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Independent Monitoring Group
Vision for Change
IHCA Response

1. General

Vision for Change is based partly on reconfiguring staff and services from institutions to the community. The adverse change in the financial circumstances of the country is reflected right across the health sector and in particular mental health services which currently are haemorrhaging posts. This has resulted in the loss of posts which makes its implementation unworkable.

1.1. The many undertakings given to ring-fence money from the sale of psychiatric institutions and lands and convert same to the benefit of the psychiatric services has not been adhered to and there is a perception of a lack of commitment on the part of the HSE to ring-fence funds in general for services.

(a) Saint Loman's Hospital & lands €40million
(b) Verville Retreat (Clontarf) €6.25million
(c) St Brendan's Hospital €60million

1.2. Conditions for patients in many long stay units, many of whom (patients) have already been the subject of failed attempts of rehabilitation because their needs have not been met in the community, continue to be unacceptable and are not fit for use. There continues to be an absolute failure to accept or realise that these poorly equipped, poorly furnished institutions which were built in the mid / late 19th century **are home to many long stay patients**. New long stay patients who are not suitable to community living/management must also be accommodated in such institutions in a manner in keeping with what is in fact their new home.

1.3. Parts of the old mental hospitals have been de-designated but they continue to be used to accommodate long stay patients but without the protection of the Mental Health Act 2001. Consultants, nurses and others who work with patients and who are responsible for their welfare see this move as an insincere and cynical exercise.

1.4. **The implementation of Vision for Change was seen as a means for closing psychiatric beds on the understanding that enhanced community teams and facilities would be made available**. The closure of beds is now being pursued as a cost saving measure without corresponding enhancement of community teams. On the contrary, non replacement of nursing staff, in particular in community teams, is compromising already severely stretched community services.

1.5. All consultant psychiatrists have psychotherapy training but are unable to use this expertise due to overload in other aspects of their work.

1.6. It is a well established fact that the percentage of the health budget spent on mental health services has decreased from 11% to 6% over the past two decades. The sad reality is that

psychiatry did not get sufficient funding in good times and therefore it is extremely badly off now that we are in difficult financial circumstances.

1.7. Despite the appointment of Executive Clinical Directors the super catchment areas have not been properly established.

2. Primary Care Referrals

- It should be noted that 1 in 10 (10%) of patients with mental health problems are referred by their GP to psychiatric services.
- In all other specialties 1 in 20 (5%) are referred by GPs to general hospital services.
- Cognisance must be taken of the significant difference in referral rates when budgets are being formulated

3. Mental Health Act

There has not been any increase in consultant numbers other than those (as negotiated by the IHCA) following to facilitate the implementation of the Mental Health Act Part 2. In many cases the promised teams attached to the new consultants have failed to materialise. There is an urgent need to review the use of the Act for the detention of children.

4. Child & Adolescent Psychiatry

4.1. There continues to be a shortage of fully staffed multidisciplinary teams. In addition, vacancies which arise are not being filled and therefore the depletion of staff continues due to the moratorium on recruitment.

4.2. Despite promises from both the HSE and former Ministers of State at the Department of Health and Children, there continues to be a severe shortage of inpatient beds.

4.3. While extra consultants have been appointed, the lack of full teams has greatly hindered their (consultants) effectiveness.

4.4. Instances can be quoted of newly appointed consultants who have neither a multidisciplinary team nor even a secretary.

4.5. As part of the five stage planned outlined in the HSE Forum Reports 1 and 2 (2006) on CAMHS, eight new teams per year for five years (i.e. forty in total) were to be provided. In 2006, funding for the appointment of eight consultants with partial teams was provided. Most of these teams have only been appointed in 2009 and the appointment process is incomplete at present.

4.6. V for C envisaged 99 multidisciplinary CAMHS teams whereas there are only 54 at present.

4.7. **The number of professionals required for CAMHS teams including adolescent day hospital and liaison identified by Vision for Change was 1,287 WTE's. At present total staff is 422 WTE's.**

4.8. The first Annual Report (2008) on the Child and Adolescent Mental Health Services states that accommodation continues to present difficulties with 18 out of 31 teams reporting that accommodation/premises are either inadequate or totally unsuitable.

4.9. It was recommended that there should be day hospitals in each catchment area of 300,000 population. At present there are still only two day hospitals in the country. (St. Vincent's, Fairview and Lucena Clinic, Rathgar)

4.10. Inpatient beds have been increased at Warrenstown House, St. Anne's (Galway) and at St. Vincent's, Fairview. Clearly the bed capacity falls far short of the 100 recommended in Vision for Change.

