CONSULTANT STAFFING
IN THE
MENTAL HEALTH SERVICES

December 2004
Comhairle na nOspidéal

CONSULTANT STAFFING IN THE MENTAL HEALTH SERVICES

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Arising from the Government’s Health Service Reform Programme, the Health Service Executive (HSE) was established on 1st January 2005 pursuant to the Health Act 2004. The Act provided for the dissolution of the ERHA and its three area health boards, the health boards established under the Health Act 1970 and certain other bodies, one of which was Comhairle na nOspidéal. Under the terms of the Act the HSE is charged with managing, delivering or arranging the delivery of health and personal social services in Ireland in the context of policy developed by the Government and the Minister for Health & Children.

In line with section 57(2) of the Health Act 2004, the functions of Comhairle na nOspidéal, as specified in section 41(1)(b)(i) and (ii) of the Health Act 1970, were transferred to the HSE on its establishment date of 1st January 2005. Prior to the establishment date, the members of Comhairle were requested by the then Minister M. Martin, T.D. and Mr K. Kelly, Chairman, HSE, to remain until the scheduled end of their term of office in December 2005 to complete ongoing specialty reviews and to provide advice to the HSE on the regulation of consultant, specialist registrar and senior registrar appointments.

This report has been prepared by Comhairle na nOspidéal and was adopted by Comhairle na nOspidéal in December 2004. It is intended that it will inform and guide the Minister for Health & Children, the Department of Health & Children and the HSE in relation to policy and consultant manpower requirements in psychiatry services in Ireland.
INTRODUCTION

In carrying out this review of consultant staffing in the mental health service, Comhairle na nOspidéal has reviewed national and international literature on psychiatric services and mental health and engaged in an extensive consultation process. This process involved meeting with and receiving submissions from representatives of health boards, relevant voluntary hospitals, appropriate professional and training bodies and other interested parties including representatives of the voluntary and community sector in psychiatry and representatives of professions allied to psychiatry. A number of site visits were also undertaken.

Comhairle na nOspidéal wishes to emphasise that this report is not a general review of the psychiatric services as a whole. It deals mainly with consultant staffing levels of the public psychiatric service and makes recommendations regarding the number of posts in each specialty and sub-specialty of psychiatry taking into consideration the issues listed in section 1.1 of the report.

TERMS OF REFERENCE

“...To examine the psychiatric services at consultant level with particular regard to the emergence of sub-specialisation and, following consultation with the interests concerned, to make recommendations to Comhairle na nOspidéal on the arrangements which should be introduced to facilitate the development of psychiatric services at consultant level, having regard to international trends.”

GENERAL PRINCIPLES

The fundamental principle which sustains and underlies this report and its recommendations, in common with all other reports from Comhairle na nOspidéal, is that high quality and safe services should be available to patients at all times. This necessitates that:

- The interests of patients are of paramount importance and should always come first.
- The patient is entitled to the highest quality service within the available resources and those resources must be used in the most efficient and effective manner possible.
- There should be an equitable spread of psychiatric services throughout the State consistent with best practice and patients suffering from a mental illness should have appropriate access to a consultant psychiatrist and a multi-disciplinary team.

METHODOLOGY

In considering the issues involved regarding consultant staffing levels for mental health services, Comhairle na nOspidéal focused on what a model population size of 300,000 would require. This enabled the Comhairle to consider the full range of specialist mental health services, including those whose population base would be greater than the average catchment area population of 100,000. This allowed Comhairle to envisage how mental health services would operate as a whole when providing services to a sizeable population.

In addressing some of the difficulties associated with sectorisation, whilst retaining its advantages, Comhairle na nOspidéal recommends that two consultant general adult psychiatrists should be appointed to larger sectors and that the possibility of combining existing sectors to give rise to larger
sectors in the future staffed by a minimum of two consultant general adult psychiatrists should be examined by the HSE. These options would utilise the infrastructure of existing sectors whilst allowing public patients to overcome the biggest limitation associated with sectorisation, that of not having a choice of consultant psychiatrist.

It seemed appropriate to Comhairle na nOspidéal to continue to overlay general adult psychiatric services organised around sectorisation with specialised services which would serve a larger population base. This approach is adopted in recommending consultant posts in specialised services for adults in this report. Comhairle na nOspidéal notes that child and adolescent psychiatric services have to date been organised on a catchment area basis, and that the concept of sectors does not generally apply in the child and adolescent psychiatric services.

KEY RECOMMENDATIONS

Comhairle na nOspidéal believes that in order to ensure the availability of high quality and safe services to patients at all times, there is a need to create additional consultant psychiatrist posts, primarily in the sub-specialties of adult psychiatry and within general child and adolescent psychiatry services. In this context, the main areas of psychiatry were examined, in terms of current consultant staffing and organisation and recommendations made regarding future consultant staffing and development of services.

Areas examined and key recommendations made include:

- **General adult psychiatry**
  Continuation of guideline of one post of consultant general adult psychiatrist per 25,000 population.

- **Child & adolescent psychiatry**
  Two posts of consultant child and adolescent psychiatrist per 100,000 population. It is envisaged that within this expansion of services, enhanced services will be provided to the general child and adolescent population and to specific groups within this population including infants, 16 – 17 year olds, ADHD/HKD\(^1\) patients and autistic patients.

- **Psychiatry of learning disability**
  With respect to services for adults, one post of consultant general adult psychiatrist with a special interest in learning disability per 100,000 population.

  For child and adolescent services, one post of consultant child & adolescent psychiatrist with a special interest in learning disability per 200,000 population.

- **Old age psychiatry**
  One post of consultant psychiatrist in the psychiatry of old age per 100,000 population.

- **Adult liaison psychiatry**
  A minimum of one post of consultant general adult psychiatrist with a special interest in liaison psychiatry in hospitals with 500 acute beds and in groups of hospitals with a minimum of 500 acute beds.

- **Adult forensic psychiatry**
  The continuation and extension of full-time forensic psychiatrist services within the Dublin region based in Dundrum, outreaching to Portlaoise Prison and the Midlands Prison. The development of consultant general adult psychiatrist posts with a special interest in forensic psychiatry is recommended to provide services to the smaller prisons throughout the rest of the state and to staff psychiatric intensive care units.

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\(^1\) ADHD = Attention Deficit Hyperactivity Disorder  
HKD = Hyperkinetic Disorder
Rehabilitation psychiatry
One post of consultant general adult psychiatrist with a special interest in rehabilitation per 100,000 population.

Adult substance misuse
One post of consultant general adult psychiatrist with a special interest in substance misuse per 300,000 population.

Other recommendations
This report also includes recommendations regarding:
- child and adolescent inpatient units
- child and adolescent high support units
- suicide and deliberate self harm
- homeless mentally ill
- sectorisation
- acute beds for learning disability services
- psychotherapy
- perinatal psychiatry
- child liaison psychiatry
- neuropsychiatry
- child and adolescent substance misuse
- academic psychiatry
- role of primary care in the delivery of mental health service

National model
This report details a plan for the development and expansion of each of the key specialty and sub-specialty areas of psychiatric services and consultant psychiatrist staffing in Ireland. The diagram overleaf provides an overview regarding how Comhairle na nOspidéal envisages consultant psychiatrist services being organised and staffed with respect to sector sizes of approximately 50,000 and catchment populations of approximately 100,000. These services will be supported by additional specialised consultant services which will have a larger population base.

Comhairle na nOspidéal believes that the recommendations set out in this report are in the best interest of patients who are entitled to the best service that modern medicine has to offer, judged by international standards. It believes that the implementation of these recommendations will go a long way towards improving the current levels of psychiatric services and consultant staffing. It hopes that the increased number of consultants in conjunction with the recommended organisational frameworks will facilitate the provision of enhanced psychiatric services nationwide.
**Catchment Area Consultant Psychiatrist Team (pop. 100,000)**
- 4 general adult psychiatrists
- 2 child & adolescent psychiatrists
- 1 learning disability – adult
- 1 old age psychiatrist
- 1 rehabilitation psychiatrist
- 0.5 learning disability – child & adolescent

**Additional consultant services overlaying catchment populations (pop. 300,000)**
- substance misuse
- liaison psychiatry
- psychotherapy (as appropriate)
- forensic psychiatry (as appropriate)

**Sectors**
Individual catchment areas will be composed of 2 – 4 sectors. In line with recommendations made in this report, consideration should be given to combining existing sectors to give rise to larger sectors of approximately 50,000.
1 INTRODUCTION

1.1 TERMS OF REFERENCE

In October 2001, Comhairle na nOspidéal established a committee to examine and report on consultant staffing in the mental health services. This committee built on the extensive and valuable work carried out by a previous committee, established by the 8th Comhairle na nOspidéal, whose draft report had been presented to the current 9th Comhairle. The membership of the previous Comhairle committee and its secretariat is given in Appendix A of this report. The current Comhairle wishes to acknowledge the contribution of the previous Comhairle to this report.

The following terms of reference guided the work of both committees:

“To examine the psychiatric services at consultant level with particular regard to the emergence of sub-specialisation and, following consultation with the interests concerned, to make recommendations to Comhairle na nOspidéal on the arrangements which should be introduced to facilitate the development of psychiatric services at consultant level, having regard to international trends.”

Comhairle na nOspidéal published a report entitled “Psychiatric Services at Consultant Level” in March 1978. For the past 20 years, that report together with “Planning for the Future” and policy documents from the Irish Psychiatric Training Committee and the Irish College of Psychiatrists, has provided the basis for policy making and decisions by the Department of Health & Children, Comhairle na nOspidéal and health agencies in relation to the development and staffing of psychiatric services.

However, in the intervening time a number of broad issues central to the development of psychiatry in Ireland, particularly relating to consultant staffing and organisation, had arisen that required further and more detailed evaluation. These included:

- The development of specialisation and sub-specialisation both within and separate from general adult psychiatry
- The future role of the general adult psychiatrist
- How a sectorised service would accommodate the trend towards specialisation
- Variations in the populations of catchment areas
- Variations in consultant to population ratios
- The impact on the practice of psychiatry arising from the location of acute psychiatric units in general hospitals
- Development of child & adolescent psychiatry
- Development of learning disability psychiatry
- Interaction between consultants in general adult psychiatry, child & adolescent psychiatry, learning disability psychiatry and old age psychiatry to ensure a co-ordinated service
- Support staff and facilities
- Epidemiology of suicide and its prevention

2. In November 2002 the committee was informed that the title of “The Irish College of Psychiatrists” was now the official business name of the Irish Division of the Royal College of Psychiatrists and the new title replaces previous representations made to the committee in the name of the Irish Division or the Irish Section of the Royal College of Psychiatrists.
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- Increase in substance misuse amongst the population
- Child sexual abuse
- The changing role of general practice and its impact on the role of the consultant psychiatrist and on the delivery of psychiatric services
- Provision of forensic psychiatry services country wide
- Impact of the Mental Health Act 2001
- Increased awareness of certain conditions e.g. ADHD and eating disorders

1.2 MEMBERSHIP OF PSYCHIATRY COMMITTEE

The following members of the ninth Comhairle na nOspidéal were appointed to serve on the committee

Dr. P. McKenna (Chairperson), Consultant Obstetrician and Gynaecologist, Rotunda Hospital
Ms. C. Carney, Assistant General Secretary, Impact
Dr. J. Daly, Consultant General Adult Psychiatrist, Wexford
Mr. D. Doherty, Director, The Health Boards Executive
Dr. K. Ganter, Consultant Child & Adolescent Psychiatrist, Lucena Clinic, Rathgar
Dr. T. Ryan, Consultant Neonatologist, Cork University Hospital Group
Mr. T. Martin, Chief Officer, Comhairle na nOspidéal

During the course of its early deliberations the committee invited Ms. B. Nic Aongusa, Principal Officer, Mental Health Division, Department of Health & Children, to become a member of the committee. This invitation was accepted.

Ms. M.J. Biggs, HEO, Comhairle na nOspidéal, was secretary to this committee and undertook the drafting of this final version of the report.

1.3 METHODOLOGY

Comhairle na nOspidéal reviewed national and international literature on psychiatric services and mental health, engaged in an extensive consultation process and met with and received submissions from representatives of each health board, relevant voluntary hospitals, appropriate professional and postgraduate training bodies and other interested parties including representatives of the voluntary and community sector in psychiatry and representatives of professions allied to psychiatry. Site visits to a range of psychiatric facilities including acute psychiatric units in general hospitals, old psychiatric hospitals built in the nineteenth century, a psychiatric intensive care unit, community residences, day centres and inpatient child & adolescent units were also undertaken.

Comhairle na nOspidéal wishes to record its sincere appreciation to the many people and agencies throughout the State that assisted it in its task by providing oral and/or written views to the committee. The information and advice received has been particularly helpful in reaching the conclusions and recommendations set out in this report. Comhairle na nOspidéal wishes to emphasise that this report is not a general review of the psychiatric services as a whole. It deals mainly with consultant staffing levels of the public psychiatric service and makes recommendations regarding the number of posts in each specialty and sub-specialty of psychiatry taking into consideration the issues listed in section 1.1.
1.4 GENERAL PRINCIPLE

The fundamental principle which sustains and underlies this committee’s report and its recommendations, in common with all other reports from Comhairle na nOspidéal, is that high quality and safe services should be available to patients at all times. This necessitates that:

- The interests of patients are of paramount importance and should always come first.
- The patient is entitled to the highest quality service within the available resources and those resources must be used in the most efficient and effective manner possible.
- There should be an equitable spread of psychiatric services throughout the state consistent with best practice and patients suffering from a mental illness should have appropriate access to a consultant psychiatrist and a multi-disciplinary team.

1.5 CONTEXT OF REPORT

This report has been written and its recommendations made in the context of the current system of medical staffing and organisation in the Republic of Ireland. It is noted that with the implementation of the European Working Time Directive from the 1st August 2004, changes will be required to meet the Directive’s requirements.

The total number of consultant psychiatrist posts recommended in this report may need to be amended to address consultant staffing requirements arising from the implementation of the Directive. An increase in the number of well staffed multi-disciplinary psychiatric teams as supported and recommended in this report and the development of effective teamwork will also contribute to meeting the requirements of the EWTD.

1.6 HEALTH SERVICE REFORM PROGRAMME

Key elements of the Health Service Reform Programme were the establishment of the National Hospitals Office (NHO) and a Primary, Community and Continuing Care Directorate (PCCC) within the Health Service Executive. The NHO is responsible for the management of the acute hospital sector nationally. The PCCC is responsible for the management and delivery of non-hospital services at local and regional levels.

Comhairle na nOspidéal notes that psychiatry services do not fit neatly into either of these two streams as it is delivered in acute hospitals, long stay hospitals and community settings and therefore spans both. Although this feature is not unique to psychiatry it could be said to occur most extensively in psychiatry. Comhairle na nOspidéal believes it is imperative that the new structures under the HSE are designed and operated in a manner which facilitates and supports the integrated delivery of psychiatric services in both the community and the acute hospital setting as both aspects of the service are delivered to a large extent by the same individuals, and often to the same patients.

In December 2004, the interim HSE issued a report entitled “Revised Procedures for Regulating Consultant and SpR/SR Appointments”. In considering the above issue the report recommended that though elements of some consultant posts, for example psychiatry posts, might fall within the ambit of the PCCC, in the interest of integrated services and uniformity of approach, all such applications would be dealt with by the officials in the NHO who deal with the preponderance of consultant applications, working in close liaison with the PCCC.
OVERVIEW

2.1 EXTENT OF AND IMPACT OF MENTAL ILLNESS

According to the World Health Organisation (WHO), mental illness affects the functioning and thinking processes of the individual, greatly diminishing his or her role and productivity in the family and wider community. In addition, because mental illnesses are disabling and can last for many years, they take a tremendous toll on the emotional and socio-economic capabilities of patients and their relatives who care for them. The World Health Report 2001, which focused solely on the issue of mental health, stated that mental and neurological conditions account for 30.8% of all years lived with disability. Six neuropsychiatric conditions figured in the top twenty causes of disability, these being unipolar depressive disorders, alcohol use disorders, schizophrenia, bipolar affective disorder, Alzheimer’s and other dementias and migraine. The WHO has estimated that by 2020 unipolar major depression will be the second leading cause of disability-adjusted life years (DALYs) with ischaemic heart disease being the first.

With respect to the prevalence of mental illness within the Irish population, comprehensive data across the spectrum of mental illnesses and the proportion of the population affected are not currently available. A number of studies in recent years in both Ireland and the UK, focusing on various aspects of mental illness and its impact, have provided an insight into the prevalence of mental health problems amongst the general population and an overview of the need for psychiatric services. Examples of information gathered and estimates made include:

- It has been estimated that 10% of the general population suffers from depression (Department of Health and Children, 2001). Depressive disorders accounted for 33% of all adult psychiatric admissions in 2002, the highest rate of admission for any psychiatric diagnosis across all age groups, genders and socio-economic groups (Health Research Board, 2003).
- It has been estimated that 1% of the general population suffers from schizophrenia (DoHC, 2001), with 18% of all adult admissions to psychiatric hospitals and units being for schizophrenia in 2003 (Health Research Board, 2004).
- With respect to substance misuse and dependence, prevalence estimates are limited as available figures relate only to people who present themselves for treatment. As of 31st December 2003, 6,883 individuals were on the methadone treatment list in Ireland (The Drug Treatment Centre Board, 2003). Alcohol disorders accounted for 16% of all adult inpatient admissions in the psychiatric service in 2003 (HRB, 2004).
- The recorded rate of suicide in Ireland has risen dramatically in recent decades, from 2.38 per 100,000 population in 1945, to 10.69 in 1995, to 11.5 in 2002. In 2003, 444 people in the state died by suicide, of which 81% were males. Suicide is now the second biggest cause of death in the 15 – 24 year old age bracket.
- Recent research within an Irish urban population of 12-15 year olds indicated a prevalence rate of 21% for psychiatric disorders in a community sample (Lynch & Fitzpatrick, 2003).
- Epidemiology studies by the Royal College of Psychiatrists and others including Corbett, 1979 and Gillberg et al., 1986, have indicated that approximately 50% of people with learning disabilities that are in contact with learning disability services have or will suffer at some time from a significant psychiatric disorder, which has or will require a specialist psychiatric service.

3 Disability-Adjusted Life Year (DALY) measures overall burden of a disease by combining the years of potential life lost due to premature death and the years of productive life lost due to the disability. One DALY is one lost year of healthy life.
The social and economic costs of mental illness can be said to include:

- diminished quality of life for sufferer
- sufferer stigmatised in society
- disruption to normal family life
- premature deaths caused by suicide
- unemployment, alienation and crime in young people whose childhood illnesses were not sufficiently well addressed for them to benefit fully from their education
- poor cognitive development in the children of mentally ill parents
- diminished quality of life for family members
- lost production from people with mental illness who are unable to work in the short, medium or long term
- lost production from family members caring for the mentally ill person

2.2 PSYCHIATRY

Psychiatry is a medical specialty which concerns itself with the assessment, diagnosis, treatment and prevention of mental illnesses including mental, addictive and emotional disorders such as psychoses, depression, anxiety disorders, substance misuse disorders, developmental disabilities, sexual dysfunctions and adjustment reactions amongst others. Like other medical illnesses, mental illnesses range from severe and life-threatening disorders to relatively mild and self-limiting conditions.

Psychiatry deals with the biological, psychological and social components of mental health, with different branches within psychiatry espousing different approaches to the treatment of psychiatric disorders. Biological psychiatry, for example, focuses on the molecular, genetic, and pharmacological approaches to the diagnosis and treatment of mental illnesses. Psychotherapy, on the other hand, involves the treatment of emotional, behavioural, personality and psychiatric disorders based primarily upon verbal or non-verbal communication and interventions with the patient and family. Most psychiatrists would employ a range of approaches to different patient cases.

2.3 CONSULTANT PSYCHIATRISTS

Consultant psychiatrists are secondary care specialists skilled in the assessment, diagnosis and management of mental disorders. They are largely community based with admission rights to in-patient beds locally for hospital care of their patients. Each consultant is the clinical leader of a multi-disciplinary secondary care team comprised ideally of doctors in training, psychiatric nurses, psychologists, social workers, occupational therapists, speech and language therapists and other important therapists. Consultant psychiatrists possess advanced treatment skills in the management of mental health conditions that have proven resistant to standard approaches in primary care. Clinical practice in psychiatry by consultant psychiatrists involves contact and involvement with other hospital doctors, general practitioners, public health doctors, community welfare officers, public health nurses and other health professionals. In addition, by the nature of their work, psychiatric services frequently come into contact and interact with other services, for example education, employment, legal and social services.

Since 1982 the number of permanent consultant psychiatrist posts in the public sector has risen from 185 to 295 as of 1st January 2005. Improvements and progress which have followed this increase in consultant posts, support staff and facilities, include:

- increased quality of life for patients
- increased capacity of the psychiatric services to treat and support more patients within community settings
In noting the increase in consultant psychiatrist posts in the past twenty years, and with a view to the future, Comhairle na nOspidéal believes that the following benefits are to be gained from additional consultant psychiatrist posts:

- Continuation and extension of all the improvements and progress as outlined above
- Increased range of alternative treatments being developed and offered to people with mental health problems
- Increased ability to identify and treat undefined conditions as happened with ADHD in the recent past
- Enhanced ability of services to deal with unexpected demands, for example that resulting from the increased numbers of asylum seekers in Ireland
- Earlier interventions in patients with the onset of mental illness, which will enhance the quality of life of the patient and can change the pattern of illness by, for example, reducing the length of acute episodes and/or increasing the length of time between episodes in chronic illnesses etc.
- Increased ability of the psychiatric services to address the unmet needs which still exist within society at large including the psychiatric component of homelessness, family breakdown, sexual abuse etc.
- Enhanced ability to meet the growing expectations of the public for access to a quality mental health service.

2.4 EDUCATION & TRAINING IN PSYCHIATRY

In order to qualify as a specialist in psychiatry it is necessary to complete general medical training at undergraduate level and specific training at postgraduate level. The following paragraphs briefly outline training in Ireland, the United Kingdom, the United States of America, Australia and New Zealand.

2.4.1 IRELAND

The Role of the Medical Council & Training Bodies in Ireland

To put into context the current organisation of psychiatric training in Ireland, it is helpful to describe the inter-related roles of the Medical Council and training bodies in Ireland. Under the Medical Practitioners Act, 1978, the Medical Council is the body charged with assuring the quality of training...
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of specialists in Ireland. Under Section 35 of the Medical Practitioners Act 1978, the Medical Council has statutory responsibility:

(a) as to the suitability of the medical education and training provided by any body in the State recognised by the Council for any such purpose.

