Adolescent Psychiatry.

The 2nd Report of the Working Party on Child and Adolescent Psychiatry examined the deficit in services for 16 and 17 year olds and was published in June 2003.

It highlighted the need for the development of this service, yet no money was made available in the 2004 letters of determination. Recently families have begun to publicise this dreadful gap in service. Generally when adolescents require a psychiatric service, they require it immediately. **The Irish College recommends that this service be provided for 14-18 year olds.** The 1st Report of the Working Party recommends the establishment of 7 units to provide a total of 144 beds for the age group 0-16 years. **At present there are approximately 20 beds in the whole of the country.** Including the 16-18 years old, would require an extra 80 beds, giving a total complement of 224 beds. These figures speak for themselves.

Services to children under the age of 16 years are compromised due to the lack of adequately resourced out-patient multi-disciplinary teams, hence there are waiting lists of more than a year in some areas.

There is no national database, and we recommend the establishment of one which has already been recommended in the 2nd Report. Yet again, no funding has been set aside for this initiative.

Again we agree with the recommendation in the 2nd Report that all Mental Health Services, Child and Adolescent and Adult, should be managed under one management structure within each Health Board or Region as may be the case in the future. We also believe specialist services such as Forensic Psychiatry, Psychiatry of Intellectual Disability, Psychiatry of Old Age and Psychiatry of Substance Misuse should also come under the same management structure. There are many good reasons for this, the main one being easy transition across and access from one service to another.

Psychiatry of Intellectual Disability

Even though there is a higher prevalence of mental illness in people with an intellectual disability, there is a lack of awareness and recognition of the need for mental health services for them. Mental Health Services are poorly developed and resourced, again with large variations across the country. No Health Board has adequate multi-disciplinary teams with the specific remit of assessment and treatment of mental illness in this population. There is a need for a catchment area based mental health service to promote the development of a multi-disciplinary mental health team, providing psychotherapies and a range of treatment settings, out-patient department, day hospital, in-patient care, continuing care and respite beds.

Psychiatry of Old Age.

Whilst progress has been made in developing specialist mental health services for older people, there are still substantial regions of the country with no service, for instance, Kildare, Wicklow, Kerry and most of Cork. Existing services, especially some in the ERHA require resourcing with basic facilities such as acute and long-stay psychiatric beds. The longest established and busiest services in Limerick and Dublin require full resourcing of multi-disciplinary teams including additional Consultant Psychiatrists.

Forensic Psychiatry

Forensic services are poorly developed outside of the Central Mental Hospital. 20% of people in prison have a mental illness, 8% of those in remand and 5.8% of sentenced people are psychotic during a six-month period. There is a need to address severe and enduring mental illness in this population, with development of humane secure psychiatric services with fewer mentally ill people in prison.

Substance Misuse

Quite rightly, there is growing concern in communities throughout Ireland regarding the problem of drug and alcohol use by Irish teenagers. There is a need to deliver an integrated, comprehensive national response to this issue. Specialist adolescent addiction services are required throughout the country. Ireland has an excellent National Drug Strategy covering the period 2001-2008. Many of its targets specify responses to drug and alcohol use by young people. Now we need the funds to deliver on the targets in this Strategy.

For example there are 12,000 heroin users in Dublin alone. There is considerable abuse of other drugs including alcohol. The overall health of the nation is burdened by the health problems associated with substance abuse and alcohol abuse. There is evidence to show significant saving to society when effective interventions and therapies are promoted and available. The underfunding of such services makes no financial or medical sense.

General Issues.