- Warrenstown Inpatient Unit – 6 inpatient beds
- St Anne's Galway – has increased from 6 to 10 inpatient beds
- St Vincent's Fairview – 6 inpatient beds for 16 and 17 year olds
- Cork – 1 inpatient bed open, capacity currently between 1 and 4 patients
- **A total of 23 beds of the 100 recommended in Vision for Change at a time when (at least) 40 patients under 16 years of age are awaiting admission for urgent treatment.**

4.11. A National Tertiary Eating Disorder Inpatient Unit has not been developed. There must be a series of interim arrangements as it is unlikely that the National Paediatric Hospital will be fully commissioned by the target date of 2015. It is unacceptable that patients should continue to be disadvantaged in such a manner for a further five or possibly 10 years.

4.12. There is no dedicated forensic service for children under 18 years of age. Two teams (including a 10 bedded unit) were recommended on a national basis but there has been no progress to date.

4.13. It was envisaged that there should be 4 specialist substance misuse CAMHS. There are only 2, one in Dublin Mid Leinster and one in Dublin North East, the latter having a team of 0.5 of a counsellor only.

4.14. Despite the recommendations in Vision for Change there has been little development of organised multidisciplinary teams in primary/community care for the diagnosis, assessment and ongoing provision of services for children with an autistic spectrum disorder. The lack of this service is placing severe pressure on Community CAMHS to provide a diagnostic and developmental service for these children when V for C clearly states this should not be the remit of the CAMHS service. **Neither has the issue of services for this cohort on reaching adulthood been addressed.**

4.15. CAMHS services for children with Intellectual Disability are still seriously deficient.

5. General Adult Psychiatry

All points in the General section (section 1) are relevant to general adult psychiatry. In particular:

- The impetus to close inpatient beds without the provision of enhanced community teams or community facilities;
- No new acute psychiatric units attached to general hospitals being opened under Vision for Change, that is during the last four years;
- The moratorium on nurse recruitment;
- Unacceptable conditions in some older psychiatric hospitals;
- A number of Allied Health Care Professionals who are retiring are not being replaced;
- There is a near complete absence of capital investment;
- There has been very little development in community structures;
- There are a number of sub specialties within General Adult Psychiatry:

5.1. Rehabilitation

5.1.1. Extra consultants have been appointed but teams, which are crucial to the provision of appropriate services and to the maximisation of consultants' contribution, have not been appointed.

5.1.2. Some rehabilitation consultants are being asked to manage patients with intellectual disability.

5.2. **Liaison Psychiatry**

5.2.1. There have been some extra consultant appointments but the lack of full teams takes from their effectiveness.

5.2.2. Two tertiary (Mater University Hospital and St Vincent's University Hospital) referral hospitals do not have full time liaison consultant psychiatrists or fully staffed teams.

5.3. **Eating Disorder Services**

5.3.1. There is a near total absence of any service nationally for patients with eating disorder difficulties. There are only three stand alone dedicated beds for patients with these conditions. (It is our estimate that there should be three such beds per HSE area with full teams.)

5.3.2. St Vincent's University Hospital was promised €750,000 to develop an eating disorder service. These funds were diverted to other (unknown) services and despite the best efforts of the IHCA including raising the matter with the then Minister of State, Mr T O'Malley, it has not been possible to establish the ultimate destination of this funding. The proposed appointment of a full time eating disorder consultant has been deferred.

5.3.3. V for C set out a blueprint to provide a comprehensive national service to treat patients with eating disorders. To date there has been minimal progress.

5.3.4. Both Adult and C&A Consultant Psychiatrists have expressed concerns at the difficulty in accessing appropriate specialist care for eating disorders patients in general and particularly those patients with severe illness.

5.3.5. Day hospital facilities must be developed as must outreach supervision and education in support of primary and secondary care levels of eating disorder treatment.

5.4. **Addiction Services**

5.4.1. **Drug and alcohol dependence are recognised as mental disorders internationally and are included in the international classification of mental disorders produced by the World Health Organisation and the American Psychiatric Association.**

5.4.2. This exclusion represents a fundamental flaw in V for C.

5.4.3. The statement in Vision for Change (page 46) that "the majority responsibility for care of people with addiction lies outside the mental health system" is at variance with best international policy and practice.