(b) as to the standards of theoretical and practical knowledge required for primary qualifications

(c) as to the clinical training and experience required for the granting of a certificate of experience and

(d) as to the adequacy and suitability of postgraduate education and training provided by bodies recognised by the Council for the purposes of medical specialist training.

The Medical Council recognises twelve postgraduate training bodies responsible for the provision of a wide range of postgraduate training programmes. In psychiatry the training body recognised by the Medical Council is the Irish Psychiatric Training Committee (IPTC). The IPTC organises and supervises training of individuals in psychiatry, both at the basic specialist training level and higher specialist training level. The Royal College of Psychiatrists (UK) is invited by the IPTC to inspect posts for training capacity.

Training & Education

Specialty training in psychiatry includes education in several basic neurosciences, in psychology and in aspects of sociology. Postgraduate training in psychiatry, following the intern year and after full registration with the Medical Council, consists of at least three years of basic specialist training in psychiatry prior to entering higher specialist training. Most Irish trainee psychiatrists take the Membership of the Royal College of Psychiatrists as their specialty qualification during their three years of basic specialist training. Acquisition of the MRCPsych is the usual postgraduate qualification required for entry to the higher specialist training scheme run by the IPTC.

In Ireland higher specialist training in psychiatry entails experience as a Senior Registrar (known as a Specialist Registrar in other medical specialties in Ireland and in all medical specialties, including psychiatry, in the UK) in a variety of hospital and community settings. The duration of higher specialist training in psychiatry is three to four years. Three years training is required for single certification in one specialty of psychiatry, for example in general adult psychiatry, in psychiatry of learning disability or in child & adolescent psychiatry. Four years of training is needed for dual certification in two specialties of psychiatry, for example in general psychiatry and old age psychiatry or in child & adolescent psychiatry and psychiatry of learning disability. (See appendix E for more information).

Once certified by the IPTC as having successfully completed higher specialist training in Ireland and been given a Certificate of Completion of Specialist Training (CCST), doctors are eligible for the award of the Certificate of Specialist Doctor (CSD) by the Medical Council and depending on their training are entitled to be on one or more of the divisions of the Register of Medical Specialists maintained by the Medical Council. Doctors with relevant CSDs can practise psychiatry in any European Union State. Doctors, who may not have been part of the formal training programme run by the IPTC in Ireland or who have trained outside the European Union, can apply to the Medical Council for assessment of their experience and training. If such is considered by the Medical Council to be equivalent to the training supervised by the IPTC, having received advice from the IPTC on the matter where deemed necessary, doctors may be included on the Specialist Register maintained by the Medical Council. Currently, in common with other medical specialties, doctors can practise as specialists in psychiatry in Ireland without being on the Register of Medical Specialists.

Continuing Education

The Medical Council of Ireland since 1st January 2003 has introduced a formal competence assurance structure for the medical profession in Ireland. To comply with the requirements as set out by the Council, specialists from all disciplines registered with the Medical Council are required to partake
in continual professional development (CPD) / continuing medical education (CME) on an on-going basis throughout the years that they practise as a specialist in Ireland.

2.4.2 UNITED KINGDOM
Specialist training in the UK in psychiatry is similar to that as outlined for Ireland. The Royal College of Psychiatrists is responsible for the organisation and supervision of individuals training in psychiatry, both at the basic specialist training level and at the higher specialist training level in the UK.

2.4.3 UNITED STATES OF AMERICA
Postgraduate medical training in the USA is overseen by the Accreditation Council for Graduate Medical Education (ACGME). The American Board of Psychiatry and Neurology certifies training in psychiatry and its sub-specialties/associated specialties and organises examinations. In the United States, doctors may enter specialist training programmes in psychiatry at either first or second year postgraduate level. Those entering at the second year postgraduate level must have completed:
- A broad-based clinical year of accredited training in the United States or Canada in programmes in clinical medicine, family practice or paediatrics
- An ACGME accredited transitional year program
- One year of an ACGME-accredited residency in a clinical specialty requiring comprehensive and continuous patient care.

In common with other specialties, higher specialist training in psychiatry in the USA is referred to as a “residency”. A complete psychiatry residency lasts 48 months.

2.4.4 AUSTRALIA & NEW ZEALAND
Specialist training for doctors to qualify as psychiatrists in Australia and New Zealand is overseen and run by The Royal Australian and New Zealand College of Psychiatrists. The program for postgraduate training in psychiatry run by the College requires successful completion of a minimum of five years full time or equivalent part-time training in psychiatry practice. Admission to the program is dependent on completion of a formal undergraduate medical degree plus two years medical officers experience, one of which has to be in a general hospital. The five-year programme will generally involve four years of basic clinical training in accordance with set criteria and an elective year of training and a dissertation. Upon successful completion, trainees become eligible for election to Fellowship of the Royal College and can achieve recognition as a consultant psychiatrist and practise as such in Australia and New Zealand.

2.5 RECOGNISED PSYCHIATRIC SPECIALTIES
In Ireland a Register of Medical Specialists, introduced and maintained by the Medical Council since 1st January 1997, originally recognised just two psychiatric specialties, psychiatry and child psychiatry. Currently the Medical Council’s specialist register has four psychiatry divisions, namely:
- psychiatry
- child and adolescent psychiatry
- psychiatry of learning disability
- psychiatry of old age
2.6 TITLES OF & QUALIFICATIONS FOR POSTS OF CONSULTANT PSYCHIATRIST

The statutory function of regulating consultant appointments and specifying the qualifications for each consultant appointment transferred from Comhairle na nOspidéal to the HSE with effect from 1st January 2005. A list of the consultant psychiatrist posts currently recognised by the HSE is given below. The qualifications specified for each of these posts are set out in Appendix C.

**General Adult Psychiatry**
- Consultant General Adult Psychiatrist
- Consultant General Adult Psychiatrist (special interest in the psychiatry of learning disability)
- Consultant General Adult Psychiatrist (special interest in substance misuse)
- Consultant General Adult Psychiatrist (special interest in rehabilitation)
- Consultant General Adult Psychiatrist (special interest in liaison psychiatry)
- Consultant General Adult Psychiatrist (special interest in psychotherapy)

**Child & Adolescent Psychiatry**
- Consultant Child & Adolescent Psychiatrist
- Consultant Child & Adolescent Psychiatrist (special interest in substance misuse)
- Consultant Child & Adolescent Psychiatrist (special interest in the psychiatry of learning disability)

**Psychiatry of Learning Disability**
- Consultant Psychiatrist of learning disability (adult)
- Consultant Psychiatrist of learning disability (child and adolescent)

**Psychiatry of Old Age**
- Consultant Psychiatrist in the Psychiatry of Old Age

**Forensic Psychiatry**
- Consultant Forensic Psychiatrist
- Consultant General Adult Psychiatrist (special interest in forensic psychiatry)

2.7 MENTAL HEALTH SERVICES POLICIES

A number of national reports have been published regarding mental health care delivery in this country, primarily by the Department of Health. These reports include

- **Psychiatric Services at Consultant Level**, Comhairle na nOspidéal, 1978
- **The Psychiatric Services, Planning for the Future**, Department of Health, 1984
- **Green Paper on Mental Health**, Department of Health, 1992
- **Shaping a healthier future**, Department of Health, 1994
- **Report of the National Taskforce on Suicide**, Department of Health & Children, 1998
- **Guidelines on Good Practice and Quality Assurance in Mental Health Services**, Department of Health & Children, 1998
- **Intensive Care Units, Disturbed Mentally Ill**, Department of Health & Children, 2000
Each of these reports made recommendations in relation to how the objective of improved mental health services might be attained and identified the human and physical resources necessary to implement this. Below is an outline of two of the reports, *The Psychiatric Services, Planning for the Future* (1984) and *Quality & Fairness, A Health System for You* (2001).

### 2.7.1 PLANNING FOR THE FUTURE

In October 1981 a study group was appointed by the then Minister for Health, Mrs. E. Desmond T.D., to report and make recommendations regarding the development of psychiatric services. The group issued their report “The Psychiatric Services, Planning for the Future” in December 1984. The report outlined a new framework for a modern psychiatric service, which would move away from old style psychiatric institutions and isolated services to a service based on a comprehensive range of care facilities being provided in the community. This framework closely followed that proposed in other developed countries.

“Planning for the Future” envisaged comprehensive psychiatric services catering for the full range of needs of people with mental illness and providing a full range of services involving early identification, diagnosis and treatment, inpatient and outpatient care, community based services, rehabilitation and training. Services would be community orientated and as the community based service developed, the old nineteenth century stand-alone psychiatric hospitals would be gradually wound down and closed. This process would be matched by the structuring of services on the basis of sectorisation of catchment areas.

A key factor in moving the focus of psychiatry services from stand-alone psychiatric hospitals to the community was the recommendation in Planning for the Future that “... ideally, the in-patient service for all admissions should be provided in psychiatric units in general hospitals. The in-patient facility in a comprehensive, sectorised service should cater for admissions from a designated catchment area. This area would consist of one or more psychiatric sectors. It is important that the in-patient service, whether this is in a hospital or unit, should take all psychiatric patients from the sectors in its catchment area who need in-patient care.” Comhairle na nOspidéal subscribes fully to this concept, believing it to be an important step towards bringing psychiatry services into the acute care arena and de-stigmatising mental illness in Irish society. In this context, Comhairle welcomes on-going developments which are taking place regarding the establishment of psychiatric units within general hospitals.

However, in developing inpatient care in this manner, Comhairle na nOspidéal has some concerns that the care and treatment of psychiatric patients, whose mental illness results in violent behaviour which render them unsuitable for treatment in acute psychiatric units in general hospitals, has been overlooked. The lack of an alternative treatment location for these patients was highlighted on a number of occasions as causing severe difficulties within the reforming psychiatry services. It is noted that this issue has recently been addressed by the Department of Health & Children via its proposals for the development of Psychiatric Intensive Care Units. Another adverse consequence of the closure of the long stay psychiatric institutions which was highlighted to Comhairle was that in a number of cases these institutions had provided accommodation for some people, in particular men. With the closing of these institutions this type of accommodation option is no longer available in these institutions.
“Planning for the Future” can be summarised as being based on three principles:

- The development of community based services which would enable many people, who heretofore would have required hospitalisation for treatment, to live at home while receiving treatment.
- The rehabilitation and resettlement of long-stay patients from institutional care to community living.
- The transfer of acute psychiatric admissions from the major psychiatric institutions to psychiatric units in general hospitals.

The implementation of these policies has been ongoing since the mid 1980’s and has yet to be completed. The pace of implementation has been influenced by a variety of factors including availability of funding, timescales for capital developments, the pace of attitudinal change, industrial relations issues, commitment to change and increased numbers of staff. Currently twenty-one acute psychiatric units based in general hospitals have been established, one unit is constructed but not yet commissioned and seven units are at the planning stage. The locations are listed in Table 2.1

Table 2.1 List of general hospitals with acute psychiatric units on-site or with units constructed but not commissioned or with units at planning stage.

<table>
<thead>
<tr>
<th>Units on-site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bantry General Hospital</td>
</tr>
<tr>
<td>Cavan General Hospital</td>
</tr>
<tr>
<td>Cork University Hospital</td>
</tr>
<tr>
<td>James Connolly Memorial Hospital</td>
</tr>
<tr>
<td>Kerry General Hospital</td>
</tr>
<tr>
<td>Mayo General Hospital, Castlebar</td>
</tr>
<tr>
<td>Mater Misericordiae Hospital</td>
</tr>
<tr>
<td>Mercy Hospital, Cork</td>
</tr>
<tr>
<td>Mid-Western Regional Hospital, Limerick</td>
</tr>
<tr>
<td>Letterkenny General Hospital</td>
</tr>
<tr>
<td>Naas General Hospital</td>
</tr>
<tr>
<td>Our Lady’s Hospital, Ennis</td>
</tr>
<tr>
<td>Our Lady’s Hospital, Navan</td>
</tr>
<tr>
<td>Roscommon General Hospital</td>
</tr>
<tr>
<td>St. James’s Hospital</td>
</tr>
<tr>
<td>St. Joseph’s Hospital, Clonmel</td>
</tr>
<tr>
<td>St. Luke’s Hospital, Kilkenny</td>
</tr>
<tr>
<td>St. Vincent’s, Elm Park</td>
</tr>
<tr>
<td>The Adelaide &amp; Meath Hospital, Dublin, incorporating the National Children’s Hospital</td>
</tr>
<tr>
<td>University College Hospital, Galway</td>
</tr>
<tr>
<td>Waterford Regional Hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Units constructed but not yet commissioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portlaoise General Hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Units at planning stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaumont Hospital</td>
</tr>
<tr>
<td>Louth General Hospital, Dundalk</td>
</tr>
<tr>
<td>Mallow General Hospital</td>
</tr>
<tr>
<td>Nenagh General Hospital</td>
</tr>
<tr>
<td>Portiuncula Hospital, Ballinasloe</td>
</tr>
<tr>
<td>Sligo General Hospital</td>
</tr>
<tr>
<td>Wexford General Hospital</td>
</tr>
</tbody>
</table>

**2.7.2 HEALTH STRATEGY**

The Health Strategy – “Quality and Fairness, A Health System for You” – published by the Department of Health and Children in November 2001 is based on the principles of equity, people-centredness, quality and accountability. The strategy identifies overall national goals to guide activity
and planning in the health system for the next 10 years. Key actions identified to improve mental health services and promote awareness of mental health include:

- development of a new national policy framework for the further modernisation of mental health services,
- further development of services aimed at specific groups including older people and those who would benefit from community based alcohol treatment programmes,
- preparation of a report on services for people with eating disorders by the Working Group on Child & Adolescent Services,
- introduction of programmes to promote positive attitudes to mental health
- intensification of suicide prevention programmes
- increased investment in community care services and acute psychiatric units,
- implementation of the recommendations of the First Report of the Review Group on child and adolescent psychiatric services and
- development of mental health services to meet the needs of children aged between 16 & 18.

Comhairle na nOspidéal welcomes the establishment of an Expert Group on Mental Health Policy by the Department of Health and Children in August 2003. The Expert Group will be responsible for the preparation of a new national policy framework for the mental health service to replace the existing policy document, Planning for the Future. The Group is expected to examine, inter alia, different models of care, the respective roles of medication and complementary therapies, measures to reduce the stigma associated with mental illness and services for specialised groups such as prisoners and the homeless.

2.8 SECTORS & CATCHMENT AREAS

The Comhairle na nOspidéal report of 1978 entitled “Psychiatric Services at Consultant Level” recommended a general guideline of one consultant general adult psychiatrist per 25,000 – 30,000 population. “Planning for the Future” subsequently defined the sector in psychiatry as a geographical area with a population of approximately 25,000 - 30,000. It was envisaged that each sector would be staffed by a multidisciplinary team, led by a consultant psychiatrist, which would be responsible for delivering a comprehensive, community orientated service, involving a range of facilities in the sector including high, medium and low support hostels, day hospitals and day centres. Each mental health service would also have access to inpatient facilities in an acute psychiatric unit located in the local general hospital.

A psychiatric catchment area is a collection of sectors. At present, catchment areas, of which there are 32, can incorporate from 2 – 6 sectors each. All catchment areas, with the exception of Community Care Area I in the Eastern region, which is served by the Hospitaller Order of St. John of God Cluain Mhuire service, are sub-divided into sectors. Catchment areas have populations ranging from 51,000 in the West Cork Mental Health Service to 277,000 in the Dublin South-West Mental Health Service.

Though the Cavan/Monaghan catchment area (population approximately 109,000) is divided officially into four sectors - two in each county - an alternative model of service delivery is in operation in the region. Acute psychiatric services are provided by multi-disciplinary teams based county-wide rather than in isolated sectors, with the focus being on a home-based care delivery service. This model of service organisation and delivery, combined with appropriate investment in staff and training and in conjunction with rehabilitation and old age psychiatry services being provided at joint county wide level, has lead to a reduction in the number of acute admissions in the region. The NEHB was recorded as having the lowest rate of admissions in the country for 2003 by the Health Research Board.
To date there are 117 sectors within the 32 catchment areas, with sector populations ranging from 13,500 in the North Sligo & South Donegal sector in the Sligo/Leitrim Mental Service to 79,700 in the Swords/Balbriggan sector in the Dublin North East Mental Health Service. Additional information regarding the organisation of catchment areas and sectors in Ireland can be obtained in Appendix D of this report or from the annual reports of the Inspector of Mental Hospitals.

In examining sectorisation and its implications, the advantages and disadvantages of this arrangement of services were reported to Comhairle na nOspidéal during the consultation process. Advantages identified include:

- it allows equity of access to psychiatric services for public patients
- it promotes stable doctor-patient relationships,
- it allows professionals within a given area to build up good working relationships
- to some extent, sectorisation overcomes difficulties of geographical distances in rural areas
- it allows patients to be under the care of one consultant psychiatrist and team, thereby leading to consistency in terms of service and continuity of care

Disadvantages identified include:

- lack of choice of consultant psychiatrist for public patients
- consultant psychiatrists may be professionally isolated without peer review and support
- inability of service to facilitate a patient’s wish to chose whether they see a male or female consultant
- members of same family having to see the same consultant psychiatrist.

In light of the substantial investment in facilities and staffing based on the sector model, Comhairle na nOspidéal envisages that any future changes to the system of mental health care delivery will, of necessity and practicality, need to give due cognisance to the existing infrastructure and organisation of services based on sectorisation and utilise it.

The Irish College of Psychiatrists in their submission to the committee observed that “having drawn attention to the problems of the geographical sector model, it must be acknowledged that there is no obvious alternative model of service at present which would satisfactorily identify service responsibility for all potential patients. This is particularly so for those who are disorganised and do not seek psychiatric help, who may not see a GP either, and are separated from their families.”

In addressing some of the difficulties associated with sectorisation, whilst retaining its advantages, Comhairle na nOspidéal recommends that two consultant general adult psychiatrists should be appointed to larger sectors and that the possibility of combining existing sectors to give rise to larger sectors in the future staffed by a minimum of two consultant general adult psychiatrists should be examined by the HSE. These options would utilise the infrastructure of existing sectors whilst allowing public patients to overcome the biggest limitation associated with sectorisation, that of not having a choice of consultant psychiatrist. The concept of two consultant psychiatrists serving a large sector is further supported in the submission by the Mental Health Commission. The Commission envisages that given the range of specialties required to adequately staff community mental health teams, sector sizes will need to increase to 50,000 for general adult mental health services and be staffed with a minimum of two consultant general adult psychiatrists in each team.
2.9 SPECIALISATION IN PSYCHIATRY

In recent decades there has been a striking rise in specialisation and sub-specialisation in medicine. While this trend has been irregular, there has been a steady increase in the number of recognised medical specialties with corresponding training programmes. The increasing specialisation within medicine, in conjunction with medical, technological and therapeutic advances, has led to better patient outcomes for a wide range of medical conditions.

Though this trend towards sub-specialisation is also taking place in psychiatry, with the Medical Council of Ireland at present recognising four specialties in psychiatry, to date and in the foreseeable future, the core of psychiatric services will be provided to the adult population by consultant general adult psychiatrists. This service will be supported and complemented by consultants in other specialty and sub-specialty areas of adult psychiatry such as substance misuse, old age, learning disability, forensic, rehabilitation and liaison psychiatry.

In contrast, little formal specialisation or sub-specialisation has developed in the area of child and adolescent psychiatry with the exception of learning disability and substance misuse. Therefore in the foreseeable future, general consultant child and adolescent psychiatrists will provide the core of psychiatric services to the child and adolescent population.

Specialisation should only take place with a view to benefiting patients and not to their detriment. It is noted by Comhairle na nOspidéal that with the increased specialisation within psychiatry, boundaries between services based on the date of birth of patients have become prominent. One group of patients, 16 – 17 year olds, have been particularly adversely affected by these boundaries, and have historically fallen into the gap between adult and child and adolescent services. As discussed in Section 4.3 of this report, Comhairle na nOspidéal is very concerned about this and expects that the interests of the patients affected will take precedence over any other matters in resolving this unsatisfactory situation.

The principle that “while small sectors are suitable for general psychiatry, there are some specialised services which can serve larger populations and which must therefore be developed to serve more than one sector” as stated in “Planning for the Future”, has been followed in the structuring of service provision at consultant level. A significant number of specialist psychiatric services for distinct patient groups, e.g. the elderly and individuals with learning disability, already incorporate the principle of general sectorised services being overlaid with specialisation on a broader catchment basis.

It seems appropriate in the medium term to continue to overlay general adult psychiatric services with specialised services which would serve a larger population base. This approach is adopted in recommending consultant posts in specialised services for adults in this report. Comhairle na nOspidéal notes that child and adolescent psychiatric services have to date been organised on a catchment area basis, and that the concept of sectors does not generally apply in the child and adolescent psychiatric services.

2.10 RESOURCES IN MENTAL HEALTH SERVICES

Good psychiatric practice requires a multidisciplinary and multi-professional approach to the patient and the treatment of their mental illness. This in turn depends on the provision of adequate numbers of well-trained personnel from professions that include medicine, nursing, psychology, social work, occupational therapy, speech and language therapy and child care. Consultant psychiatrists, like other members of the team, rely on this multi-disciplinary framework, and a number of support structures and facilities including appropriate clerical and administrative expertise, in order to provide a safe, efficient and effective service. However, Comhairle na nOspidéal is only in a position
to specify requirements for the consultant psychiatrist component of the team. Nonetheless, it is very concerned that there appears to be a large discrepancy with respect to the staffing of psychiatric teams between health board areas, with some health board’s mental health services having for example no social workers and few, if any, psychologists.

Comhairle na nOspidéal feels that the appointment of additional consultant psychiatrists, without employing authorities ensuring that they are supported by and are members of a well staffed multidisciplinary team, will have limited impact on patient care. This will become of even greater relevance in light of the gradual move from predominantly hospital based care to care in the community, which by necessity will need to utilise to a greater extent the framework and resources of the multidisciplinary team. Movement into community based treatment will mean that case loads will expand beyond the capacity of a poorly staffed team to manage and deliver such a service. Multidisciplinary teams must be developed in order to provide safe, good quality, effective and sustainable services to patients with mental ill health. Without well staffed multidisciplinary teams, serious constraints are placed and will be placed on service delivery and patient care. In this context, it is recommended that employing authorities, when seeking a consultant psychiatrist post, ensure that additional resources are secured for all essential supporting personnel and facilities rather than, as has happened sometimes in the past, relying on new appointees to consult to posts to lobby for and secure resources.

Outlined below is a brief description of the required resources and infrastructure needed for various aspects of psychiatry services.