- The Chairman of the **Mental Health Commission** estimates that there will be 3,000+ annual hearings at the Mental Health Tribunals following involuntary admission. These are all acute situations. We are already understaffed and the **implementation of the Mental Health Act 2001**, will create a further burden. The Mental Health Commission has already made public their lack of funding, slowing down progress. We must also be funded at local level, otherwise the work entailed in being compliant with the Mental Health Act 2001, will take away services from other patients.
- As I said before, 6.6% of the Health Budget was spent on Mental Health Services, compared to 13% in the UK, and is by far the smallest increase in the last 5 years of any programme under the Department of Health and Children. The overall growth in the non-capital health budget between 1990 and 2001 was over 300%, for psychiatry it was 131%. During the Celtic Tiger years (1997-2002) the increase in overall new capital expenditure was 120%. For psychiatry it was 74%. When adjusted for the rate of inflation the overall increase is 72% and only 36% for psychiatry. This difference is not accounted for by any transfer of funding for psychiatric services to the community programme as almost all community psychiatric services are still funded through the psychiatry programme. Good community based care costs as much as in-patient care, there are similar outcomes but better social and vocational outcomes. The move to community care will not save money, just provide a slightly better outcome.
- **The National Treatment Purchase Fund and Waiting List Initiatives** have never been available for mental health patients. There are many areas of psychiatry where there are waiting lists. Child and Adolescent Psychiatry has waiting lists of a year and more. In a number of health board areas, many people are waiting for psychotherapy (where it can be provided). Staff such as clinical psychologists and psychotherapists who provide such services are thin on the ground. Out of 400 clinical psychology posts funded, 180 are vacant. It is difficult to recruit qualified people as described earlier as an insufficient

number are being trained. More recently **the cap on manpower numbers**, means that when someone vacates a post, they are not replaced regardless of the needs of the service. This is again reducing the breadth of treatments available within each specific catchment area and producing inequities across areas.

- There is poor **recruitment** here among medical students because of the facilities they see us working in, the fabric and maintenance of the buildings is often poor. It is the area of lowest interest as a specialty for female students and second lowest for males, both at 4%. We are the third largest specialty yet we cannot attract new recruits which will lead to problems unless addressed. The old pension provision of double years from 55, has now been removed. We need a large investment in our services to make the specialty attractive.

The UK are experiencing recruitment problems with a 15% vacancy rate for Consultant Psychiatrists. We feel we are just behind them.

We are aware of the financial constraints of the Government but we are not looking for high cost technology, just to restore equity and to provide staff that can make a difference in a large number of people's lives. We welcome the fact that a Minister of State has the specific brief of Mental Health Services, and the establishment of the Expert Group.

We would recommend that at the Department of Health and Children, we require specific representation at the **Management Advisory Committee**. Neither the Chief Medical Officer, nor his Assistants deal with Mental Health issues. Following the Mental Treatment Act 1945, the Inspector of Mental Hospitals attended but this ceased in the 1960s or 1970s. We would suggest that either one of the Assistants to the Chief Medical Officer or the Inspector of Mental Health Services should have a specific brief for Mental Health at this Committee.

In Summary, we recommend:

1. All Mental Health Services be managed and funded under the Directorate of the National Hospitals Office.
2. Specific representations at Management Advisory Committee by one of the Assistants to the Chief Medical Officer or the Inspector of Mental Health Services.
3. The level of funding at 6.6% of the health budget be reviewed.
4. Removal of the cap on manpower numbers, relating this to specific service needs.
5. Address the inequity in services, including bed provision, across Health Boards/Regions.
6. Fund and develop in-patient units for children and adolescents.
7. Fund and develop Adolescent Services.
8. Develop psychotherapy services including Consultant Psychiatrists in Psychotherapy.
9. The Department of Health and Children fund innovative schemes, supported by the Health Boards/Regions, such as D.E.T.E.C.T.
10. Resource services for prisoners.
11. Fund and develop Mental Health Services for people with an Intellectual Disability.
12. Fund and develop Mental Health Services for Older People with Mental Illness.
13. Greater investment in alcohol and drug treatment programmes.
14. Develop multi-disciplinary teams in all age ranges and specialist services.
15. Establish a database for services for children and adolescents.

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16. Develop specialist Adolescent Addiction services.

17. Provide services through the National Treatment Purchase Fund and the Waiting List Initiative.