5.4.4. It is unacceptable to have addiction services excluded from the remit of Vision for Change.

5.4.5. **The proposal to develop separate drug and alcohol treatment services represents a waste of scarce resources and duplication of services.** It fails to recognise that the competency and skills required to treat drug and alcohol disorders are the same as those required to treat many other mental health disorders. Both services require psychiatrists, psychiatric nurses, individual, group and family therapists etc.

5.4.6. The Faculty of Addictions, College of Psychiatry of Ireland strongly disagrees with the exclusion of addiction from mental health services.

5.4.7. V for C recommended the establishment of an extra 17 teams to treat co-morbid mental illness and addiction with 15 of these teams for adult services and the remaining 2 (additional) for adolescents. There has not been any progress in the establishment of these teams to date.

6. Neuropsychiatry

- There has not been any development of the two teams as envisaged in Vision for Change.

7. Psychiatry of Learning Disability (Intellectual Disability)

7.1. There has been no significant development in this specialty under the Vision for Change.

7.2. The recommendations of the Forum Report have been largely ignored.

7.3. In 2006, €2 million earmarked for developments which have not been progressed was diverted to other uses.

7.4. Currently there are two centres approved under the Mental Health Act 2001 for the treatment of Learning Disability (Intellectual Disability) and co-morbid mental disorders. This is grossly inadequate and regrettably there seems to be no further plans for additional capacity.

7.5. Extra multidisciplinary teams have not been appointed.

7.6. In some instances there are consultants in posts who do not have any multidisciplinary teams.

7.7. There has been no development in services for Children and Adolescents with Intellectual Disability and in one instance, a service which had been developed, has been withdrawn. 13 teams are recommended in V for C and in addition there is no inpatient facility for this population of children.

8. Psychiatry of Old Age

8.1. Many of the points in Vision for Change on psychiatric services for older people section (Chap 13) do not represent the views of the Consultants in Psychiatry of Old Age. Despite a number of requests the speciality of Psychiatry of Old Age was refused representation on the Expert Group. The Irish Association of Consultants in Psychiatry of Old Age (IACPOA) prepared a report for the Expert Group on the draft Vision for Change but this was ignored.

8.2. The Vision for Change document is purported to be evidence based. In the case of Older Peoples' mental health needs and their service requirements this is simply not correct. There is **no** evidence base for the recommendations that the 'Expert' Group made in both documents. The Expert Group decided that there should be one consultant per 100,000 of the general population. Clearly the norm should be based on the number of elderly people since their percentage of total population varies throughout the country from under 10% – 17%. The requirement, as recommended by The Royal College of Psychiatrists, is for one consultant per 10,000 of the older population. Using the V for C recommendations would result in services with vastly different older populations receiving the same service level.

8.3. It is vital to acknowledge the differing needs of dementia sufferers, the needs of those with late onset mental illness and the needs of older people with lifelong severe and enduring mental illnesses (the graduates). Services for graduates need to be outlined, resourced and provided following involvement and consultation between General Adult Psychiatry, Psychiatry of Old Age and Rehabilitation Psychiatry. Such services will need to be adequately resourced.

8.4. International guidelines and best practice recommend the norm of 30 continuing care beds for severe dementia per 10,000 people over 65 years. It is the view of the Association that one third of these beds should be in an approved and two thirds in a non approved setting with regular reviews provided by the Psychiatry of Old Age Service to the latter.

8.5. International guidelines and best practice recommend the norm of 2 day hospital places per 1,000 people over the age of 65 i.e. 20 per 10,000 older population, however only one third of old age psychiatry services have access to a day hospital.

8.6. Only one of the 19 services has a complete multidisciplinary team. This needs urgent redress.

8.7. Vision for Change recommends a specialist Psychiatry of Old Age unit of 8 beds per catchment area. Rather than trying to reach the Vision for Change targets, two such units have been closed recently.

8.8. The resources required for Psychiatry of Old Age Liaison Services to general hospitals are not mentioned in VFC or the HSE's Implementation Plan. Liaison Psychiatry to older people forms a substantial part of the Psychiatry of Old Age workload with approximately 80% of medical admissions aged 65 years and over. The workload is particularly high where a service is linked to a large general, regional or tertiary referral hospital. This workload must be acknowledged and resourced.

8.9. Consideration should be given to resourcing Psychiatry of Old Age to develop services for people who develop dementia under the age of 65 years. The V for C recommendation that this patient group be cared for by the national neuropsychiatry service is clearly unworkable.

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