2.10.1 MULTIDISCIPLINARY TEAMS

Clinical psychiatric practice includes working closely with other professionals as part of a multidisciplinary team for the benefit of the patient and their family. Wide-ranging training enables consultant psychiatrists to take a lead role in these multidisciplinary teams. The multidisciplinary team in psychiatry would normally be composed as follows:

- Consultant psychiatrists
- Doctors in training
- Mental health nurses
- Mental health social workers
- Occupational therapists
- Clinical psychologists
- Special therapists depending on specialty and remit of the team e.g. family therapists, cognitive behaviour therapists, bereavement counsellors etc.
- Speech and language therapists
- Care workers
- Administrative support

The Mental Health Commission has advocated the appointment of a team co-ordinator within each mental health team, who would have a background in a senior capacity in a clinical specialty, and would act as the single point of access to the team, with all referrals to the team going through him/her. Team co-ordinators would have responsibility to build close working relationships with primary care and other referring agencies.
2.10.2 REQUIRED RESOURCES & INFRASTRUCTURE BY SPECIALTY

General Adult Psychiatry
- Team base in an acute psychiatric unit of a general hospital
- Day hospital
- Day centre
- Psychiatric hostels offering varying levels of support – it is essential that each service has access to high, low and medium support hostels.
- Access to nursing home places, psychiatric and non-psychiatric, for frail elderly people with chronic mental illness
- Access to psychiatric intensive care beds
- Access to rehabilitation facilities in a secure environment
- Access to mother and baby unit

Psychiatry of Old Age
- Team base in an acute psychiatric unit of an acute general hospital
- Day hospital
- Acute psychiatric in-patient beds as part of, but ideally separate from, the acute psychiatric in-patient unit for general psychiatry
- Long stay psychiatric beds for people with dementia and associated severe behavioural problems not responding to treatment
- Access to high support hostel places for elderly people with recurrent functional mental illness
- Access to non-psychiatric facilities such as nursing home places (whether statutory, voluntary or private), local day centres and respite facilities.

Psychiatry of Learning Disability for Adults
- Team base in psychiatric learning disability unit
- Day hospital and day centre within the learning disability service
- Rehabilitation beds
- Long stay psychiatric beds
- Respite facilities
- In addition the service must have access to a variety of facilities provided for people with learning disabilities such as day centres and residential care in the catchment area

Rehabilitation Psychiatry
- Team base in acute general hospital or long stay psychiatric institution
- Day centre
- Psychiatric hostels offering varying levels of support
- Physical resources include access to acute and extended rehabilitation facilities

Liaison Psychiatry
- Team base in acute general hospital
- Access to acute psychiatric beds and facilities based in general hospital
- Access to rehabilitation services
Substance Misuse
- Team base in appropriately sited clinic or treatment centre
- Range of treatment centres and satellite clinics
- Inpatient beds offering detoxification and stabilisation for drug misusers
- Access to drug free hostels

Forensic Psychiatry
- Team base in a high or medium secure psychiatric facility
- Access to secure beds of varying levels of security i.e. maximum and medium
- An outreach programme with appropriate personnel and facilities such as the requisite outreach teams, out patient clinics and hostels of varying levels of dependency and security.
- Access to appropriate personnel and facilities in prison environments
- Access to appropriate and secure respite facilities
- Provision of consultant staffed out patient clinics in prisons

Child and Adolescent Psychiatry
- Team base in an appropriately sited clinic
- Outpatient clinic with appropriate facilities for interviewing of children, adolescents and families including two way mirrors, video facilities etc.
- Access to beds in designated child and adolescent psychiatric unit
- Special schools
- Liaison to paediatric and maternity units
- Access to high support unit

Psychiatry of Learning Disability for Children & Adolescents
- Team base in psychiatric learning disability unit
- Rehabilitation beds
- Respite facilities
- In addition the service must have access to a variety of facilities provided for children and adolescents with learning disabilities such as day centres and residential care in the catchment area
- Access to paediatric and maternity units

2.10.3 COMMUNITY FACILITIES IN GENERAL ADULT PSYCHIATRY
The provision of suitable facilities in the community can enable people to remain in the community while receiving treatment and facilitates the rehabilitation and resettlement of long-stay patients from institutional care to community living. Comprehensive, community-orientated services involve a range of facilities including high, medium and low support hostels, day hospitals and day centres. These are complemented by access to inpatient facilities in an acute psychiatric unit based in the local general hospital. A brief description of these facilities is given below.

- **High-Support or Supervised Residence or Hostel**
  24-hour supervision, whether by nurses or by a combination of nurses / attendants.

- **Medium-Support Residence or Hostel**
  Medium-support residences or hostels provide nurse supervision for a number of hours morning and evening, but not otherwise.
Unsupported Housing
Unsupported housing, which may be provided by health boards or by voluntary agencies such as Mental Health Associations, is necessary for individuals with minimal impairment who would otherwise be homeless.

Day Hospital
As envisaged in “Planning for the Future”, the purpose of a day hospital is to provide intensive treatment to psychiatric patients, equivalent to that which is available in a hospital inpatient setting for acutely ill patients. In day hospitals, a comprehensive range of treatments can be provided on a short-term basis. They are used to prevent inpatient hospitalisation of a patient, shortening an inpatient’s length of stay and preparing an inpatient for discharge i.e. a step down facility.

Day Centre
The purpose of day centres is to provide social care for psychiatric patients, many of whom live in supported accommodation. It may also offer treatment. “Planning for the Future” envisaged that rehabilitation and activation services may be provided and that these could include therapy, social skills training and light industrial therapy.

2.11 CONSULTANT PSYCHIATRIST AS ADVOCATE
The stigma associated with all forms of mental illness is still prevalent in Irish society and generally increases the more an individual’s behaviour differs from that of the norm. The stigmatisation of mental illness is far reaching in its impact and includes, as noted by the World Health Organisation in their Report of 2001:

- detrimental effect on a mentally ill person’s recovery,
- adversely affects access to services in society and the type of treatment and level of support received
- individual often denied equal participation in family life, normal social networks and productive employment
- individual often rejected by friends, relatives, the community and employers leading to aggravated feelings of rejection, loneliness and depression

A major cause of the stigma associated with mental illness are the myths, misconceptions and negative stereotypes about mental illness held by many people, both within society at large and within the medical profession. Comhairle na nOspidéal strongly believes that consultant psychiatrists, as the professionals leading the service, have a vital and important role to play as advocates for people with mental illness and in reducing the stigmatisation attached to this range of medical illnesses. This role involves a number of different facets including

- raising awareness about mental illness in society
- providing accurate information on the causes, prevalence, the course and effect of mental illness
- countering the negative stereotypes and misconceptions surrounding mental illness
- providing support and treatment services that enable persons suffering from a mental illness to participate fully in all aspects of community life
- ensuring the existence of legislation to reduce discrimination in the workplace
- ensuring access to adequate health and social community services
3 EXISTING PSYCHIATRIC SERVICES & WORKFORCE

3.1 ACTIVITY OF PSYCHIATRIC SERVICES

A useful overview of the activity of psychiatric services at national level is provided in “Irish Psychiatric Hospitals and Units Census 2001” and “Activities of Irish Psychiatric Services 2003” published by the Health Research Board in May 2002 and December 2004 respectively. The information in this chapter regarding psychiatric services is taken from the latter report. It should be noted that in the two reports, locations of psychiatric admissions are divided into three categories, namely; stand alone psychiatric health board hospital; general hospital psychiatric unit and private hospital. A list of each hospital/unit in each category is given in Appendix F.

3.1.1 ADMISSIONS

In 2003, there were 23,031 admissions to psychiatric facilities in Ireland, resulting in an average rate of 760 admissions per 100,000 population aged 16 years and over. The number of admissions over the last 35 years peaked in 1986 at 29,392 and has been generally decreasing ever since as illustrated in Table 3.1

Table 3.1 Number of admissions to psychiatric facilities in Ireland from 1965 – 2003

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>15,440</td>
<td>25,892</td>
<td>29,082</td>
<td>27,765</td>
<td>26,656</td>
<td>24,282</td>
<td>23,677</td>
<td>23,031</td>
</tr>
</tbody>
</table>

3.1.2 ADMISSION ACTIVITY IN 2003

Outlined in table 3.2 is a breakdown of admissions in 2003 to adult psychiatric facilities in terms of numbers, rates of admission, first time admissions, re-admissions, gender of patients admitted, location of admissions and diagnosis. Observations made by the Health Research Board in relation to these figures include:

- most admissions were to general hospital psychiatric units rather than to psychiatric hospitals, reflecting the programme of providing such units throughout the country and the phasing out of psychiatric hospitals
- the 45-54 year age group maintains the highest rate of admission
- considerable differences, as great as threefold, were evident in inpatient rates between health boards
- there has been no reduction in the proportion of admissions that were non-voluntary (11%) in the last 13 years
- first admissions constituted less than 30% of all admissions, re-affirming a reversal which began 40 years ago when first admissions out-numbered re-admissions
Table 3.2  Details of admissions in 2003 to adult psychiatric facilities in Ireland

<table>
<thead>
<tr>
<th>Numbers</th>
<th>Total no. of admissions</th>
<th>23,031</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Involuntary admissions</td>
<td>11%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Rates of admission</th>
<th>Overall rate (per 100,000 population*)</th>
<th>760</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age of highest rate of admissions</td>
<td>45-54 (961 per 100,000*)</td>
</tr>
<tr>
<td></td>
<td>Age of lowest rate of admissions</td>
<td>16-19 (272 per 100,000*)</td>
</tr>
<tr>
<td></td>
<td>Health Board with highest rate</td>
<td>SEHB (939 per 100,000*)</td>
</tr>
<tr>
<td></td>
<td>Health Board with lowest rate</td>
<td>NEHB (479 per 100,000*)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First/re-admissions</th>
<th>First time admissions</th>
<th>29%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Re-admissions</td>
<td>71%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex of patients</th>
<th>Males</th>
<th>51%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females</td>
<td>49%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of admission</th>
<th>Stand alone psychiatric hospitals</th>
<th>38%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Hospital Psychiatric Unit</td>
<td>44%</td>
</tr>
<tr>
<td></td>
<td>Private Hospitals</td>
<td>18%</td>
</tr>
</tbody>
</table>

| Main diagnosis | Depressive Disorders | 33% |
|               | Schizophrenia            | 18% |
|               | Alcoholic disorders      | 16% |

*Rates given per 100,000 population aged 16 years and older.

3.1.3 CHILD & ADOLESCENT PSYCHIATRIC INPATIENT SERVICES

In 2003, there were 66 admissions to two children’s centres, namely Warrenstown House, Dublin and St. Anne’s Children’s Centre in Galway. There were no admissions to Court Hall, Dublin, in 2003. Females accounted for 55% of these admissions. Of those admitted 23% were aged 16, 21% were aged 14, while a further 18% were aged 15 years. Neuroses accounted for 38% of all admissions, other psychoses accounted for 11% while depressive disorders and mania each accounted for 6%.

It should be noted that these figures do not include those children and adolescents who may have been admitted to paediatric wards in general hospitals or those admitted to adult psychiatric wards. Anecdotal evidence suggests that this does happen, particularly with respect to admissions to paediatric wards. The Second Report of the Department of Health and Children’s Working Group on Child and Adolescent Psychiatric Services (June 2003), reported that 201 sixteen and seventeen year olds were admitted to adult inpatient psychiatric services in 2001.

3.1.4 DISCHARGE ACTIVITY IN 2001

In 2003, there were 22,911 discharges and 249 deaths in the psychiatric services in Ireland. In recent years there has been an increasing trend towards shorter episodes of inpatient care and 2003 was no exception. 48% of all discharges (including deaths) occurred with two weeks of admission, with 69% of all discharges occurring within one month of admission and 93% occurring within three months of admission. 2% of discharges took place after one year or more in the hospital. Excluding patients in hospital for more than one year, the average length of stay of patients on discharge was 26 days. This compares to 1965 when 43% of care episodes were less than one month in duration and 1985 when 61% were less than one month in duration.
3.1.5 PSYCHIATRIC INPATIENT SERVICES

The census completed on 31st December of each year indicates that the number of patients in inpatient psychiatric care at any one time has steadily and substantially decreased from 19,801 in 1963 to 3,658 in 2003. The decrease in numbers over the years is illustrated in Table 3.3. This decline has been largely attributed to the death of older long-stay patients, their non-replacement by new long-stay patients, along with the development of more extensive community based psychiatric facilities and community based psychiatric teams which allow patients to be supported within the community after an acute psychiatric episode.

Of the 3,658 inpatients on 31st December in 2003

- 27% were aged 20-44
- 34% were aged 45-64
- 36% were aged 65 and over

Eighteen percent of the inpatients were non-voluntary.

Table 3.3
Number of psychiatric inpatients from 1963 – 2002 as of 31st December each year

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>19,801</td>
<td>16,403</td>
<td>14,967</td>
<td>13,342</td>
<td>12,097</td>
<td>7,334</td>
<td>5,327</td>
<td>3,658</td>
</tr>
</tbody>
</table>

Outlined in Table 3.4 is a breakdown of psychiatric inpatients as of 31st December 2003 in terms of diagnosis, length of stay, inpatient rate and type of hospital/unit.

Table 3.4 Details of psychiatric in-patients as of 31st December 2003

<table>
<thead>
<tr>
<th>Numbers</th>
<th>3,658</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main diagnosis</td>
<td>33%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>18%</td>
</tr>
<tr>
<td>Mental Handicap</td>
<td>14%</td>
</tr>
<tr>
<td>Length of stay</td>
<td>36%</td>
</tr>
<tr>
<td>&lt; 3 months</td>
<td></td>
</tr>
<tr>
<td>3 – 12 months</td>
<td>9%</td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>16%</td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>39%</td>
</tr>
<tr>
<td>Inpatient rates*</td>
<td>SEHB (210 per 100,000)</td>
</tr>
<tr>
<td>Health Board area with highest SWAHB (26 per 100,000)</td>
<td></td>
</tr>
<tr>
<td>Type of hospital/unit</td>
<td>66%</td>
</tr>
<tr>
<td>Stand alone psychiatric hospitals</td>
<td></td>
</tr>
<tr>
<td>General Hospital Psychiatric Unit</td>
<td>22%</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>12%</td>
</tr>
</tbody>
</table>

* Rates given per 100,000 population aged 16 years and over.
In comparing inpatient rates between different health board areas, readers should give due cognisance to the availability of inpatient beds for each region. The South Eastern Area, with a population of 423,616, has the highest number of health board hospitals of any health board at five, and therefore has an increased capacity to accommodate older long stay patients, not all of whom will be from the South Eastern Area originally. The eastern region, with a population of 1,401,441, has only seven such health board hospitals.

3.1.6 COMMUNITY PSYCHIATRIC SERVICES
Since the publication of “Planning for the Future” in 1984, there has been continued growth and development of community-based psychiatric facilities and services, alongside the provision of acute psychiatric units in general hospitals, to replace services previously provided in large psychiatric hospitals throughout the country. There were 66 day hospitals and 110 day centres in operation as of 2003, providing a total of just under 3,500 places. This compares to 39 such centres providing approximately 1,200 places in 1984.

With respect to day hospitals, there were 171,196 attendances in 2003, with day centres having 426,576 attendances. Similar expansion of services have taken place in the area of community residences, with 3,146 community residential places (low, medium and high support) being available in 2003, as compared to less than 1,000 places in 1984. In 2003, there were 1,187 admissions to, and 1,175 discharges from, community residences. Another area of psychiatric service activity in the community is the provision of out-patient clinics. In 2003, outpatient clinics were held in 235 locations throughout the state, with a total of 238,650 attendances at these clinics.

3.2 PSYCHIATRIC WORKFORCE - CONSULTANTS & NCHDs
It should be noted that, unless otherwise stated, population figures used in the following tables are based on the population census figure of 3,917,203 for 2002, as calculated by the Central Statistics Office (CSO).

3.2.1 PERMANENT CONSULTANT POSTS
As of 1st January 2005, the consultant establishment in psychiatry in the public sector was 295 posts, comprising 235 permanent consultants in practice, 51 vacant approved posts which were in the process of being filled on a permanent basis and 9 posts either under consideration by Comhairle na nOspidéal or unprocessed. This last group of posts i.e. unprocessed, are posts that are known to be vacant but were not yet in a position to be considered by Comhairle na nOspidéal due to the absence of a completed application form from the relevant employing authorities, the absence of financial clearance by the Department/ERHA and/or other reasons. Table 3.5 shows a summary of the consultant establishment in psychiatry by specialty and sub-specialty.
Table 3.5  Summary of permanent consultant psychiatric staffing as of 1st January 2005

<table>
<thead>
<tr>
<th>Psychiatry Specialty/Sub-specialty</th>
<th>Consultant Establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Psychiatry</strong></td>
<td></td>
</tr>
<tr>
<td>General (no s.i.)</td>
<td>153</td>
</tr>
<tr>
<td>s.i. Liaison</td>
<td>9</td>
</tr>
<tr>
<td>s.i. Substance Misuse</td>
<td>6</td>
</tr>
<tr>
<td>s.i. Rehabilitation</td>
<td>7</td>
</tr>
<tr>
<td>s.i. Forensic</td>
<td>2</td>
</tr>
<tr>
<td><strong>Child &amp; Adolescent</strong></td>
<td></td>
</tr>
<tr>
<td>General (no s.i.)</td>
<td>54</td>
</tr>
<tr>
<td>s.i. Substance Misuse</td>
<td>2</td>
</tr>
<tr>
<td><strong>Psychiatry of Learning Disability</strong></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>24</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>12</td>
</tr>
<tr>
<td><strong>Forensic Psychiatry</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td><strong>Psychiatry of Old Age</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>295</strong>*</td>
</tr>
</tbody>
</table>

* It should be noted that not all of these posts are full time posts, i.e. 11 sessions per week. At January 2005, there were 15 permanent part time consultant posts in psychiatry. Two of these posts were in the general adult service, seven in the child and adolescent service, three in the learning disability service for children and adolescents and three in the learning disability service for adults.

A substantial increase in the consultant establishment in psychiatry in the public service has taken place since 1990, with the figure increasing from 182 in January 1990 to 295 in January 2005. Relating this increase in permanent consultant psychiatric posts to the increase in the population of the country, it can be calculated that the ratio of consultant posts to head of total population for all psychiatric specialties stood at 1 post per 19,139 population in 1986, 1 post per 17,688 population in 1996 and 1 post per 13,279 in January 2005.
Graph 3.6  Graph displaying changes in the consultant establishment in psychiatry in the public sector from 1984 to 2005.
Source: Comhairle na nOspidéal. Census of consultant establishment taken at 1st January of each year

Comparison of percentage increase in consultant establishment in all specialties to increase in consultant establishment in psychiatry relevant to 1982 figures.

Graph 3.7  Graph comparing percentage increase in total consultant establishment in all specialties relevant to 1982 total figure to percentage increase in consultant establishment in psychiatry relevant to 1982 psychiatry figure.
Source: Comhairle na nOspidéal
The increase in the consultant establishment in psychiatry from 185 in 1982 to 295 as of 1st January 2005 when compared to the overall increase in the consultant establishment in all specialties from 1,168 in 1982 to 1,947 as of January 2005 shows a similar pattern as illustrated in the above graph. This large increase in consultant posts has been made possible due to extra funding being made available to the health services in successive national budgets.

The expansion in consultant psychiatry services from 1982 to 2005 has taken place primarily in child and adolescent psychiatry services concurrent with an expansion in the sub-specialty areas of adult psychiatry, as shown in Table 3.8.

**Table 3.8** Table showing the increase in the consultant establishment in psychiatry in the public sector by sub-specialty and special interest and relevant consultant to population ratio from May 1982 to January 2005.

<table>
<thead>
<tr>
<th>Psychiatry Specialty</th>
<th>May 1982</th>
<th>Ratio to population*</th>
<th>May 1990</th>
<th>Ratio to population*</th>
<th>Jan. 2005</th>
<th>Ratio to population*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General no s.i.</td>
<td>161</td>
<td>1/21,000</td>
<td>147</td>
<td>1/24,000</td>
<td>153</td>
<td>1/25,600</td>
</tr>
<tr>
<td>s.i. Liaison</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>s.i. Substance Misuse</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>s.i. Rehabilitation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>s.i. forensic</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General no s.i.</td>
<td>21</td>
<td>1/164,000</td>
<td>23</td>
<td>1/154,000</td>
<td>54</td>
<td>1/72,500</td>
</tr>
<tr>
<td>s.i. Substance Misuse</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatry of Learning Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>1/590,000</td>
<td>24</td>
<td>1/163,000</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>1/1,180,000</td>
<td>12</td>
<td>1/326,000</td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td>3</td>
<td>1/1,148,000</td>
<td>3</td>
<td>1/1,148,000</td>
<td>5</td>
<td>1/783,000</td>
</tr>
<tr>
<td>Psychiatry of Old Age</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>21</td>
<td>1/187,000</td>
</tr>
<tr>
<td>Total</td>
<td>185</td>
<td></td>
<td>182</td>
<td></td>
<td>295</td>
<td></td>
</tr>
</tbody>
</table>

Source: Comhairle na nOspidéal
*1981 Census Population: 3,443,045, source CSO.
*1986 Census Population: 3,540,643, source CSO.
*2002 Census Population: 3,917,203, source CSO.

3.2.2 **PSYCHIATRISTS SOLELY IN PRIVATE PRACTICE**
As of 1st January 2005, there were approximately 28 specialists working whole time in private psychiatry practice, the majority of whom work in Dublin at St. Patrick’s Hospital or St. John of God’s Hospital, Stillorgan. On the whole private psychiatry services tend to focus on general adult psychiatry rather than such specialties as learning disability, old age and substance misuse.

3.2.3 **NON-PERmanent Consultant Psychiatrists**
Comhairle na nOspidéal has expressed concern for many years at the duration and number of temporary consultant posts, both approved and unapproved, in the health service. In particular, Comhairle has noted this issue with respect to psychiatry. As of 1st January 2005 there were 41 approved non-permanent consultant posts in psychiatry.
In addition, the excessive length of time taken by many employing authorities to advertise and fill Comhairle approved permanent consultant psychiatrist posts, choosing to fill them instead with temporary postholders on a long-term basis, has also been noted by Comhairle. Comhairle na nOspidéal believes that the continuation of these temporary arrangements is hindering the development of services, deprives qualified candidates (including those in the temporary posts) of the opportunity to apply for permanent posts and has implications for best practice in patient care. In recent times, Comhairle has approved a number of permanent consultant psychiatrist posts in the context of their being advertised within a year and the cessation of existing temporary arrangements. This has not been implemented in some instances.

3.2.4 NON CONSULTANT HOSPITAL DOCTORS IN PSYCHIATRY

The Postgraduate Medical and Dental Board’s report “NCHD Staffing Complements at 1st October 2004” states that there were 485 (wte) Department of Health & Children approved NCHD posts in psychiatry. The number of unapproved posts was not covered in the survey. Of the approved posts, there were 59 senior registrars, 156 registrars and 270 senior house officers. The table below shows the distribution of these NCHD posts between the different specialties and sub-specialties of psychiatry. It should be noted that these figures will include trainees from other specialties or disciplines who are rotating through psychiatry as part of the training for their course, for example GP trainees and paediatric trainees.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of NCHD posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Adult Psychiatry</td>
<td>346</td>
</tr>
<tr>
<td>Child &amp; Adolescent psychiatry</td>
<td>64.5</td>
</tr>
<tr>
<td>Psychiatry of learning disability</td>
<td>16</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>18</td>
</tr>
<tr>
<td>Psychiatry of Old Age</td>
<td>27.5</td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td>10</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>485</strong></td>
</tr>
</tbody>
</table>

The statutory role of regulating the number and type of appointments of senior registrar and specialist registrar in public hospitals in Ireland transferred from Comhairle na nOspidéal to the HSE as of 1st January 2005. Focusing specifically on approved senior registrar posts within psychiatry, the distribution of these posts between the different specialties and sub-specialties of psychiatry as of 1st January 2005 is given below:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Senior Registrar posts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approved by Comhairle na nOspidéal</td>
</tr>
<tr>
<td>General Adult Psychiatry</td>
<td>24</td>
</tr>
<tr>
<td>Child &amp; Adolescent psychiatry</td>
<td>20</td>
</tr>
<tr>
<td>Psychiatry of learning disability</td>
<td>2</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry of Old Age</td>
<td>9</td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td>2</td>
</tr>
<tr>
<td>Liaison</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>
The consultant establishment in psychiatry in the public service from 1990 to 2005 increased by 113, from 182 to 295, whilst the number of NCHD psychiatry posts increased by 238, from 247 to 485. The surpassing of the steady growth in consultant staffing by the growth in overall NCHD numbers in psychiatry is not in keeping with national health policy, as stated in various reports including "Medical Manpower in Acute Hospitals", 1993 and "Report of the Forum on Medical Manpower", 2001.

Graph 3.9 Graph displaying number of approved NCHD posts in psychiatry from 1986 to 2004
Source: Postgraduate Medical and Dental Board

3.3 DISTRIBUTION OF THE CONSULTANT PSYCHIATRIST WORKFORCE USING WHOLE TIME EQUIVALENTS (WTES)

The following tables are based on the official type of post and special interest, if any, approved by Comhairle na nOspidéal. It is acknowledged that de facto specific areas of interest will have been developed by individual consultants, who will provide services in those areas in their regions. The number of posts given in each of the following tables is the whole time equivalents in existence as of 1st January 2005, and will include those posts which were replacement posts under consideration by Comhairle at that time or unprocessed.

It should be noted that with respect to posts with a special interest in learning disability, Comhairle na nOspidéal was requested in 1983 by the Department of Health to regulate consultant posts in mental handicap agencies in line with the regulation of all other consultant posts in the public sector. At that time, most mental handicap agencies had an administrative/medical director who provided services to both adult and children. Following the publication of the Comhairle report entitled “Medical Aspects of the Mental Handicap Services” in April 1988, consultant posts in the mental handicap services were subsequently divided and categorised as either general adult psychiatrist with a special interest in learning disability, or child and adolescent psychiatrist with a special interest in learning disability. However, to date there still remains some overlap between the two specialties in some regions and agencies due to the organisation of the services.
In addition, due to the organisation of psychiatry services to patients with learning disabilities, some postholders with a special interest in learning disability provide the service on a full time basis, whilst others provide psychiatry services to patients both with and without learning disability. This leads to a cross-over and integration of these services in some regions. An example of this can been seen in the Southern Area, with the three posts of consultant child and adolescent psychiatrist with a special interest in learning disability based in the Brothers of Charity, providing learning disability and general services in a 1:2 split.

3.3.1 DISTRIBUTION OF ALL CONSULTANT PSYCHIATRIST POSTS BY AREA

When the distribution of the consultant establishment in psychiatry in the public sector was examined, as tabulated in table 3.10 it was clear that disparities exist between different areas regarding consultant staffing levels with the ratio of WTE post to population ranging from 1 per 10,000 in the Northern Area, to 1 per 17,200 in the North-Eastern Area.

Table 3.10 Table showing the distribution of the consultant establishment in all psychiatry specialties as of January 2005.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>WTEs</th>
<th>% Population</th>
<th>% WTE</th>
<th>Ratio of WTE posts to population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast Area</td>
<td>27</td>
<td>9</td>
<td>9</td>
<td>1/12,400</td>
</tr>
<tr>
<td>Northern Area</td>
<td>48.5</td>
<td>12</td>
<td>17</td>
<td>1/10,000</td>
</tr>
<tr>
<td>South-Western Area</td>
<td>50</td>
<td>15</td>
<td>17</td>
<td>1/11,600</td>
</tr>
<tr>
<td>Midland Area</td>
<td>15</td>
<td>6</td>
<td>5</td>
<td>1/15,000</td>
</tr>
<tr>
<td>Mid-Western Area</td>
<td>22</td>
<td>8</td>
<td>8</td>
<td>1/15,400</td>
</tr>
<tr>
<td>North-Eastern Area</td>
<td>20</td>
<td>9</td>
<td>7</td>
<td>1/17,200</td>
</tr>
<tr>
<td>North-Western Area</td>
<td>18</td>
<td>5</td>
<td>6</td>
<td>1/12,300</td>
</tr>
<tr>
<td>South-Eastern Area</td>
<td>27</td>
<td>11</td>
<td>9</td>
<td>1/15,700</td>
</tr>
<tr>
<td>Southern Area</td>
<td>34</td>
<td>15</td>
<td>11</td>
<td>1/17,100</td>
</tr>
<tr>
<td>Western Area</td>
<td>26</td>
<td>10</td>
<td>9</td>
<td>1/14,600</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287.5</td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>1/13,600</strong></td>
</tr>
</tbody>
</table>

3.3.2 DISTRIBUTION OF POSTS OF GENERAL ADULT PSYCHIATRIST WITH NO DESIGNATED SPECIAL INTEREST

The distribution of the consultant establishment in general adult psychiatry with no designated special interest throughout the country was fairly even in manner, with a number of areas having approximately one WTE post per 25,000 population. The exceptions noted were the Mid-Western Area and North Eastern Area.
Table 3.11  Table showing the distribution of the consultant establishment in general adult psychiatry with no designated special interest as of January 2005.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>WTEs</th>
<th>% Population</th>
<th>% WTEs</th>
<th>Ratio of WTE posts to population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast Area</td>
<td>13</td>
<td>9</td>
<td>9</td>
<td>1 / 25,700</td>
</tr>
<tr>
<td>Northern Area</td>
<td>23</td>
<td>12</td>
<td>15</td>
<td>1 / 21,100</td>
</tr>
<tr>
<td>South-Western Area</td>
<td>20</td>
<td>15</td>
<td>13</td>
<td>1 / 29,100</td>
</tr>
<tr>
<td>Midland Area</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>1 / 28,200</td>
</tr>
<tr>
<td>Mid-Western Area</td>
<td>11</td>
<td>8</td>
<td>7</td>
<td>1 / 30,900</td>
</tr>
<tr>
<td>North-Eastern Area</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>1 / 31,400</td>
</tr>
<tr>
<td>North-Western Area</td>
<td>10</td>
<td>5</td>
<td>7</td>
<td>1 / 22,100</td>
</tr>
<tr>
<td>South-Eastern Area</td>
<td>16</td>
<td>11</td>
<td>10</td>
<td>1 / 26,500</td>
</tr>
<tr>
<td>Southern Area</td>
<td>23</td>
<td>15</td>
<td>15</td>
<td>1 / 25,200</td>
</tr>
<tr>
<td>Western Area</td>
<td>17</td>
<td>10</td>
<td>12</td>
<td>1 / 22,400</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
<td>100</td>
<td>1 / 25,800</td>
</tr>
</tbody>
</table>

3.3.3 DISTRIBUTION OF POSTS OF CONSULTANT GENERAL ADULT PSYCHIATRIST WITH A SPECIAL INTEREST IN LEARNING DISABILITY

As of January 2005, the consultant establishment in general adult psychiatry with a special interest in learning disability was 22.5 WTE. A large discrepancy exists between areas regarding consultant staffing levels in this area. It should be noted that many patients with a learning disability reside in mental handicap facilities which are not necessarily located in their original county of residence. This factor should be born in mind when considering the distribution of consultant posts in this area.

Table 3.12  Table showing the distribution of the consultant establishment in general adult psychiatry with a special interest in learning disability as of January 2005.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>WTEs</th>
<th>% Population</th>
<th>% WTEs</th>
<th>Ratio of WTE posts to population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast Area</td>
<td>0</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Northern Area</td>
<td>6.5</td>
<td>12</td>
<td>29</td>
<td>1 / 74,800</td>
</tr>
<tr>
<td>South-Western Area</td>
<td>7</td>
<td>15</td>
<td>31</td>
<td>1 / 83,100</td>
</tr>
<tr>
<td>Midland Area</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>1 / 225,600</td>
</tr>
<tr>
<td>Mid-Western Area</td>
<td>1</td>
<td>8</td>
<td>4</td>
<td>1 / 339,900</td>
</tr>
<tr>
<td>North-Eastern Area</td>
<td>2</td>
<td>9</td>
<td>10</td>
<td>1 / 172,500</td>
</tr>
<tr>
<td>North-Western Area</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>1 / 110,700</td>
</tr>
<tr>
<td>South-Eastern Area</td>
<td>1</td>
<td>11</td>
<td>4</td>
<td>1 / 423,500</td>
</tr>
<tr>
<td>Southern Area</td>
<td>1</td>
<td>15</td>
<td>4</td>
<td>1 / 580,600</td>
</tr>
<tr>
<td>Western Area</td>
<td>1</td>
<td>10</td>
<td>4</td>
<td>1 / 380,10</td>
</tr>
<tr>
<td>Total</td>
<td>22.5</td>
<td>100</td>
<td>100</td>
<td>1 / 174,100</td>
</tr>
</tbody>
</table>
3.3.4 DISTRIBUTION OF POSTS OF CONSULTANT PSYCHIATRIST IN THE PSYCHIATRY OF OLD AGE

The consultant establishment in the psychiatry of old age stood at 21 WTE posts as of January 2005. There exists a huge discrepancy between regions regarding consultant staffing levels in old age psychiatry, with the South Eastern Area having a ratio of one WTE post per 105,900 population and the Southern Area having one WTE post per 580,600 population.

Table 3.13 Table showing the distribution of the consultant establishment in the psychiatry of old age as of January 2005.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>WTEs</th>
<th>% Population</th>
<th>% WTEs</th>
<th>Ratio of WTE posts to population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast Area</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>1 / 333,500</td>
</tr>
<tr>
<td>Northern Area</td>
<td>2</td>
<td>12</td>
<td>10</td>
<td>1 / 243,200</td>
</tr>
<tr>
<td>South-Western Area</td>
<td>2</td>
<td>15</td>
<td>10</td>
<td>1 / 290,800</td>
</tr>
<tr>
<td>Midland Area</td>
<td>2</td>
<td>6</td>
<td>10</td>
<td>1 / 112,800</td>
</tr>
<tr>
<td>Mid-Western Area</td>
<td>2</td>
<td>8</td>
<td>9</td>
<td>1 / 170,000</td>
</tr>
<tr>
<td>North-Eastern Area</td>
<td>3</td>
<td>9</td>
<td>14</td>
<td>1 / 115,000</td>
</tr>
<tr>
<td>North-Western Area</td>
<td>2</td>
<td>5</td>
<td>9</td>
<td>1 / 110,700</td>
</tr>
<tr>
<td>South-Eastern Area</td>
<td>4</td>
<td>11</td>
<td>19</td>
<td>1 / 105,900</td>
</tr>
<tr>
<td>Southern Area</td>
<td>1</td>
<td>15</td>
<td>5</td>
<td>1 / 580,600</td>
</tr>
<tr>
<td>Western Area</td>
<td>2</td>
<td>10</td>
<td>9</td>
<td>1 / 190,000</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>100</td>
<td>100</td>
<td>1/186,600</td>
</tr>
</tbody>
</table>

3.3.5 DISTRIBUTION OF POSTS OF CONSULTANT GENERAL ADULT PSYCHIATRIST WITH A SPECIAL INTEREST IN LIAISON PSYCHIATRY

Liaison psychiatry is a relatively new sub-specialty of psychiatry in Ireland, with the first post having been approved by Comhairle in May 1994. There are nine WTE posts in the public service, seven of which were created in the past five years.

Table 3.14 Table showing the distribution of the consultant establishment in general adult psychiatry with a special interest in liaison psychiatry as of January 2005.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>WTEs</th>
<th>% Population</th>
<th>% WTEs</th>
<th>Ratio of WTE posts to population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast Area</td>
<td>1</td>
<td>9</td>
<td>11</td>
<td>1 / 333,500</td>
</tr>
<tr>
<td>Northern Area</td>
<td>3</td>
<td>12</td>
<td>33</td>
<td>1 / 162,100</td>
</tr>
<tr>
<td>South-Western Area</td>
<td>3</td>
<td>15</td>
<td>33</td>
<td>1 / 193,900</td>
</tr>
<tr>
<td>Midland Area</td>
<td>-</td>
<td>6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mid-Western Area</td>
<td>1</td>
<td>8</td>
<td>11</td>
<td>1 / 339,900</td>
</tr>
<tr>
<td>North-Eastern Area</td>
<td>-</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>North-Western Area</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>South-Eastern Area</td>
<td>-</td>
<td>11</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Southern Area</td>
<td>1</td>
<td>15</td>
<td>11</td>
<td>1 / 580,600</td>
</tr>
<tr>
<td>Western Area</td>
<td>-</td>
<td>10</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>100</td>
<td>100</td>
<td>1/435,200</td>
</tr>
</tbody>
</table>
3.3.6 DISTRIBUTION OF POSTS OF GENERAL ADULT PSYCHIATRIST WITH A SPECIAL INTEREST IN SUBSTANCE MISUSE
As of 1st January 2005, Comhairle na nOspidéal had approved six WTE posts of consultant general adult psychiatrist with a special interest in substance misuse of which three were approved in the past three years. Of the six posts, five are based in the eastern region. All of the posts within the eastern region have a sessional commitment to the Drug Treatment Centre Board in Pearse Street, with a number of the posts also providing sessions to the prison service from within their health board commitment. There is also one post in the Midland Area.

3.3.7 DISTRIBUTION OF POSTS OF CONSULTANT GENERAL ADULT PSYCHIATRIST WITH A SPECIAL INTEREST IN REHABILITATION
As of 1st January 2005, there were seven WTE approved permanent posts of consultant general adult psychiatrist with a special interest in rehabilitation, of which six were approved by Comhairle na nOspidéal since 2000. Of the areas, the South Western Area, the Mid-Western Area, the North Eastern Area, the North Western Area and Western Area have one WTE post, with the Northern Area having two WTE posts.

3.3.8 DISTRIBUTION OF POSTS OF CONSULTANT GENERAL ADULT PSYCHIATRIST WITH A SPECIAL INTEREST IN FORENSIC PSYCHIATRY
In October 2003, Comhairle approved the first post of consultant general adult psychiatrist with a special interest in forensic psychiatry under the Mid-Western Area to be based at the Mid-Western Regional Hospital, Limerick. The structure of the post approved was 6 sessions to the general adult psychiatry service, 3 sessions for forensic consultations and 2 sessions to Limerick Prison. Subsequently, a similar post was approved for the Southern Area in July 2004, structured 6 sessions to the region’s psychiatric intensive care unit, Carraig Mór Centre, 3 sessions to the Cork prison service and 2 sessions for forensic consultations to the area.

3.3.9 DISTRIBUTION OF POSTS OF CONSULTANT FORENSIC PSYCHIATRIST
Comhairle na nOspidéal has approved five WTE posts of consultant forensic psychiatrist, all of which are based in the Central Mental Hospital. Four of these posts have attachments to the prison services in Dublin, while one post has sessional commitments to Portlaoise Prison and Midland Prison.

3.3.10 DISTRIBUTION OF POSTS OF CONSULTANT CHILD & ADOLESCENT PSYCHIATRIST WITH NO DESIGNATED SPECIAL INTEREST
From May 1982 to January 2005, the proportionally biggest expansion in terms of consultant posts took place in child & adolescent psychiatry, from 21 to 50.5 WTEs. There are significant disparities between areas regarding consultant staffing levels in this specialty.
Table 3.15 Table showing the distribution of the consultant establishment in child & adolescent psychiatry with no designated special interest as of January 2005.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>WTEs</th>
<th>% Population</th>
<th>% WTEs</th>
<th>Ratio of WTE posts to population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast Area</td>
<td>5.5</td>
<td>11</td>
<td>11</td>
<td>1 / 60,600</td>
</tr>
<tr>
<td>Northern Area</td>
<td>8</td>
<td>17</td>
<td>16</td>
<td>1 / 60,800</td>
</tr>
<tr>
<td>South-Western Area</td>
<td>14</td>
<td>28</td>
<td>27</td>
<td>1 / 41,500</td>
</tr>
<tr>
<td>Midland Area</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>1 / 112,800</td>
</tr>
<tr>
<td>Mid-Western Area</td>
<td>4</td>
<td>7</td>
<td>8</td>
<td>1 / 113,300</td>
</tr>
<tr>
<td>North-Eastern Area</td>
<td>3</td>
<td>7</td>
<td>8</td>
<td>1 / 115,000</td>
</tr>
<tr>
<td>North-Western Area</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1 / 73,900</td>
</tr>
<tr>
<td>South-Eastern Area</td>
<td>4</td>
<td>7</td>
<td>8</td>
<td>1 / 105,900</td>
</tr>
<tr>
<td>Southern Area</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>1 / 193,500</td>
</tr>
<tr>
<td>Western Area</td>
<td>4</td>
<td>7</td>
<td>8</td>
<td>1 / 95,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50.5</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>1/77,600</strong></td>
</tr>
</tbody>
</table>

* There are also three posts of consultant child and adolescent psychiatrist with a special interest in learning disability, based in the Brothers of Charity in the south region. As noted previously in Section 3.3, these provide general child and adolescent psychiatry services and learning disability services in a 2:1 split. Thus when taken into consideration the consultant to population ratio is approximately 1 post per 116,000 population in the HSE-Southern area.

3.3.11 DISTRIBUTION OF POSTS OF CONSULTANT CHILD & ADOLESCENT PSYCHIATRIST WITH A SPECIAL INTEREST IN THE PSYCHIATRY OF LEARNING DISABILITY

As of January 2005 the consultant establishment in child and adolescent psychiatry with a special interest in the psychiatry of learning disability was 10.5 WTE. There are significant disparities regarding consultant staffing levels in this specialty, with three areas having no posts. As noted in Section 3.3.1, some postholders in this specialty provide general child & adolescent psychiatry services in addition to learning disability services. This is the arrangement in for example the Southern Area and the Western Area. This factor needs to be considered when examining consultant staffing in this area.

Table 3.16 Table showing the distribution of the consultant establishment in child & adolescent psychiatry with a special interest in the psychiatry of learning disability as of January 2004.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>WTEs</th>
<th>% Population</th>
<th>% WTEs</th>
<th>Ratio of WTE posts to population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast Area</td>
<td>0.5</td>
<td>9</td>
<td>5</td>
<td>1 / 333,500</td>
</tr>
<tr>
<td>Northern Area</td>
<td>1</td>
<td>12</td>
<td>10</td>
<td>1 / 486,300</td>
</tr>
<tr>
<td>South-Western Area</td>
<td>-</td>
<td>15</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Midland Area</td>
<td>1</td>
<td>6</td>
<td>10</td>
<td>1 / 225,600</td>
</tr>
<tr>
<td>Mid-Western Area</td>
<td>1</td>
<td>8</td>
<td>10</td>
<td>1 / 170,000</td>
</tr>
<tr>
<td>North-Eastern Area</td>
<td>-</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>North-Western Area</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>South-Eastern Area</td>
<td>2</td>
<td>11</td>
<td>18</td>
<td>1 / 211,800</td>
</tr>
<tr>
<td>Southern Area</td>
<td>4</td>
<td>15</td>
<td>37</td>
<td>1 / 145,100</td>
</tr>
<tr>
<td>Western Area</td>
<td>1</td>
<td>10</td>
<td>10</td>
<td>1 / 380,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10.5</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>1/373,100</strong></td>
</tr>
</tbody>
</table>
3.3.12 DISTRIBUTION OF POSTS OF CONSULTANT CHILD & ADOLESCENT PSYCHIATRISTS WITH A SPECIAL INTEREST IN SUBSTANCE MISUSE

In September 2002, Comhairle na nOspidéal approved the first post of consultant child & adolescent psychiatrist with a special interest in substance misuse for the South Western Area with one session per week to the Drug Treatment Centre in Pearse Street, Dublin. A second such post for the Northern Area was approved in July 2004, structured 6 sessions to the area, 2 sessions to the Mater Hospital, 2 sessions to the Drug Treatment Centre and 1 session to the South Western Area.

3.4 INTERNATIONAL CONSULTANT STAFFING LEVELS IN PSYCHIATRY

There are considerable differences in consultant psychiatry posts to population ratios between the USA, Canada and various European countries in comparison to the UK and Ireland. However, because of the significantly different types of medical practice and organisation in existence in north America and mainland Europe, it is difficult to make meaningful comparisons other than with the UK system. Tabulated below is the whole time equivalent consultant staffing in various psychiatry specialties for Scotland, England, Wales and the Republic of Ireland.

Tables 3.17 Consultant staffing, presented as whole time equivalents (WTE), in the various specialties of psychiatry in Scotland, England and Wales as of September 2003 and Republic of Ireland as of January 2005.


<table>
<thead>
<tr>
<th>Scotland (5,062,011 population)</th>
<th>England (49,138,831 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>WTE</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>52.3</td>
</tr>
<tr>
<td>Forensic</td>
<td>30.1</td>
</tr>
<tr>
<td>General</td>
<td>226.2</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>24</td>
</tr>
<tr>
<td>Old Age</td>
<td>59.7</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>405.2</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wales (2,903,085 population)</th>
<th>Republic of Ireland (3,917,203 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>WTE</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>23.1</td>
</tr>
<tr>
<td>Forensic</td>
<td>7.2</td>
</tr>
<tr>
<td>General</td>
<td>62.5</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>11.7</td>
</tr>
<tr>
<td>Old Age</td>
<td>23.2</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128.6</strong></td>
</tr>
</tbody>
</table>

| Specialty                       | WTE  | WTE: Population |
| Child & Adolescent              | 52.5 | 1/74,600        |
| Forensic                        | 5    | 1/783,500       |
| General                         | 176  | 1/22,300        |
| Learning Disability             | 33   | 1/118,700       |
| Old Age                         | 21   | 1/186,500       |
| Psychotherapy                   | 0    | -              |
| **Total**                       | **287.5** | **1/13,600**    |
Though there are time scales differences involved regarding when the above consultant statistical information was collected for the different countries, it can still be seen from the tables above, that Ireland compares favourably in a number of specialties. In general psychiatry, child and adolescent psychiatry and learning disability, the Republic of Ireland has the lowest WTE per population ratios. However, in the other three specialties, namely old age psychiatry, forensic psychiatry and psychotherapy, the Republic of Ireland has the highest WTE per population ratios of all countries, with Scotland having the highest levels of consultant staffing in these specialties.

3.5 THE MEDICAL MANAGER IN PSYCHIATRY

The model of medical management in psychiatry which goes back to the 19th century, involved the appointment of a ‘Resident Medical Superintendent’ as the person in charge of each mental hospital or asylum. This tradition continued with the role and duties of the Resident Medical Superintendent (RMS) or ‘Chief Psychiatrist’ being enshrined in the 1945 Mental Treatment Act. In recent years these terms have changed in some areas to ‘Clinical Director’ or ‘Medical Director’. The Mental Health Act 2001 recommended that the governing body of each approved psychiatric centre appoint in writing a consultant psychiatrist to be the clinical director of the centre. These posts continue to play a vital role in the development, management and administration of each mental health catchment area and this is formally acknowledged in the payment of two additional consultant sessions to those consultants holding clinical directorships.

The question of whether or not a particular consultant psychiatrist post should have the clinical directorship permanently attached to it, or whether a rotational arrangement between permanent posts should apply, has always been regarded by successive Comhairles as primarily a matter for determination by the local health agency in conjunction with the Department of Health. In the past, posts of clinical director/consultant psychiatrist have been approved by Comhairle na nOspidéal and subsequently advertised and filled accordingly. Alternatively, the employing authority’s intention to assign the duties, responsibilities and title of clinical director for a fixed term to one of the consultant psychiatrist posts has been noted by Comhairle na nOspidéal in its approval letter.

Comhairle na nOspidéal in considering this issue favours the latter route and recommends that in future a rotational model on a 5 – 7 year basis or a renewable appointment model should be used by employing authorities in relation to assigning clinical directorships to posts and individuals. Furthermore, it is recommended that holders of full-time academic posts of Professor of Psychiatry, who have responsibility for a teaching department, would not hold simultaneously the clinical directorship due to the onerous responsibilities of both jobs.
RECOMMENDATIONS

4.1 INTRODUCTION

In making recommendations regarding consultant staffing levels in psychiatry that will provide a high quality and safe service to all patients, Comhairle na nOspidéal had due regard to demographics, national and international best practices and the outcome of the consultation process involving health boards, voluntary hospitals, the Irish College of Psychiatrists, voluntary and community agencies, the Irish Psychiatric Training Committee, the Mental Health Commission and other interested parties.

In considering the issues involved regarding consultant staffing levels for mental health services, Comhairle based its recommendations on what a model population size of 300,000 would require. This facilitated Comhairle to consider the full range of specialist mental health services, including those whose population base would be greater than 100,000, and allowed Comhairle to envisage how mental health services would operate as a whole when providing services to a sizeable population. In their submission, the Mental Health Commission stated that “to allow for the necessary range of specialist services, the catchment areas recommended in Planning for the Future will need to be increased in size to 300 – 400,000.”

4.1.1 POPULATION STATISTICS USED

Comhairle na nOspidéal examined and considered the option of making its recommendations using age specific populations for example consultant child and adolescent psychiatry posts being recommended based on the population under 18 years of age and old age psychiatry posts being recommended based on the population over 65 years of age. However, although these population data are available, it was felt that as the profile of a national population is not static in nature but rather continually changes over time it would be more useful to make recommendations based on total population. It was also felt by Comhairle that this would encourage flexibility in the mental health services between services for different age groups.
4.2 GENERAL ADULT PSYCHIATRY

General adult psychiatrists provide the majority of consultant psychiatric services to the adult population in Ireland. The general adult psychiatrist is defined in the submission by the Irish College of Psychiatrists as being “particularly responsible for assessment of referred patients and for treatment of a wide range of patients with psychoses, anxiety-related disorders, affective disorders, personality problems of all types, substance misuse, organic brain disorders, deliberate self-harm, transient situational reactions and psychological reactions of all types.”

Patients are normally referred through general practitioners, community care, accident and emergency services or departments of acute general hospitals. Many of the special interest areas being developed in the area of psychiatry for adults, for example liaison, substance misuse and rehabilitation, have traditionally been delivered by consultant general adult psychiatrists who have developed expertise in these areas. With evidence indicating that more specialised care approaches to certain clinical areas are needed in order to reduce the associated morbidity and with the advent of alternative methods of delivering acute services i.e. assertive outreach, home based care etc, it is has become necessary to develop specific specialised psychiatric services for adult patients in certain special interest areas. With the development of consultant psychiatric services with specific special interests, patients may be referred for further specialist care by their consultant general adult psychiatrist to other consultant psychiatrists specialising in these areas.

As of 1st January 2005 the consultant establishment in general adult psychiatry without a formally designated special interest in the public sector was 152 WTE posts. Examination of the table presented in Section 3.3.2 indicates that, with a few exceptions, most regions meet recommended ratio of one post per 25,000 population, with the overall national ratio being one WTE post per 25,800 population. However, examination of individual catchment areas and sector sizes show the great variations that can exist within and between catchment areas as to the population served by individual consultant general adult psychiatrist posts.

The most recent census from the Central Statistics Office carried out in 2002 indicated that the population of the Republic of Ireland stood at 3,917,203. Therefore, the total number of consultant general adult psychiatrist posts in the state should be in the region of 157 WTE posts based on the ratio of one post per 25,000 population and on the CSO’s figure of 2002. The CSO has estimated that the population of Ireland will continue to grow over the next few decades, reaching over 4.5 million by 2031.

Recommendations

In the context that the population between different sectors can vary enormously, it is recommended that the HSE review the populations being served by individual consultant general adult psychiatrists and their teams. Where necessary, steps should be taken by the HSE in order to address any imbalances in populations being served. This could be done by additional posts of consultant general adult psychiatrist being appointed based on the ideal ratio of 1 post per 25,000 population, thereby leading to the larger sectors having two consultant general adult psychiatrists. Alternatively two sectors could be merged giving rise to larger sectors in the future of approximately 50,000 population staffed by a minimum of two consultant general adult psychiatrists (see section 2.8).

In the context of the increasing urbanisation of Irish society and shifting demographics, the HSE and relevant employing authorities should undertake a periodic review of catchment area configuration, sector sizes, access to services and continuity of care, to ensure equitable resource allocation. These reviews should also take due account of total population, geographic distances and social deprivation as well as number, type and location of existing facilities.
4.3 CHILD & ADOLESCENT PSYCHIATRY

Child and adolescent psychiatry addresses the emotional and behavioural difficulties of children from birth until school leaving age - and in some cases, beyond. Child psychiatrists deal with a range of psychiatric conditions, including emotional disorders, conduct disorders, psychotic disorders and neuropsychiatric problems. Consultant child & adolescent psychiatry services are also involved in the areas of learning disability, paediatric liaison work, forensic work, sexual abuse, deliberate self harm and eating disorders.

The number of consultant posts in child & adolescent psychiatry in Ireland has expanded significantly over the past two decades. In 1980, there were fourteen posts of consultant child psychiatrist in Ireland - a ratio of 1 per 223,000 population. Following the Comhairle na nOspidéal report “Psychiatric Services at Consultant Level” (1978) which recommended that there should be a ratio of 1 post of consultant child psychiatrist per 100,000 population, the number of posts increased by 13 to 27 posts by 1990 - a ratio of 1 post per 130,000 population. As of 1st January 2005, the consultant establishment in child and adolescent psychiatry without a designated special interest in the public sector was 50.5 WTE posts. This gives a ratio of 1 post per 77,600 population.

When considering and examining this area of psychiatric services with a view to making recommendations regarding consultant staffing, the attention of Comhairle na nOspidéal was brought repeatedly to the issue of service provision for 16 and 17 year olds. The general adult psychiatry service, which has traditionally provided a limited service to this age group, maintains that patients within this age group should be the responsibility of child and adolescent psychiatry services arising from the definition of a child in the Child Care Act 1991. Consultant general adult psychiatrists indicated that they were not adequately trained or the adult service adequately resourced to deal with and treat mental illness in this age group. Child and adolescent psychiatrists acknowledged the appropriateness of their service treating this group of patients but felt that due to under resourcing and under staffing, the child and adolescent service could simply not assume full responsibility for these patients. Historically, therefore, patients in the 16 – 17 age group have fallen into the gap between the two services. Specialisation should only take place with a view to benefiting patients and not to their detriment. Comhairle na nOspidéal is very concerned about this and expects that the interests of the patients affected will take precedence over any other matters in resolving this unsatisfactory situation.

Recommendations

Comhairle na nOspidéal in making the following recommendations took due cognisance of the above issues, the various views expressed to the committee during the consultation process and the definition in both the Child Care Act 1991 and the new Mental Health Act 2001 that a child is such until the age of 18. Due consideration was also given to the Irish College of Psychiatrists’ recommendation of 2002 of three posts of general consultant child and adolescent psychiatrist per 100,000 population.

However with a view to the staffing levels in the UK (England: one WTE post per 110,000 population; Scotland: one WTE post per 97,000 population; Wales: one WTE post per 125,000 population) and having noted the percentage of the Irish population under the age of eighteen (25.8%), Comhairle na nOspidéal recommends two posts of consultant child and adolescent psychiatrist per 100,000 general population. Using age specific statistics this will give one post per 12,900 persons under the age of eighteen. This recommendation involves an increase in consultant child and adolescent psychiatrist posts nationwide from 50.5 WTE posts at present to 78 in the future.
In considering the issue of service provision to 16 and 17 year olds, the recommendations contained in the Second Report of the Working Group on Child and Adolescent Psychiatric Services (June 2003) established by the Department of Health and Children in June 2000 were noted. Comhairle na nOspidéal does not feel it would be appropriate to recommend the creation of posts with a special interest in later adolescence as it does not desire to introduce another divide in psychiatric services based on age. Rather it feels that psychiatric services for 16 and 17 years should become the responsibility of the child and adolescent psychiatric service as a whole rather than an identified section within it with a special interest. It may be useful for employing authorities, in consultation with existing postholders, to identify specific existing or future postholders who will be charged with the responsibility of co-ordinating, leading and advising on the transfer of services for 16/17 year olds from the adult service to the child and adolescent service in each region.

The transfer of responsibility for the treatment of 16 and 17 year olds from the adult service to the child and adolescent service will require a great deal of flexibility from both services both now and in the future. Comhairle would advise against the strict divide of services solely based on dates of birth of patients but rather recommends that on going flexibility would be built into service provision. This would facilitate for example a 17 year old diagnosed after assessment with a chronic psychiatric illness being treated by the adult service, rather than having to transfer from the child and adolescent service to the adult service after a small number of months. Conversely, a 17 year old diagnosed with an acute psychiatric illness could be treated by the child and adolescent service, even if the necessary treatment extended beyond the patient’s 18th birthday. Ultimately smooth transfer and continuity of treatment across services should be a priority and it is recommended that all services are involved in putting in place agreed protocols in each region to ensure that the care of this patient group is not compromised and that the transition between services is planned and seamless.

In making its recommendation, Comhairle na nOspidéal envisages that within this expansion of consultant child and adolescent psychiatric services, enhanced services will be provided both to the general child and adolescent population and to specific groups within this population including infants, 16 – 17 year olds, ADHD/HKD patients and autistic patients. It is recommended that when the above posts are in place, a further review be carried out to assess continuing needs in consultant psychiatric services for children and adolescents.

### 4.3.1 CHILD & ADOLESCENT PSYCHIATRY BEDS

At present there are a small number of psychiatric inpatient beds for children under 16 in three Children’s Centres in the Republic of Ireland. These are located at St. Anne’s, Taylors Hill, Galway and Warrenstown and Court Hall in northwest Dublin. There are no other designated inpatient psychiatric facilities for children. Comhairle na nOspidéal notes that the issue of the availability of, access to and provision of acute psychiatric beds for children and adolescents has repeatedly come before it over the past two decades, and was a problem frequently cited in the consultation process. In this context, Comhairle welcomed the first and second reports of the Working Group on Child and Adolescent Services established by the Department of Health & Children in June 2000. The terms of reference of the Working Group are set out below:

- to examine the current state of child and adolescent services in the country
- to carry out a needs analysis of the population aged 0-18 years for such services and identify shortcomings in meeting needs
- to make recommendations on how child and adolescent psychiatric services should be developed in the short, medium and long term to meet identified needs.
The Working Group issued its first report in March 2001. This first report contains proposals for the development of services for the management and treatment of Attention Deficit Hyperactivity Disorders/Hyperactivity Kinetic Disorder (ADHD/HKD) and for the development of Child (under 12) and Adolescent (12-16) Psychiatric Inpatient Units. The Report recommends that a total of seven child and adolescent inpatient psychiatric units for children ranging from 6-16 years should be developed throughout the state. It is envisaged that the focus of the centres will be "the assessment and treatment of psychiatric, emotional or family disorders including major adjustment disorders, anxiety disorders, mood disorders, eating disorders and schizophrenia using a combination of family systemic, individual psycho-dynamic and medical model perspectives."

It is noted that five of these seven units are to be developed and funded under the National Development Plan (2000 to 2006) and that at present the Department of Health and Children is in the process of putting in place four of the recommended seven units, one in Bessborough House, Cork, one at the Merlin Park Hospital Complex, Galway (St. Anne’s Taylors Hill Unit will be moving to this new unit), one at St. Vincent’s, Fairview, Dublin and one at the Mid-Western Regional Hospital, Limerick. Comhairle na nOspidéal notes and welcomes these developments and hopes that all units will come on stream in the near future with each consultant child & adolescent psychiatrist postholder having access to the dedicated child psychiatric acute beds in their region. In staffing these units, it is recommended that the HSE bear in mind the importance of cross-cover, support staff and avoidance of professional and unit isolation when structuring consultant posts for these proposed units in order to make these posts viable and attractive in the long term. Consideration should be given to the concept of appointments to such units being for a specific number of years with the prospect of rotation to other elements of the service and replacement by another consultant, new or existing.

The Second Report of the Working Group issued in June 2003 focused on the service needs of 16 – 18 year olds. Reference has been made already to the Report’s recommendation regarding consultant staffing for this age group. With respect to inpatient facilities, it was acknowledged by the Working Group that at present patients in this age group are admitted to adult psychiatric wards which are noted in the report as being inappropriate for most under 18s. Currently, no specifically designated or designed inpatient units exist for this age group. The Working Group’s report states that "acute same day inpatient admission should be available to adolescents with major psychiatric illness who require it’; and recommends that “consideration must be given to the development of specialist inpatient adolescent units”. In the short to medium term, the report recommends that patients in this age group continue to be accommodated in adult psychiatric wards, albeit under a consultant child and adolescent psychiatrist. While noting the stated practicality of this recommendation in the absence of specific units now, Comhairle na nOspidéal recommends that specific recommendations regarding the establishment of these units be formulated and implemented to ensure that inappropriate admission of adolescents to adult units will continue to occur only on an interim basis and that a definite end will be in sight for this practice. It is further recommended that inpatient services for 16 – 17 year olds be located on the same site as those for 6 – 16 years, albeit in separate accommodation from younger patients. This would be a better use of resources, would enhance team work, would facilitate cross cover between consultant child and adolescent psychiatrists and their teams and lead to the creation of integrated inpatient units for the totality of the child and adolescent psychiatric services.

4.3.2 CHILD & ADOLESCENT PSYCHIATRIC HIGH SUPPORT UNITS

In addition to an increase in in-patient child and adolescent psychiatric beds Comhairle na nOspidéal believes that a high support psychiatric unit for mentally ill children with disturbed and challenging behaviour, which render them unsuitable and unmanageable in general children’s psychiatric inpatient
units, is urgently needed in the state. At present, children and adolescents in need of such care are sent abroad to access the appropriate facilities or else are left untreated and often end up within the justice system. The high support unit being proposed by Comhairle na nOspidéal would differ from existing high support and special care places for children, as its primary focus would be medical care and treatment and it would operate like an inpatient unit. It would be staffed by psychiatric service personnel and would aim to manage the mental illness of the children presenting by providing an appropriate supportive therapeutic inpatient environment not available elsewhere.

The need for such a unit is recognised by service providers, but no units have been established to date. The initial establishment of one such unit is recommended, to which all regions would have access. Referrals could be made to the unit from (i) the court system after appropriate consultation with a consultant child and adolescent psychiatrist and (ii) from child & adolescent psychiatric inpatient units. Comhairle na nOspidéal proposes that the Health Service Executive be responsible for this initiative for the purpose of achieving consensus as to the development, location, and access to such a unit. It is recommended that the location for the unit should be in the greater Dublin region. The successful operation of any such unit would necessitate the involvement of the Departments of Health & Children, Education and Justice.

In recommending the development of a high support psychiatric inpatient unit for children and adolescents, Comhairle na nOspidéal is aware of the difficulties involved in establishing, and running such a unit. It is recommended therefore that prior to the establishment of the unit, an in-depth study and review be carried out regarding the proposed service, which would examine and address in detail such issues as staffing, training and management of the unit and would conduct comparative studies of similar units abroad.

4.3.3 EATING DISORDERS

In examining the areas of general adult psychiatry and child and adolescent psychiatry due consideration was given to the treatment of eating disorders. Comhairle na nOspidéal did not think the development of consultant psychiatrist posts with a special interest in eating disorders would be the appropriate way to develop services for sufferers of these chronic conditions. It was deemed more appropriate that the treatment of these disorders should come within the remit of the general child and adolescent psychiatric services and the general adult psychiatric services. Comhairle na nOspidéal notes that the Working Group on Child & Adolescent Psychiatry Services in the Department of Health & Children are currently in the process of drawing up recommendations regarding the treatment of eating disorders.
4.4 PSYCHIATRY OF LEARNING DISABILITY

Learning disability is usually first noted by parents, public health nurses, teachers or general practitioners. The initial pattern of referral is firstly to a consultant paediatrician. A multidisciplinary assessment involving psychology, speech therapy, occupational therapy and sometimes physiotherapy is undertaken, and plans formulated for ongoing multidisciplinary support and educational placement. In many instances, problems are evident at birth, e.g. children with Down’s Syndrome. There may be significant medical co-morbidity, for example, 50% of children with Down’s Syndrome have congenital heart disease, so that on-going paediatric medical support is important. The focus of treatment and intervention by service providers is on parental support, optimising the potential of the individual and prevention of secondary behavioural problems.

As of 2002, there were 25,448 people registered on The National Intellectual Disability Database maintained by the Health Research Board. Of the 25,448 people, 9,412 have mild intellectual disability, 9,495 have moderate intellectual disability, 4,004 have severe intellectual disability and 1,058 have profound intellectual disability. The degree of intellectual disability of 1,479 people was not verified. Extensive information regarding the number and proportion of people at each level of intellectual disability in each health board area is available in the annual HRB Report.

Epidemiology studies, like those by the Royal College of Psychiatrists (1986), Corbett (1979) and Gillberg et al, (1986), have indicated that approximately 50% of people with learning disabilities in institutional care or in contact with the community services, have or will suffer at some time from significant psychiatric disorders, which require a specialist psychiatric service. The focus of psychiatry of learning disability is to treat and address the mental illnesses which arise in patients with learning disability and not to treat the learning disability itself or other medical conditions. The Irish College of Psychiatrists notes that the diagnosis of psychiatric disorder in people with learning disabilities “requires special expertise in the face of atypical presentation, communication difficulties and often the absence of subjective complaints”. Psychiatry of learning disability is recognised by the Medical Council as a separate specialty and there is a division of psychiatry of learning disability on the Council’s Register of Medical Specialists.

The preponderance of care, in particular residential care, for people with learning disabilities is provided by voluntary agencies, now funded by the HSE. These agencies include the Brothers of Charity, the Daughters of Charity, St. Michael’s House, the St. John of God Order and Stewarts Hospital. While most consultant posts with a special interest in learning disability are based in these agencies, many have small sessional commitments to their local general psychiatric services. In addition to the voluntary agencies, a significant portion of residential care is provided in state owned and managed institutions and hospitals. Many patients with mental illness and severe learning disability reside in long stay units managed by HSE-health board areas, for example St. Ita’s Hospital in Portrane.

4.4.1 ADULTS

Comhairle na nOspidéal uses two titles when approving psychiatry of learning disability posts for the adult service – consultant psychiatrist with a special interest in learning disability and consultant psychiatrist of learning disability (adult). The latter title was introduced in recent years. The determination of which title is appropriate centres on the proposed extent of interaction of the postholder with the general adult psychiatric service, the number of colleagues in the same area and what on-call rota the postholder will take part in. As the number of posts of consultant psychiatrist of learning disability (adult) approved is relatively small, for convenience all posts will be referred to as ones with a special interest.
As of 1st January 2005, the consultant establishment in the psychiatry of learning disability services for adults was 21 WTE posts. Consultant psychiatrists with a special interest in the psychiatry of learning disability are responsible for the mental health of people with moderate or greater degrees of learning disability regardless of whether these patients are based in the community or institutions. Mentally ill people with mild degrees of learning disability are currently the responsibility of the general adult psychiatry service. Patients in this group normal reside in family or group homes and attend local general adult psychiatry services.

Recommendations
Having due regard to views expressed during the consultation process, Comhairle na nOspidéal recommends one post of consultant general adult psychiatrist with a special interest in the psychiatry of learning disability per 100,000 of the general population. This recommendation involves a near doubling of the number of WTE posts throughout the country, from 21 at present to 39 in the future.

4.4.2 CHILDREN & ADOLESCENTS
As of 1st January 2005, the consultant establishment of child and adolescent psychiatrists with a special interest in the psychiatry of learning disability was 10.5 WTE posts.

Recommendations
Comhairle na nOspidéal recommends one post of consultant child and adolescent psychiatrist with a special interest in the psychiatry of learning disability per 200,000 of the general population. This recommendation would involve a near doubling in the number of WTE posts from 10.5 to 20.

The significant increase in consultant paediatrician posts with a special interest in community child health, whose remit includes close liaison with the child care services in identifying, assessing and managing children with special needs, both physical and mental, is expected to improve the screening and initial support services for children with learning disabilities.

4.4.3 MODELS OF SERVICE – ADULT & CHILD AND ADOLESCENT
In examining the delivery of psychiatric services to patients with learning disability, adults and children & adolescents, Comhairle na nOspidéal noted that in different regions of the country, different models apply. In some areas, consultant psychiatrists responsible for providing the service to either adults or children and adolescents do so on a full time basis, providing no general psychiatry services. In other areas, consultants provide psychiatric services to patients both with and without learning disabilities. This applies particularly in child psychiatry. Support for both types of models was expressed during the consultation process. The latter type of model had been recommended by Comhairle in the past, with posts in this area being structured with sessional commitments to the general service in order to overcome the isolation postholders may encounter. However, such an arrangement had not always been feasible for all postholders, as the advantages of such linkages had been outweighed by the additional workload that such linkages had involved. Scope does exists for the two models of service delivery, and Comhairle recommends that local service needs and organisation be taken into account when decisions are being taken regarding the structure of services.
Comhairle na nOspidéal feels that the issue of integration is vitally important with respect to posts that are structured full time to psychiatry of learning disability services and which are also stand alone posts, separate from the general mental health services. The issue of professional isolation is critical in these circumstances and should be addressed by the HSE and relevant employing authorities in the best interests of both post holders and patients.

If sessional commitments to the general service are not considered appropriate or practical, Comhairle recommends that the model of linkage used with liaison psychiatry and old age psychiatry services be employed. This model would involve consultants in the area of psychiatry of learning disability working as an integrated part of the relevant psychiatric catchment team and taking part in the relevant general on-call rota. This arrangement would protect learning disability appointees from professional isolation, ensure linkages with their colleagues in other specialties of psychiatry and would provide emergency cover to their patients.

**Acute Beds in Service**

The lack of acute beds within the psychiatry service for patients with learning disability was highlighted to the committee during the consultation process. It was noted that the St. John of God Service in Dublin had recently put in place two beds, akin to ICU beds, which had greatly aided the treatment of emergency patients, who otherwise would have been treated in inappropriate facilities and surroundings. The committee was informed that this difficulty was widespread in the country, with acute emergency patients being treated in any facility that was available including community bungalows and parent’s homes. **In this context, Comhairle na nOspidéal recommends that the HSE review the need for acute inpatient beds in the psychiatry of learning disability service, with a view to putting in place a number of beds for services across regions.** It is envisaged that the actual number of beds needed would be small but will enhance greatly the service available to people with learning disability who suffer an acute psychiatric episode. This recommendation is supported by the National Disability Authority (NDA), who highlighted the need for such facilities in their report entitled “Review of Access to Mental Health Services for People with Intellectual Disability.” The NDA support the development of “specialist regional assessment and treatment units”, which would ensure that a “service would be available to deal with acute episodes that in the opinion of the Community Team in liaison with colleagues in the referred services, cannot be managed successfully in the community or in the generic mental health service.”
4.5 OLD AGE PSYCHIATRY

The Irish College of Psychiatrist’s submission notes that “the Psychiatry of Old Age is a recognised psychiatric specialty which is concerned with the mental disorders arising anew in people over the age of 65 years”. Old age psychiatrists deal with two groups of people - firstly with “elderly people developing functional psychiatric disorders for the first time over the age of 65 years” and secondly with “dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.” Elderly people are described as having an “increased likelihood of co-morbidity in terms of co-existing medical problems and the often atypical presentation of depression in old age. The identification and treatment of psychiatric and behavioural disturbance in dementia sufferers requires specialist skills.”

Close links between medical services for the elderly and old age psychiatry services are essential. The Joint Report of the Royal College of Physicians and the Royal College of Psychiatrists on the care of elderly people with mental illness states that the “Psychiatry of old age belongs to the family of psychiatry but is married to geriatrics”. Old age psychiatry is recognised by the Irish Medical Council as a separate specialty and there is a division of old age psychiatry on the Council’s Register of Medical Specialists. In order to protect appointees in this specialty from professional isolation, ensure linkages with their colleagues in other areas of the psychiatry services and provide and receive emergency cover from colleagues, it is recommended that postholders in this area would be an integrated part of the relevant catchment team and take part in the relevant general adult psychiatry on-call rota. As of 1st January 2005, the consultant establishment in the psychiatry of old age in the public service was 21 WTE posts.

Recommendations

Comhairle na nOspidéal recommends one post of consultant psychiatrist in the psychiatry of old age per 100,000 general population, or alternatively in regions with a high proportion of elderly people, the ratio of 1 post per 10,000 population over the age of 65 should be adopted. These recommendations would involve a near doubling in the number of WTE posts throughout the country, from 21 to 40.

In considering this specialty of psychiatry, it was acknowledged to Comhairle that the arbitrary rule that consultants in this area treat only those individuals who first suffer from mental illness over their 65th year came about when these posts were first introduced to the Irish medical system to protect the small number of post holders from an impossible workload. In the context that the number of consultant posts and teams in old age psychiatry has grown to 21 and is expected to continue to increase, Comhairle recommends that post holders in this area and their teams should begin to accept patients over 65 years of age into their service from the general adult psychiatric service.
4.6 ADULT LIAISON PSYCHIATRY

Liaison psychiatry focuses on providing psychiatric and psychological assessment and therapy to patients attending general hospitals primarily for non psychiatric illnesses. Two models of liaison psychiatry exist. In the “consultation model” consultant psychiatrists assess the patient in the hospital and refer them, when deemed appropriate, for treatment to the relevant catchment area or sector based psychiatric service. In the “liaison model” the consultant psychiatrist assesses the patient in hospital and if deemed appropriate treats patients directly, working as part of a multi-disciplinary team. The former model has been delivered traditionally by general adult psychiatrists providing sessions to their local hospital, whilst the latter model has been offered by consultant general psychiatrists with a special interest in liaison psychiatry appointed full time to specific general hospitals in recent years.

On 1st January 2005, the consultant establishment in general adult psychiatrist with a special interest in liaison psychiatry in the public sector was 9 WTE posts. The structure of each post is set out in table 4.1.

Table 4.1 Structure and sessional commitments of posts of consultant general adult psychiatrist with a special interest in liaison psychiatry

<table>
<thead>
<tr>
<th>Hospital/Service</th>
<th>Sessional Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post 1</td>
<td></td>
</tr>
<tr>
<td>Mater Hospital</td>
<td>6</td>
</tr>
<tr>
<td>Rotunda Hospital</td>
<td>4</td>
</tr>
<tr>
<td>NAHB (Area 7)</td>
<td>1</td>
</tr>
<tr>
<td>Post 2</td>
<td></td>
</tr>
<tr>
<td>Beaumont Hospital</td>
<td>5.5</td>
</tr>
<tr>
<td>RCSI</td>
<td>5.5</td>
</tr>
<tr>
<td>Post 3</td>
<td></td>
</tr>
<tr>
<td>RCSI</td>
<td>5.5</td>
</tr>
<tr>
<td>NAHB (Area 8)</td>
<td>3</td>
</tr>
<tr>
<td>Beaumont Hospital</td>
<td>2.5</td>
</tr>
<tr>
<td>Post 4</td>
<td></td>
</tr>
<tr>
<td>St. James’s Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Post 5</td>
<td></td>
</tr>
<tr>
<td>St. James’s Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Post 6</td>
<td></td>
</tr>
<tr>
<td>Tallaght Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Post 7</td>
<td></td>
</tr>
<tr>
<td>St. Michael’s Hospital, Dublin</td>
<td>4</td>
</tr>
<tr>
<td>St. Columcille’s Hospital, Dublin</td>
<td>4</td>
</tr>
<tr>
<td>Cluain Mhuire Service</td>
<td>3</td>
</tr>
<tr>
<td>Post 8</td>
<td></td>
</tr>
<tr>
<td>Limerick Regional Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Post 9</td>
<td></td>
</tr>
<tr>
<td>Cork University Hospital</td>
<td>11</td>
</tr>
</tbody>
</table>

Submissions

Two distinct views regarding liaison psychiatry emerged from the consultation process undertaken by the committee. Firstly, there was the view that each large teaching hospital should have a full-time liaison psychiatrist to deal with the full spectrum of psychiatric illness presenting in hospital inpatients, with other general hospitals being provided with a consultation liaison service by the sector consultant psychiatrists in the catchment area. The alternative (minority) view was that each of the consultant psychiatrists in the catchment area should provide a consultation liaison service to the relevant general hospital or that hospital inpatients should be looked after by their sector psychiatrist while in hospital being treated for other medical conditions. It was suggested that this model should not only apply to the smaller hospitals but also to the larger hospitals.
Recommendations

Comhairle na nOspidéal having regard to the distinct views expressed during the consultation process and the reported positive impact that the small number of liaison posts currently in place have had within the hospitals concerned, recommends that there should be a minimum of one post of consultant general adult psychiatrist with a special interest in liaison psychiatry in hospitals with 500 acute beds and in groups of hospitals with a minimum of 500 acute beds.

Similar to the arrangement recommended for old age psychiatry services, it is recommended that post holders with a special interest in liaison psychiatry, while based in acute hospitals, would work as an integrated part of the relevant catchment team and take part in the general adult psychiatry on-call rota. This arrangement would protect appointees in this area from professional isolation, ensure linkages with their colleagues in other areas of the psychiatry services and would provide emergency cover to their patients.

For hospitals that may not have the services of a consultant general adult psychiatrist with a special interest in liaison psychiatry, it is envisaged that sector psychiatrists would provide a consultation liaison psychiatry service to the hospital either on a rotational basis or by the designation of one of the consultant general adult psychiatrists as having the lead role in the provision of this service and their sector responsibilities being adjusted accordingly. For these hospitals the focus of the service would be on initial assessment and referral of the patient to their relevant sector psychiatrist if deemed necessary.

4.6.1 CHILD LIAISON SERVICES

During the discussions on liaison psychiatry, reference was made to child liaison services. It was noted that such a service exists within some areas where consultant child & adolescent psychiatrists have identified sessions to general and children’s hospitals. Comhairle na nOspidéal recommends that the HSE gives consideration to the development of such a service in other hospitals and regions when new and replacement consultant child & adolescent psychiatrist posts are being put in place by building into the post specific sessions for this purpose. It is noted that this has been done recently for two consultant child and adolescent psychiatrist posts for the HSE-South Western area which have designated sessions to Tallaght Hospital to provide a liaison service.

4.6.2 PERINATAL PSYCHIATRY

Perinatal psychiatry is liaison psychiatry to women who are either pregnant, have recently given birth or who have a psychiatric illness and are considering pregnancy. Comhairle na nOspidéal is of the view that perinatal psychiatry services should be provided by liaison or general psychiatrists as part of their general commitments to hospitals with maternity units. One of the existing posts of liaison psychiatrist is structured to include sessions to the Rotunda Hospital whilst the Coombe Hospital and the National Maternity Hospital, Holles Street have four designated sessions each from existing consultant general adult psychiatrist posts. In this context it is envisaged that perinatal psychiatry services will be provided for within the above recommended increase in liaison psychiatry posts.
4.7 ADULT FORENSIC PSYCHIATRY

Forensic psychiatrists work “at the interface of psychiatry and the law” (Irish College of Psychiatrists) and are involved in the treatment of mentally ill offenders within the prison population. Forensic psychiatrists also provide assessment and in certain circumstances treatment for disturbed psychiatrically ill individuals referred from the general psychiatry services. Forensic opinions on certain patients are also required of the forensic psychiatry service. Studies of the Irish prison population have reported that while 8% of the prison population have serious psychiatric disorders, there is a more widespread incidence of minor affective disorders, personality disturbance and drug and alcohol misuse. The forensic psychiatry service represents a highly specialised, national tertiary service providing conditions of special security (high & medium security) in the Central Mental Hospital.

As of 1st January 2005, there were five WTE posts of consultant forensic psychiatrist. The sessional commitment of the five posts is outlined below in Table 4.2

Table 4.2 Structure and sessional commitment of the five posts of consultant forensic psychiatrist

<table>
<thead>
<tr>
<th>Post No.</th>
<th>Central Mental Hospital</th>
<th>Prison Service</th>
<th>Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post No. 1</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Post No. 2</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Post No. 3</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Post No. 4</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Post No. 5</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

The patients likely to come within the remit of the forensic psychiatry services fall into three categories:

- Individuals found “not guilty by virtue of insanity” or found unfit to plead by the legal system
- Prisoners with mental illness
- Persons who have not offended or who have not been charged with an offence but who have a mental illness that results in their behaviour being characterised by violence. This violence is usually physical, is of a magnitude which puts others at risk and renders them unmanageable in general psychiatry outpatient settings or inpatients units. Such patients often have a dual diagnosis of a major psychiatric illness (such as schizophrenia or an affective disorder), which is associated with a personality disorder, substance misuse, or both.

At present, individuals in the first category are transferred to the care of the national forensic psychiatry service based at the Central Mental Hospital.

Service provision for the other two categories is run on parallel lines. Those in prison are the responsibility of the forensic psychiatry services. Those not in prisons are the responsibility of the general adult psychiatry services. From both perspectives this is unsatisfactory.

Key Issues

The committee identified five keys issues which needed to be addressed with respect to the delivery of a forensic psychiatry service nationwide. These were:

1. The difficulties encountered in general adult psychiatry services across the country in dealing with disturbed mentally ill patients whose behaviour renders them inappropriate for care in the
open environment of acute wards in psychiatric units in hospitals. These patients have traditionally been managed through admission to a locked ward in a large mental hospital, an option now considered unsatisfactory and no longer therapeutically acceptable.

2. Limited capacity at the Central Mental Hospital (CMH).
3. The difficulties encountered by the forensic psychiatry service based in the CMH when trying to refer patients back to their local general adult psychiatric services.
4. Access of prison services outside of the Dublin region to forensic psychiatry services.
5. Difficulties experienced by general adult psychiatry services across the country in trying to obtain a forensic assessment for patients in their service from the Dublin based forensic psychiatry service.

Department of Health & Children’s Report
The committee took due cognisance of the Department of Health & Children’s proposals and recommendations regarding the accommodation of disturbed mentally ill patients in the general adult psychiatry services. The recommendations, contained in the report entitled “Intensive Care Unit, Disturbed Mentally Ill” (2000), centre around the establishment of a Psychiatric Intensive Care Unit (PICU), with 10 – 15 beds each, in each health board region. The report envisages that each unit “should have the capacity to provide specialist multidisciplinary care and treatment for patients at several levels of security and observation” and “have the capacity to manage threatening, violent or self injurious behaviour and to provide active psycho-social rehabilitation and individualised therapeutic activity”. It is recommended in the Department’s report that “treatment programmes with the objective of discharging the patient back to less restrictive forms of care should also be an integral part of the units”. The Department of Health & Children envisages that the maximum length of stay for patients in a PICU should be two years.

Recommendations
1. Types of consultant posts
The committee in formulating its recommendations regarding the consultant staffing of forensic psychiatry services identified the potential for two types of posts to deliver forensic psychiatry services, one being a consultant forensic psychiatrist and the other being a consultant general adult psychiatrist with a special interest in forensic psychiatry.

It is expected that the first type of post holder would work full time in the national forensic psychiatry services. These posts would always be appointed to the Central Mental Hospital (CMH), and would provide forensic psychiatry services to local prisons and remand centres, a forensic consultation to general adult psychiatric services and would partake in the on-call rota operating at the CMH.

It is envisaged that the second type of post, i.e. one with a special interest in forensic psychiatry, would be used to meet a number of needs. These include providing a forensic psychiatry service to the local prison, providing a forensic consultation service to the local health region, providing a general adult psychiatry service and staffing the proposed PICUs. These posts should be incorporated into the local general adult psychiatric catchment team on-call rota.

2. Mentally ill patients within the criminal justice system
The committee believes that all prisons should have access to the services of a consultant psychiatrist with forensic training. The decision as to which of the above post types is required should be based on the number of prison places. Comhairle na nOspidéal recommends the continuation and extension of existing forensic psychiatry services within the Dublin region, i.e. full time
consultant forensic psychiatry posts, based in the CMH, with sessional commitments to Dublin prisons and the local health services.

Due to their proximity to Dublin and their operational capacity which would be comparable in size to the entire Mountjoy Complex, it is recommended that the Portlaoise Prison and the Midlands Prison be linked into the Dublin forensic psychiatry service. Comhairle na nOspidéal recently approved two replacement consultant forensic psychiatrist posts for the CMH in line with this recommendation. One of these posts is structured with three sessions to the Portlaoise Prison and three sessions to the Midlands Prison.

It is envisaged that the forensic psychiatry service needs of all other regions with prisons can be met by posts of consultant general adult psychiatrist with a special interest in forensic psychiatry due to the smaller operational capacities of these prisons. It is recommended that assessment of need in each region should be undertaken. Two such posts have already been approved by Comhairle na nOspidéal, one for the MWHB in October 2003 and one for the SHB in July 2004. The table below outlines the sessional structure of these two posts.

<table>
<thead>
<tr>
<th>Post</th>
<th>Prison Services</th>
<th>Forensic consultation to the region</th>
<th>General Adult Psychiatry Services</th>
<th>PICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>MWHB post</td>
<td>2 (Limerick Prison)</td>
<td>3</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>SHB post</td>
<td>3 (Cork Prison)</td>
<td>2</td>
<td>6 (Carraig Mór)</td>
<td></td>
</tr>
</tbody>
</table>

3. Violent disturbed mentally ill persons within the general psychiatry services

Comhairle na nOspidéal supports the Department of Health & Children’s proposal regarding the establishment of a Psychiatric Intensive Care Unit (PICU) in each health board region in order to provide for the care and management of the small number of patients in each region whose “disturbed behaviour is of such a serious nature or of such a prolonged duration as to be unmanageable in general psychiatric facilities and requires special accommodation and the care of appropriately trained personnel to adequately manage and care for them.” Comhairle concurs with the view expressed in the report that these units should form an integral component of the general mental health service in each region. **Comhairle na nOspidéal recommends that the PICUs be staffed by consultant general adult psychiatrists with a special interest in forensic psychiatry.** It is further recommended that holders of these posts be an integrated part of the relevant catchment team where the unit is based and take part in the general on-call rota which would include the PICU. It is felt that such an arrangement would protect these appointees from professional isolation, ensure linkages with their colleagues and would provide emergency cover to their patients. Patients in the PICUs who are considered to require more secure settings than the unit can offer, can be transferred to the Central Mental Hospital, and when appropriate, can be transferred back to the PICU.

4. Integration of Services

With respect to the proposed Psychiatric Intensive Care Units (PICUs), Comhairle na nOspidéal recommends that the Department and the HSE prioritise the development of these units in areas which are in close proximity to prisons. This will allow the appointee providing forensic psychiatry services to the local prison to assume responsibility for the PICU as has been done in the southern region, or depending on the workload, a second appointment could be made. This latter option would have the added advantage of addressing the issue of single-handed appointments in these prisons and PICUs.
Comhairle na nOspidéal envisages that with the continuation and extension of services based in the CMH and the development of posts of consultant general adult psychiatrist with a special interest in forensic psychiatry, a much more cohesive and streamlined forensic service will be provided throughout the country.

It is noted that in discussions with the forensic services based at Dundrum, it is proposed to develop specific liaison relationships with all prisons and regions in the country. This will facilitate the building up of a collegiate network which would allow for a co-ordinating approach to the provision of forensic psychiatry services in Ireland. This would involve each CMH consultant having responsibility to build a relationship with a particular prison/area of the country and travel there approximately 10 times a year.

In light of the limited capacity at Dundrum, Comhairle na nOspidéal did consider whether PICUs would be able to a) provide inpatient care for low security prisoners and b) act as a step down route for patients from Dundrum before they return to their local general adult psychiatry service. However, Comhairle was informed by the forensic psychiatry services in the CMH that at present 120 patients per year are admitted to the CMH. It is anticipated that the CMH will be able to admit up to 300 patients per year when the five multidisciplinary teams, each led by a consultant forensic psychiatrist, are operational. It was indicated that this figure would cover the inpatient needs of mentally ill prisoners. In addition, it was envisaged that PICUs would have insufficient security to ensure that all prisoners were retained as the CMH is legally obliged to do. With respect to PICUs acting as a step down route for patients referred directly to the CMH from local adult psychiatric services, it was proposed that the units would be too secure. Treatment for such patients in the CMH includes a series of step down procedures through different levels of security. One of the last types of accommodation used by patients is hostel accommodation under the remit of the CMH. In this context the PICUs would actually represent a step up.

Below is a diagrammatic representation of how Comhairle na nOspidéal envisages forensic psychiatry services will be provided to both prisoners and non-prisoners at a national and local level.

Diagram 4.3  Diagrammatic representation of how Comhairle na nOspidéal envisages forensic psychiatry services will be provided to both prisoners and non-prisoners at national and local level.
4.8 REHABILITATION PSYCHIATRY

Rehabilitation psychiatry focuses on the psycho-social rehabilitation of psychiatric patients, sometimes in conjunction with de-institutionalisation and the transfer of patients from old psychiatric hospitals into community settings. While rehabilitation and the social management of patients are part of the task of all general adult psychiatrists, rehabilitation psychiatrists deal with the impairments, disabilities and handicaps of long-term chronic psychiatric illness. Rehabilitation psychiatrists require support from, and links with, a variety of rehabilitation facilities and organisations.

"Planning for the Future" (1984) noted that "The primary aim of rehabilitation programmes is to re-integrate mentally ill persons with their community. It follows that rehabilitation services within hospitals should have a strong community orientation and must, if they are to be effective, be accompanied by a simultaneous development of support facilities in the community . . . Many persons living at home or in community residential occupation need rehabilitation services. The patient should be thoroughly assessed and offered rehabilitation services geared to meet his or her needs. A rehabilitation service should always be provided on a day attendance basis and would in many cases form a large part of the service provided at day facilities."

As of 1st January 2005, the consultant establishment in general adult psychiatry with a special interest in rehabilitation was 7 WTE posts.

Table 4.4 Structure and sessional commitment of the seven posts of consultant general adult psychiatrist with a special interest in rehabilitation

<table>
<thead>
<tr>
<th>Post No.</th>
<th>Hospital Mental Health Service</th>
<th>Sessional Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>St. Brendan’s, Dublin Area 7</td>
<td>11</td>
</tr>
<tr>
<td>2</td>
<td>St. Ita’s Hospital Area 8</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Beaumont Hospital</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>St. Loman’s Area 4/5</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Tallaght</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Ennis General Hospital Clare MHS</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>St. Bridgid’s Hospital, Ballinasloe East Galway MHS</td>
<td>11</td>
</tr>
<tr>
<td>6</td>
<td>St. Davnet’s, Monaghan Cavan/Monaghan MHS</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Sligo General Hospital Sligo-Leitrim MHS</td>
<td>11</td>
</tr>
</tbody>
</table>

Recommendations

Comhairle na nOspidéal notes that during the consultation process support had been expressed by the majority of parties regarding designated posts with a special interest in rehabilitation in each region. Some health boards did indicate though that the service could be provided by sector psychiatrists on the same model as for other non-designated special interests.
Comhairle na nOspidéal recommends that there should be one post of consultant general adult psychiatrist with a special interest in rehabilitation per 100,000 population, i.e. one per average sized catchment area. This recommendation will lead to 40 WTE posts nationally in this area of psychiatry, an increase of 33 posts. It is envisaged that these consultants would oversee the provision of psychiatric rehabilitation services in each region by –

1) providing on-going psychiatric services and support to those patients with chronic enduring mental illness,
2) providing consultant services and input to day hospitals, hostels and sheltered accommodation and
3) supporting and leading the continuing efforts on the part of employing authorities to facilitate the transfer of care of psychiatric patients from institutional to community settings.

It is noted that with the closure of old style psychiatric institutions, it is vitally important that community services are adequately resourced to receive and support patients from acute hospitals, who, due to the chronic nature of their condition, may have in the past been placed in the old style institutions. Rehabilitation psychiatry has a key role to play in this area in community services.

Comhairle na nOspidéal recommends that consultant psychiatrist posts in this area should initially be linked to old style psychiatric hospitals or institutions responsible for the care of long term psychiatric patients where these are present, in order to focus on the transfer of patients to the community. In the absence of this service being developed and supported, the mental health service will be in danger of developing a “new long stay” group of patients within the acute hospital setting.

In addition to links with old style psychiatric hospitals, postholders in this area should still have a substantial commitment to the care of patients in the community. In the Dublin region, it is recommended that, where feasible, posts should link in with the neuro-rehabilitation services provided in the National Rehabilitation Hospital, Dun Laoghaire.

Similar to the arrangement recommended with respect to old age psychiatry and liaison services, it is recommended that rehabilitation psychiatrists work as an integrated part of the relevant catchment area team and take part in the general adult psychiatry on-call rota. This arrangement would protect appointees in rehabilitation psychiatry from professional isolation, ensure linkages with their colleagues in other areas of the psychiatry services, provide emergency cover to their patients and enable smooth transfer of care between services for patients.

It is noted that local circumstances will have a big effect on the development of this specialty, as a number of consultant general adult psychiatrists have already begun to develop rehabilitation services or have expressed an interest in so doing within existing catchment areas. In 2004, the NEHB, with Comhairle approval, formally converted a vacant consultant general adult psychiatrist post in Cavan/Monaghan into one with a designated special interest in rehabilitation, thereby reconfiguring consultant psychiatric staffing to incorporate the formal provision of an already established rehabilitation service. How rehabilitation services are provided or initiated will therefore not be the same across all regions, as local arrangements may significantly influence the organisation and initiation of the service.

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4 A new long stay patient is defined as one who passes from under one year of continuous in-patient hospital care to over one year in that care (Health Research Board)
4.9 NEUROPSYCHIATRY

Neuropsychiatrists deal with patients with acquired gross brain/spinal cord dysfunction where macroscopic or microscopic changes in structure are visible. As defined by the Irish College of Psychiatrists, neuropsychiatry focuses on patients, whose disordered brain function is causing psychological, psychiatric, behavioural or cognitive difficulties, resulting in major impairment of an individual’s function. “Patient groups falling into this category include brain-injured patients, early onset dementias, diagnoses such as epilepsy, multiple sclerosis, some neurosurgical patients, patients with psychiatric sequelae of conditions such as Huntingdon’s disease, Wilson’s disease, Creutzfeldt-Jakob disease and prion diseases, HIV associated illness and post-encephalitic states.”

There is no post of consultant general adult psychiatrist with a special interest in neuropsychiatry in the Republic of Ireland.

Recommendations

Comhairle na nOspidéal believes posts specialising in neuropsychiatry in neuroscience units incorporating neurosurgery would have merit. The two neurosurgical/neuroscience units in the country are located in Beaumont Hospital and Cork University Hospital. It is recommended that the HSE give consideration to the possibility of having at least one post of consultant general adult psychiatrist with a special interest in neuropsychiatry and support team per unit and that these posts would have academic commitments given the research and teaching potential of such work. It is envisaged that close collaboration between the holders of these posts and the neurology and neurosurgery services, the neuro-rehabilitation services based in the National Rehabilitation Hospital in Dun Laoghaire, the national spinal injuries unit in the Mater Hospital and rehabilitation psychiatry services would be required.
4.10 SUBSTANCE MISUSE

4.10.1 ADULT SUBSTANCE MISUSE PSYCHIATRY

Psychiatric co-morbidity has long been recognised as presenting a particular set of challenges in the care and management of patients with a history of substance misuse. Research carried out by the Drug Treatment Centre Board, Dublin, indicated that 50% of individuals attending the DTCB met Research Diagnostic Criteria (RDC) for depressive illness at some stage in their past. As of 1st January 2005, the consultant establishment in general adult psychiatry with a special interest in substance misuse in the public sector was 6 WTE posts. Of these 6 posts, five are based in the HSE-Eastern region and one is based in the HSE-Midland area.

The extent of substance misuse in Ireland is considerable. A study carried out by the Eastern Health Board in the late 1990’s estimated that there were between 12-14,000 persons in need of methadone treatment within the Dublin region. The Drug Treatment Centre Board, to which all five Dublin posts have sessional commitments ranging from 2 – 8 sessions per week, recorded 1,462 individuals accessing its services in 2003, of which 902 were entered into the Centre’s treatment programme. The remaining 506 clients received a variety of services, which included psychiatric, psychological and social interventions. Recent figures published by the Drug Treatment Centre indicate that as of 31st December 2003, there were 6,883 individuals on the methadone treatment list in Ireland, representing a 91% increase in the number of people since 1998, when the figure stood at 3,610.

In 2000, the Midland Health Board recorded 499 new clients accessing its substance misuse counselling service, with alcohol disorders accounting for over 25% of admissions to its two acute psychiatric inpatient units.

Within substance misuse psychiatry, separate services have evolved to manage drug misuse and alcohol dependence leading to different arrangements in the regions in the country that have the services of a consultant general adult psychiatrist with a special interest in substance misuse. All five Dublin posts specialise in drug misuse whilst the Midland region post specialises in both drug and alcohol misuse. With respect to psychiatry services being involved in the treatment of alcohol misuse, different representations were made to the committee. The Irish College of Psychiatrists expressed the view that “psychiatrists are the appropriate doctors to manage alcohol dependence”, whilst the view of the Inspector of Mental Hospitals was that “uncomplicated alcohol-related problems are not subject to inpatient care and …..detoxification is a general medical activity and not one of psychiatry”.

Recommendations

In making its recommendations Comhairle na nOspídéal took account of the above views in relation to separate or combined services, the appropriateness of psychiatry in treating alcohol misuse, and submissions received from various parties. In addition a meeting was held with three consultant psychiatrists with a special interest in substance misuse based in the Dublin region.

1. It is recommended that each region serving a population of 300,000 would have at least one post of consultant general adult psychiatrist with a special interest in substance misuse. The exact number necessary for each region will be determined by demographics factors and the prevalence of substance misuse in the region. Some regions, for example the eastern region, will require a higher ratio of posts per population given the extent of the drug misuse problem in Dublin.
2. Comhairle sees scopes for two models of service delivery in this area of psychiatry i.e. a service that specialises solely in drug misuse and a service that specialises in both drug misuse and alcohol misuse. It is recommended that ideally, especially outside urban areas, the mixed model, whereby a post specialises in both alcohol and drug misuse, be adopted. However, it is recognised that ultimately the decision as to whether posts with a special interest in substance misuse deal with drugs only, or drugs & alcohol, will be influenced by local circumstances within each region, each of which may have different priorities and be facing different levels and mix of substance misuse. Due cognisance would also need to be given to existing local services, both voluntary and statutory, their structure, capacity, integration and delivery within each region.

3. It is further recommended that in structuring consultant general adult psychiatric posts with a special interest in substance misuse, consideration be given by employing authorities to incorporating sessional commitments to nearby prisons, as has been done for three of the Dublin area posts.

4. Comhairle na nOspidéal recognises that a large number of other services and agencies, both medical and non-medical, are involved in providing services in the area of substance misuse. It is recommended that all consultant psychiatrist-provided services in substance misuse develop links with these other services and agencies including primary care, counselling services and voluntary agencies. This will facilitate a good network of communication and co-ordination across the spectrum of services available to deal with substance misuse.

4.10.2 CHILD & ADOLESCENT SUBSTANCE MISUSE PSYCHIATRY

In September 2002, Comhairle na nOspidéal approved the first post of consultant child and adolescent psychiatrist post with a special interest in substance misuse for the South Western Area Health Board with one session per week to the Drug Treatment Centre in Pearse Street, Dublin. Comhairle recommended that the appointee to the post would develop strong links with the adult substance misuse service, thereby preventing professional isolation and also facilitating the smooth transfer of patients from the child and adolescent service to the adult service where necessary. A second such post was approved in July 2004 for the NAHB, structured 6 sessions to the health board, 2 sessions to the Mater Hospital, 2 sessions to the Drug Treatment Centre and 1 session to the SWAHB.

It is important that postholders in this area develop links with general consultant child and adolescent services, both for referral purposes and to prevent professional isolation from the general child & adolescent service.

Comhairle na nOspidéal has not made specific recommendations regarding the numbers needed of such posts required, but rather advises the HSE that if deemed appropriate, taking into consideration relevant factors such as demographics, prevalence of substance misuse among young people in the region and services currently available, consideration would be given to developing this type of service.
4.11 PSYCHOTHERAPY

Psychotherapy is considered by the Irish College of Psychiatrists to be the “most appropriate treatment for the broad categories of personality disorder, non-psychotic depressive illness, psychoneurosis, sexual dysfunction, eating disorders, adjustment and post-traumatic disorders.”

Psychotherapy is one of the methods of treatment available to all consultant psychiatrists. Supportive psychotherapy, which entails general support, discussion and exploration of issues, should be available to all patients. However, the extent to which the more detailed psychotherapies are practised by individual consultant psychiatrists is frequently limited by time. More detailed psychotherapies are time consuming, involving in some forms and in some cases, at least weekly sessions for one hour with individual patients, sometimes for one year or more.

Psychotherapy is an established specialty in the USA, Australasia, Europe and the UK, with most European training guidelines requiring all psychiatrists to be trained in dynamic, behavioural, family therapy and cognitive psychotherapies. Comhairle na nOspidéal notes that the Irish College of Psychiatrists in line with the Royal College of Psychiatrists (UK) recommends one post of consultant psychotherapist per 100,000 population. However, the actual ratios in the UK are quite different, with England for example having one post per 540,000 population as of September 2003 (see table 3.17).

Comhairle na nOspidéal notes that although there are no officially designated consultant psychiatrists with a special interest in psychotherapy in the public sector in the Republic of Ireland, there exist a number of consultant general adult psychiatrists who have developed an informal special interest in psychotherapy. Psychotherapy is used by consultant psychiatrists in up to 50% of cases in treating child & adolescent psychiatric patients. In addition, a number of qualified psychotherapists from a non-medical background are employed in the health service to meet patients’ needs for such a service. There are also a small number of doctors practising psychotherapy in the private sector.

Recommendations

Comhairle na nOspidéal acknowledges the increased expectation of the public for a psychotherapeutic approach by the psychiatric service either as complementary to physical and social interventions or as an alternative to them. Comhairle notes that as of January 2005 the Royal College of Psychiatrists (UK) has stipulated that training in psychotherapy is a mandatory requirement for specialist psychiatric training. This stipulation will need to be met in Ireland, as all psychiatric training schemes organised and supervised by the IPTC receive their educational approval from the Royal College of Psychiatrists in London.

In addressing these issues, Comhairle notes that this report in its totality recommends a 50% increase in consultant posts. It is envisaged by Comhairle that this increase in posts will enable existing and new postholders to practise more frequently and extensively the detailed psychotherapies with their patients. The major obstacles to doing this at present cited by the psychiatry profession were heavy workload commitments and lack of time.

With a view to aiding the development of formalised training modules in psychotherapy in order to meet that training requirements identified by the Royal College of Psychiatrists (UK) and to oversee the co-ordination of these training modules, Comhairle na nOspidéal recommends the creation of a small number of posts of consultant general adult psychiatrist with a special interest in psychotherapy, one post linked to each of the medical schools and based in the relevant catchment area. Where feasible, these posts should be formal academic posts, thereby enhancing their education and training role. It is envisaged that in addition to aiding the organisation and development of training in psychotherapy, the holders of these posts will also provide a clinical service in psychotherapy to patients.
In order to ensure the integration of postholders in this area with their colleagues in other areas of psychiatry and to overcome the professional isolation that can be associated with single handed posts, each of these postholders should work as an integrated part of a catchment team and take part in the general adult psychiatry on-call rota in the catchment area where they are based, akin to the arrangements recommended for old age psychiatry, liaison psychiatry and rehabilitation psychiatry.

In order to support the development and increased availability of psychotherapy within the mental health service as a whole, Comhairle na nOspidéal recommends that the HSE and the Department of Health and Children aim to increase the number and harness fully the expertise that is available from non-medical psychotherapists with relevant qualifications and expertise in psychotherapy.
4.12 HOMELESS MENTALLY ILL

As of March 2002, estimates of the number of homeless by local authorities using the definition of homelessness provided in the Housing Act, 1988, puts the total figure at 5,581 in the Republic of Ireland, with the Dublin area having the highest figure at 4,060. The mortality rate amongst the homeless is very high, with homeless people dying younger and having a markedly higher incidence of psychiatric illness than the general population. Studies indicate a 40% prevalence of psychiatric illness amongst this section of the population.

Comhairle na nOspidéal recognises the complex nature of homelessness and the wide variety of socio-economic conditions including unemployment, poverty and violence in the home, which can give rise to a person becoming homeless. Comhairle, in particular, notes a report entitled “Homeless & Mental Health – A Research Report” (1998), which states that “there appears to be compelling evidence that national health strategies in the form of deinstitutionalisation of patients from psychiatric hospitals is implicated in homelessness. The first feature of this process, the discharge of psychiatric patients to community accommodation does not appear, at least in England and Ireland, to be responsible for increasing the homeless population. However there is evidence that the second element of the deinstitutionalisation process, the reduction of psychiatric hospital beds, has influenced the number of homeless people. The old large-scale psychiatric hospitals appear to have performed an important residual accommodation function for some people, particularly men. This accommodation option is no longer available.” This belief is also supported by a number of individual consultant psychiatrists, some of whom are currently working with homeless mentally ill people within the eastern region. It is clear that comprehensive social, medical and rehabilitative strategies need to be developed and implemented in a national context in order to reduce the substantial psychiatric morbidity in this section of the population.

At present, there are three WTE posts of consultant general adult psychiatrist which have designated responsibility for the homeless mentally ill. All three posts are in the Dublin region, with two based in St. Brendan’s Hospital. These three posts have been included in previous figures regarding general adult psychiatry.

Recommendations

Outside the Dublin region, though the problem of homelessness exists, the numbers may not justify the appointment of a consultant psychiatrist to deal with the issue on a full time basis. Therefore it is recommended that the psychiatric needs of homeless people in each region would be assessed and that services for them would be structured accordingly. Where numbers justify it, consideration should be given to one of the existing sector consultant psychiatrists within a catchment area, having two to three sessions per week designated to the homeless mentally ill. These postholders could lead the delivery of mental health services to the homeless mentally ill, advise on the development of homeless services and aid co-ordination of services.
4.13 SUICIDE & DELIBERATE SELF HARM

In 2003, 444 people in the Republic of Ireland died by suicide of which the majority were male (81%). Suicide accounted for 29% of all deaths in the 15-24 year old age bracket, making it the biggest cause of death for that age group. The National Task Force on Suicide which published its report in 1998 reported that in terms of economic productivity the cost of 280 young adult suicides between 1991 and 1994 is estimated to amount to approximately 75.6 million pounds (96 million euro). If suicides among those in older groups were added the economic cost would be considerably more. The effect in terms of human suffering is immeasurable, with suicide having a major and lasting impact on family, friends and the wider community. Mental illness, particularly depression, has long been recognised as a major contributing factor in suicide. Alcohol and drug misuse is increasingly being recognised as a contributory factor in some suicides.

Comhairle na nOspidéal acknowledges that suicide is generally agreed to be a societal problem and that a comprehensive approach involving many agencies is necessary to reduce the number of deaths. In making its recommendations regarding this sensitive issue, Comhairle feels that though psychiatric services should not be made solely responsible for dealing with suicide, as many people who commit suicide do not express suicidal intentions or present themselves to the health services seeking treatment, it does feel that psychiatric services should play a vital and pivotal role.

Recommendations

Comhairle na nOspidéal feels it is necessary and essential for psychiatric services to be actively involved in the development and implementation of strategies designed to prevent suicide, generate and promote awareness about the risk of suicide and provide a comprehensive service to individuals who deliberately self harm. The Report of the National Task Force on Suicide 1998 made a number of recommendations of relevance to Comhairle.

Comhairle na nOspidéal recommends that every person presenting in A&E with deliberate self harm be seen by a member of the liaison psychiatrist team based in the hospital or in the absence of a liaison team, be seen by a member of the relevant sector based psychiatric team before being discharged from hospital.

It is further recommended that each psychiatric team treating cases of deliberate self harm, nominate a health professional to oversee the future management of these patients, and that the patients be made aware of who this person is.

Certain groups are at a greatly increased risk of suicide. These include psychiatric patients in the period after their discharge from inpatient care, prisoners, young men, drug and alcohol abusers and the homeless. Comhairle na nOspidéal recommends that each local mental health service develop multidisciplinary guidelines for the recognition, treatment and follow-up of patients at risk and that pre-discharge assessments on patients leaving in-patient psychiatric care have regard to this high risk in newly discharged patients.

To support these developments and promote seamless transfer of care between services, Comhairle recommends increased levels of communication between all relevant parties involved in developing and implementing protocols dealing with cases of deliberate self harm and at risk patients. Relevant parties include hospital services, prison services, mental health services and primary care.
4.14 ACADEMIC PSYCHIATRY

Academic psychiatry includes the planning, organisation and implementation of undergraduate and postgraduate psychiatric education and the design, planning, implementation and publication of research work. Psychiatrists with formal and recognised teaching and research responsibilities were first appointed within the Irish psychiatric services towards the end of the 1960’s. These consultant psychiatrists usually hold the title of ‘Professor’ or ‘Senior Lecturer / Lecturer’, have attachments to a teaching hospital and one of the five medical schools – University College Dublin, Trinity College Dublin, Royal College of Surgeons in Ireland, University College Cork and University College Galway - and may hold the academic contract if considered a “full-time” academic within the terms of the Consultants’ Contract by the relevant medical school.

As of 1st January 2005, the consultant establishment in academic psychiatry was 18, comprising 10 posts categorised as full-time academic and 8 posts categorised as part-time academic. Twelve of the eighteen posts are in general adult psychiatry; four are in child and adolescent psychiatry and two in liaison psychiatry. These posts will have been included and counted in the relevant earlier sections of the report.

Table 4.5 Distribution of full time and part-time permanent academic consultant psychiatrist posts between the five medical schools as approved and recorded by Comhairle na nOspidéal.

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Specialty</th>
<th>Full-time</th>
<th>Part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.C.D.</td>
<td>General Adult Psychiatry</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Child &amp; Adolescent Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T.C.D.</td>
<td>General Adult Psychiatry</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Child &amp; Adolescent Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R.C.S.I.</td>
<td>General Adult Psychiatry</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Liaison Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.C.C.</td>
<td>General Adult Psychiatry</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>N.U.I. Galway</td>
<td>General Adult Psychiatry</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Recommendations

Comhairle na nOspidéal supports an increase in academic consultant psychiatrist posts in order to increase academic development and research in psychiatry and enhance undergraduate and postgraduate training. It is hoped that the recommendations contained in this report regarding increases in consultant psychiatric staffing for the mental health service as a whole will encourage the creation of additional academic posts within psychiatry. Comhairle notes that the academic component of these posts will need the support of an appropriate infrastructure in order to facilitate and enable high quality teaching and research. Evidence based research on the value of psychiatry generally and specific psychiatric interventions and therapies would also be facilitated by such appointments.

As happens in many other medical specialties, heads of academic departments, assistant professors, senior lecturers and lecturers often carry full-time or virtually full-time clinical commitments in addition to teaching and administrative duties. In this context, Comhairle na nOspidéal would urge that academic sessions of consultant posts be protected from clinical pressures and that the holders of academic posts be required to undertake clinical work and partake in the on-call rota in a manner that is in proportion to their defined clinical commitment. The Comhairle na nOspidéal report, “Report of the Academic/ Clinical Research Consultant Committee” (2002), explores the issue of posts at consultant level that would further contribute to medical research and makes a number of recommendations regarding how best these posts can be incorporated and facilitated within the Irish health system.
4.15 MENTAL HEALTH ACT 2001

The primary aim of the Mental Health Act 2001 is to provide for changes to the existing rules on admission to psychiatric hospitals, in particular the procedures for the involuntary detention of people for psychiatric treatment. The Act provides for an independent review procedure in the case of all involuntary detentions. It is the most significant piece of legislation in relation to mental health services for over fifty years and brings Irish mental health law into conformity with the European Convention for the Protection of Human Rights and Fundamental Freedoms. The Act provided for an independent Mental Health Commission, which was duly established in 2002, and whose primary function is to “promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services”.

Of the 25,000 adult admissions to psychiatric facilities each year in Ireland, approximately 10% are involuntary admissions. One of the primary roles of the Mental Health Commission is to review and oversee all involuntary admissions and detentions. This will be carried out via the establishment of mental health tribunals by the Commission. The tribunals, consisting of three people, one being a consultant psychiatrist, will be obliged to complete each review within a 21 day period, either upholding the detention order or revoking it. Intrinsic within this review process is the requirement that every involuntarily admitted patient be examined by an independent consultant psychiatrist appointed by the Commission. This examination will be in addition to the examination by the consultant psychiatrist on the staff of the centre where the patient is located. This will be done in order to determine in the interests of the patient whether the patient is suffering from a mental disorder. The need for a second assessment of each involuntarily admitted patient by an independent consultant psychiatrist will have an impact on the workload of the psychiatric services.

The Mental Health Act 2001 also lays out procedures to be followed regarding the involuntary admission of persons under 18 years of age. In these cases, the relevant health board must make an application to the relevant District Court for an order authorising the detention of the child in an approved centre.

Recommendations

It is hoped that the recommendations contained in this report regarding increases in consultant psychiatric posts for the mental health services as a whole may address to a certain extent the additional consultant staff required to implement the Mental Health Act 2001. It is not yet clear to Comhairle or the psychiatry services how exactly the Act will affect service provision and what regions, if any, will require additional posts. It is recommended that each region and psychiatric service monitor the impact of the Act on service provision and that if necessary this is an area that should be reviewed in the future.
4.16 ROLE OF PRIMARY CARE

The majority of mental health services are provided in primary care settings. Studies have indicated that fewer than 10% of individuals with mental illness are referred to specialist mental health services by primary care (WHO 2001, Gask & Croft, 2000). These findings are supported by a recent survey of general practitioners in the then South Western Area Health Board, in which 85% of the GPs who took part in the survey (response rate of 64%) indicated that they referred fewer than 5% of their patients with mental illness to mental health specialists (Mental Health in Primary Care, 2003). In a complementary survey of consultant psychiatrists in the SWAHB, 63% of consultant psychiatrists (response rate of 77%) indicated that at least 80% of their patients were referred to them by GPs.

The role of primary care in the delivery of mental health services and its interaction with specialist mental health services is therefore of paramount importance, on account of GPs’ gatekeeper role, their leadership role within primary care and the levels of mental illness that are treated within primary care settings. This latter aspect will only increase in the future in light of mental health services becoming more community orientated, with many individuals suffering from chronic mental illness living in the community and receiving services from their general practitioners as well as their consultant psychiatrist.

In examining the role of primary care in mental health services, a number of issues were identified by Comhairle na nÓspidéal. These included:

- the insufficient mental health training provided to general practitioners despite the fact that they may treat 90% of individuals with mental illness,
- the lack of formal communication between the two services, i.e. primary care services headed by general practitioners and specialist psychiatric services headed by consultant psychiatrists,
- the variety of routes used by general practitioners to refer their patients to specialist mental health services, with some for example referring to hospitals whilst others refer directly to the relevant sector consultant psychiatrist,
- dissatisfaction among GPs regarding the organisation of psychiatric services into sectors which provides them with only one service and consultant psychiatrist to refer their patients to,
- the belief among consultant psychiatrists that a significant portion of patients referred to specialist services would be more appropriately treated within primary care,
- uncertainty amongst general practitioners regarding the exact role of allied health professionals, what services they offer, to whom and how accessed.

Recommendations

General practitioners and primary care have a crucial role to play in the delivery and development of mental health services, and with mental health services moving towards a more community based model, there is an even greater need for closer collaboration between specialist mental health care teams and primary care teams. The national strategy for primary care in Ireland, “Primary Care, A New Direction” (2001), focuses on the introduction and development of multidisciplinary primary care teams, to include GPs, nurses/midwives, social workers, OTs and physiotherapists. These primary care teams in turn will be supported by a wider primary care network of other health care professionals such as speech and language therapists, community pharmacists and psychologists. The Strategy also promotes the development of integration initiatives, aimed at enhancing communication and exchange between primary and secondary care. These initiatives will involve the development of referral guidelines and protocols for consultant care and diagnostic services, the development of integrated care pathways facilitated by key workers, the development of individual care plans for particular cohorts of patients that are appropriate to their needs and the putting in place of shared care arrangements for specific health conditions. These developments will further enhance the ability of primary care to treat and support patients with mental illness in the
community, as well as facilitate co-ordinated interaction and communication with specialist psychiatric teams. GPs working in teams as envisaged in the Strategy could even facilitate individual GPs to develop special expertise and interest in mental illness, allowing them to provide a lead role in mental health issues within their primary care team catchment population.

Taking due cognisance of the above, Comhairle na nOspidéal therefore makes the following recommendations:

- Joint development by primary care and mental health teams of protocols and pathways of care, addressing issues like detection, assessment, treatment and referral for mental ill health. It may be that different protocols may need to be developed for different illness for example depression versus schizophrenia.

- Improved communication between primary care and specialist mental health services. This could be initiated in a variety of ways including regular face-to-face contact between the consultant psychiatrist and the GP to discuss patient cases, relocation of consultant psychiatrist delivered outpatient clinics to primary care settings thereby facilitating greater links and informal meetings between the GP and psychiatrist and/or the designation of individuals to act as a liaison person between the two services.

- Improved undergraduate and postgraduate medical education and training on identifying and treating mental illness in primary care.

- A single referral point for general practitioners to mental health teams for their patients, in order to ensure that the patient receives the appropriate care by the relevant professional without unnecessary delay.

- Improved dissemination of information to primary care regarding the availability of mental health services, addressing such issues as the location of mental health services, who provided by, how accessed and types of patients eligible. This exercise could be co-ordinated by the relevant sections of the Health Service Executive.
5.1 NATIONAL MODEL
This report details a plan for the development and expansion of each of the key specialty and sub-specialty areas of psychiatric services and consultant psychiatrist staffing in Ireland. The diagram below provides an overview regarding how Comhairle na nOspidéal envisages consultant psychiatrist services being organised and staffed with respect to sector sizes of approximately 50,000 and catchment populations of approximately 100,000. These services will be supported by additional specialised consultant services which will have a larger population base.

Catchment Area Consultant Psychiatrist Team (pop. 100,000)
- 4 general adult psychiatrists
- 2 child & adolescent psychiatrists
- 1 learning disability – adult
- 1 old age psychiatrist
- 1 rehabilitation psychiatrist
- 0.5 learning disability – child & adolescent

Additional consultant services overlaying catchment populations (pop. 300,000)
- substance misuse
- liaison psychiatry
- psychotherapy (as appropriate)
- forensic psychiatry (as appropriate)

Sectors
Individual catchment areas will be composed of 2 – 4 sectors. In line with recommendations made in this report, consideration should be given to combining existing sectors to give rise to larger sectors of approximately 50,000.
A summary table detailing the existing number of consultant posts in the key psychiatric specialties, the recommendations made in relation to each, and the proposed future consultant staffing in each psychiatric specialty is given below.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Permanent consultant posts as of 01.01.05 (WTE)</th>
<th>Recommendation</th>
<th>Additional Posts (WTE)</th>
<th>Future consultant posts (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Adult Psychiatry</td>
<td>152</td>
<td>1 per 25,000</td>
<td>5</td>
<td>157</td>
</tr>
<tr>
<td>s.i. liaison</td>
<td>9</td>
<td>1 per 500 acute beds</td>
<td>9</td>
<td>18+</td>
</tr>
<tr>
<td>s.i. forensic</td>
<td>2</td>
<td>Dependent on development of PICUs</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>s.i. rehabilitation</td>
<td>7</td>
<td>1 per 100,000</td>
<td>33</td>
<td>40</td>
</tr>
<tr>
<td>s.i. substance misuse</td>
<td>6</td>
<td>1 per 300,000</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>s.i. psychotherapy</td>
<td>0</td>
<td>1 per medical school</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Psychiatry of Learning Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s.i. adult</td>
<td>22.5</td>
<td>1 per 100,000</td>
<td>17.5</td>
<td>40</td>
</tr>
<tr>
<td>s.i. child &amp; adolescent</td>
<td>10.5</td>
<td>1 per 200,000</td>
<td>9.5</td>
<td>20</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>50.5</td>
<td>2 per 100,000</td>
<td>27.5</td>
<td>78</td>
</tr>
<tr>
<td>s.i. substance misuse</td>
<td>2</td>
<td>Dependent on local needs</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Continuation &amp; extension of services based at the CMH</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Old Age Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>1 per 100,000</td>
<td>19</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>287.5</strong></td>
<td></td>
<td><strong>132.5+</strong></td>
<td><strong>420+</strong></td>
</tr>
</tbody>
</table>

In examining current consultant psychiatrist staffing and services around the county, Comhairle na nOspidéal notes large discrepancies between different regions across the range of specialist services. In the context that the Health Service Executive is now responsible for developing an annual service plan for the health service as a whole and prioritising consultant posts nationally, Comhairle na nOspidéal recommends that in the short term priority be given to those HSE-areas that at present do not have services in place in particular specialties or which are understaffed relative to other regions. Details regarding current staffing levels as given in Chapter 3 of this report will aid this process.

It is envisaged that the increase in consultant psychiatrist posts recommended throughout this report will enhance the provision of a network of community and hospital based psychiatric services and will bring specialised multi-disciplinary psychiatric services within the reach of all, including GPs, social workers, hospital departments, voluntary agencies and individuals.
6.2 CONCLUDING REMARKS

Comhairle na nOspidéal believes that the recommendations set out in this report are in the best interests of patients who are entitled to the best service that modern medicine has to offer, judged by international standards. It is recognised that implementation of the recommendations set out in the report require additional and redirected resources, commitment on the part of all staff involved and will take time. Implementation of these recommendations will also require detailed planning by those involved in the organisation and delivery of psychiatric services.

Comhairle na nOspidéal feels that implementation of its recommendations will go a long way towards improving the current levels of psychiatric services and consultant staffing. It hopes that the increased number of consultants and the recommended organisational frameworks will facilitate the provision of enhanced psychiatric services nationwide and will have real benefits for patient care.
1. Activities of Irish Psychiatric Services 2003
   Health Research Board, 2004

2. Adults with Incapacity Act 2000
   Scottish Parliament, 2000

3. An Action Plan for Dementia
   National Council on Ageing and Older People, 1999

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5. A Handbook on Child and Adolescent Mental Health: Mental Health Services
   Department of Health (United Kingdom), 1995

6. A New Mental Health Act - White Paper
   Department of Health, Dublin, 1995

7. Alternative Acute Care - A Study in Mental Health Care

   Central Statistics Office, 2002

9. Changing Patterns in Mental Health Care
   World Health Organisation, 1980

10. Charter of Hospital Rights for Hospital Patients
    Department of Health & Children, 1991

11. Consultant Staffing
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    Royal College of Psychiatrists, 1999

13. Estimating Psychiatric Manpower Requirements based on patient needs
    Faulkner and Goldman, Psychiatric Services: 666-669, 1997

    Eastern Health Board, 1995

15. Green Paper on Mental Health
    Department of Health, 1992

16. Green Paper on Services for Disabled People
    Department of Health, 1984
17. Guidelines on Good Practice and Quality Assurance in Mental Health Services
   Department of Health & Children, 1998

18. Health of the Nation
   Department of Health (UK), 1995

19. Health Services Available for Mental Disorders in Later Life
   Clinical Review
   Dr. M. Wrigley, Irish Medical Times, Vol 33, No.44, October 29, 1999

   Cleary, A. & Prizeman, G. Social Science Research Centre, UCD, 1998.

21. Intensive Care Units. Disturbed Mentally Ill.
   Department of Health & Children, 2000

22. Irish Psychiatric Hospitals and Units Census 2001
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23. Joint Statement on an integrated mental health service for children and adolescents
   Royal College of Psychiatrists, 1995

24. Manpower and Training in Psychiatry
   Irish Psychiatric Training Committee, 1995

25. Medical Aspects of the Mental Handicap Services
   Comhairle na nOspidéal, 1988

26. Medical Manpower in Acute Hospitals
   Department of Health / Comhairle na nOspidéal / Post Graduate Medical & Dental Board
   Department of Health, 1993

27. Medical Manpower in Acute Hospitals – 2nd Report
   Department of Health, 1996

28. Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment.
   Conference proceedings

29. Mental Health in Primary Care
   M. Copty. Irish College of General Practitioners, 2003

30. Mental Health of the Nation, The Contribution of Psychiatry
    (Council Report CR16)
    Royal College of Psychiatrists, 1992

31. Mental Health: New Understanding, New Hope
    The World Health Report, 2001

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    Midland Health Board, 1998
33. Mental Illness in an elderly rural population in Ireland: a prevalence study.  
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34. Methods of working with primary care.  

35. Report of the National Taskforce on Suicide  
Department of Health and Children, 1998

36. NCHD Staffing Complements at 1st October 1998  
The Postgraduate Medical and Dental Board, 1998

37. NCHD Staffing Complements at 1st October 2000  
The Postgraduate Medical and Dental Board, 2000

38. NCHD Staffing Complements at 1st October 2002  
The Postgraduate Medical and Dental Board, 2002

39. Needs and Abilities - A Policy for the Intellectually Disabled  

40. Needs Assessment and Eating Disorders  
Treasure J. and Smith U. in Measuring Mental Health Needs, Gaskell, 2nd Edition

41. Population and Migration Estimates  
Central Statistics Office, 1999

42. Providing Specialised Services for Anorexia Nervosa  

43. Psychiatric Disorders in Mildly and Severely Mentally Retarded Urban Children & Adolescents; Epidemiological Aspects  

44. Psychiatric Morbidity and Mental Retardation.  In Psychiatric Illness & Mental Handicap  
Corbett, J.A.  (Eds. Snaith & James), 1979

45. Psychiatric Services at Consultant Level  

46. Psychiatric Services - Development Programme into the next Millennium  
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47. Psychiatry of Mental Handicap  
Members of the Sub-Committee of the Mental Handicap Section, Irish Division, Royal College of Psychiatrists, 1998

48. Quality & Fairness, A Health System for You  
Department of Health & Children, 2001
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Eastern Health Board Area
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National Disability Authority, 2003

Department of Health & Children, 1994

54. Social Public Services: Quality of Working Life and Quality of Service
J. Pillinger – European Foundation for Living and Working Conditions, 2000

55. Standards of Care
The National Association for the Mentally Handicapped of Ireland, 1999

56. The Development of the Psychiatric Services
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57. The Health Service Reform Programme
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Meltzer, H., Gatward, R., Goodman, R., & Ford, T., 2000

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Report of a Study Group on the Development of Psychiatric Services
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60. Together we stand: Child and Adolescent Mental Health Services
Health Advisory Service, UK, 1995

61. Walls of Silence - Ireland’s Policy Towards People with a Mental Disability
Annie Ryan, 1999

Department of Health & Children, 2001

Department of Health & Children, 2003
APPENDICES

APPENDIX A

MEMBERSHIP OF PSYCHIATRY COMMITTEE ESTABLISHED BY 8TH COMHAIRLE NA nOSPIDÉAL

Dr. F. Flynn (Chairperson), Consultant General Adult Psychiatrist, Sligo
Ms. C. Carney, Assistant General Secretary, Impact
Prof. A. Clare, Consultant General Adult Psychiatrist, St. Patrick’s Hospital, Dublin
Mr. D. Doherty*, CEO, Midland Health Board
Prof. B.G. Loftus, Professor of Paediatrics and Consultant Paediatrician, UCHG
Ms. W. O’Conghaile, Research Manager, European Foundation for Improved Living & Working Conditions
Ms. S. O’Sullivan, Councillor, Cork County Council
Dr M. Wrigley, Consultant Psychiatrist of Old Age, Dublin
Mr. T. Martin, Chief Officer, Comhairle na nOspidéal
Dr. D. Walsh, Inspector of Mental Hospitals and Consultant General Adult Psychiatrist, nominated by the Department of Health & Children

* Mr. Doherty now holds the position of CEO of the Office of Health Management and Director of the Health Boards Executive.

Ms C. Vincent and subsequently Mr. A. Condon was secretary to the committee. The 8th Comhairle’s term of office ended in December 2000. The psychiatry committee was asked to continue its work and to finalise its draft report. The 9th Comhairle, which took office in February 2001, considered the committee’s report in October 2001. Mr Condon had undertaken the research for and initial drafting of the report.

APPENDIX B

SUBMISSIONS RECEIVED AND MEETINGS HELD

In examining psychiatric services at consultant level, the committee engaged in a formal consultation and information gathering process which involved meetings with - and the receipt of submissions from -

- Health boards
- Voluntary hospitals
- The Irish College of Psychiatrists
- The Irish Psychiatric Training Committee
- Representatives of service providers in each health board area
- Representatives of the voluntary and community sector in psychiatry
- Representatives of professions allied to psychiatry.

Included in the submissions received by the committee, were those from

- AWARE
- Alzheimer Society of Ireland
- National Council on Ageing and Older People
- Schizophrenia Ireland
- GROW
- Recovery Ireland
- Mental Health Association of Ireland
- Bodywhys
- Psychological Society of Ireland

A number of personal submissions were also made to the committee by a range of individuals.
APPENDIX C

QUALIFICATIONS FOR CONSULTANT PSYCHIATRIST POSTS AS SPECIFIED BY THE HEALTH SERVICE EXECUTIVE

Note: Parts (a) and (b) of the qualifications apply to all posts. Parts (c) and (d) are specific to each post.

(a) Full registration in the General Register of Medical Practitioners maintained by the Medical Council in Ireland or entitlement to be so registered and

(b) The possession of the MRCPsych. or a qualification equivalent thereto and

6.1 Consultant General Adult Psychiatrist
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland or

(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in general adult psychiatry.

6.2 Consultant Child and Adolescent Psychiatrist
(c) (i) Inclusion on the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland or

(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in child and adolescent psychiatry.

6.3 Consultant general adult psychiatrist with a special interest in the psychiatry of learning disability/Consultant Psychiatrist of learning disability (adult)
(c) (i) Inclusion on the divisions of psychiatry and psychiatry of learning disability of the Register of Medical Specialists maintained by the Medical Council in Ireland or

(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which two years were in general psychiatry and two years were in learning disability psychiatry.

6.4 Consultant Child and Adolescent Psychiatrist with a special interest in the psychiatry of learning disability/Consultant Psychiatrist of learning disability (child & adolescent)
(c) (i) Inclusion on the divisions of child and adolescent psychiatry and psychiatry of learning disability of the Register of Medical Specialists maintained by the Medical Council in Ireland or

(ii) Seven years satisfactory postgraduate training and experience in the medical profession of which three years were in child and adolescent psychiatry and two years in learning disability psychiatry.

6.5 Consultant Psychiatrist in the psychiatry of old age
(c) (i) Inclusion on the divisions of psychiatry and psychiatry of old age of the Register of Medical Specialists maintained by the Medical Council in Ireland or

(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which two years were in old age psychiatry and two years in general adult psychiatry.

6.6 Consultant General Adult Psychiatrist with a special interest in substance misuse
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland or

(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in general adult psychiatry and

(d) including one year in substance misuse

5 The qualifications specified for consultant appointments are currently under review.
6.7 Consultant Child & Adolescent Psychiatrist with a special interest in substance misuse
(c) (i) Inclusion on the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland
or
(iii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in child & adolescent psychiatry.
and
(d) including one year in substance misuse

6.8 Consultant General Adult Psychiatrist with a special interest in rehabilitation
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland
or
(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in general adult psychiatry
and
(d) including one year in rehabilitation psychiatry.

6.9 Consultant General Adult Psychiatrist with a special interest in liaison psychiatry
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland
or
(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in general adult psychiatry
and
(d) including one year in liaison psychiatry.

6.10 Consultant Forensic Psychiatrist
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland
or
(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry
and
(d) including three years in forensic psychiatry.

6.11 Consultant General Adult Psychiatrist with a special interest in forensic psychiatry
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland
or
(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in general adult psychiatry
and
(d) including one year in forensic psychiatry.

6.12 Consultant General Adult Psychiatrist with a special interest in psychotherapy
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland
or
(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry of which three years were in general adult psychiatry
and
(d) including one year in psychotherapy.

6.13 Consultant Psychiatrist / Professor of Psychiatry or Consultant Psychiatrist / Lecturer in Psychiatry
(a) Full registration in the General Register of Medical Practitioners maintained by the Medical Council in Ireland or entitlement to be so registered
and
(b) The possession of the MRCPsych. or a qualification equivalent thereto
and
(c) (i) Inclusion on the division of psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland
or
(ii) Seven years satisfactory postgraduate training and experience in the medical profession including five years in psychiatry.
### APPENDIX D

#### SECTOR AND CATCHMENT AREAS.


<table>
<thead>
<tr>
<th>Health Board</th>
<th>Catchment Region</th>
<th>Catchment Population</th>
<th>Sectors</th>
<th>Sector Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHB</td>
<td>Laois/Offaly MHS</td>
<td>124,139</td>
<td>Portlaoise</td>
<td>44,845</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tullamore</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Birr</td>
<td>34,665</td>
</tr>
<tr>
<td></td>
<td>Longford/</td>
<td>105,000</td>
<td>Mullingar</td>
<td>48,631</td>
</tr>
<tr>
<td></td>
<td>Westmeath MHS</td>
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APPENDIX E

HIGHER SPECIALIST TRAINING IN PSYCHIATRY

Set out below is an extract from a document produced by the Irish Psychiatric Training Committee on
Higher Specialist Training in Ireland.

IRISH PSYCHIATRIC TRAINING COMMITTEE
HIGHER TRAINING PROGRAMMES LEADING TO AWARD OF CSDs IN PSYCHIATRY

PART I. GENERAL PSYCHIATRY

Training programmes leading to award of a single CSD in different specialties of psychiatry are
described in the first part of this document; those leading to award of dual CSDs are addressed in
the latter part.

Although training programmes are considered in terms of experience in certain clinical settings, the
Irish Psychiatric Training Committee (IPTC) and the Joint Committee on Higher Psychiatric Training
(JCHPT) have recently defined the educational goals of higher training for each psychiatric specialty,
in addition to the appropriate clinical experience. Details are set out in Part II of this document.

Trainees will have completed at least three years’ training in psychiatry prior to commencing higher
training and will have passed the MRCPsych. Examination. The usual higher training period will be
three years leading to a single CSD. When relevant, a fourth year of training will be available for
specific training needs relevant to special responsibility in a consultant post. More prolonged training
will be required for dual certification.

The IPTC and the JCHPT are keen to maintain flexibility in training programmes so that the individual
training programme is closely matched to a trainee’s needs. The training programme will be closely
related to future consultant appointment, taking into consideration relevant past experience and any
individual training needs.

I. SINGLE CSDS

In order to gain a CSD the individual will have acquired the professional attributes, skills in research
and audit, teaching, supervision and management outlined in Part II. The clinical experience of each
psychiatric specialty must include the basic skills of assessment and management of psychiatric
disorders and treatment, including psychological and physical approaches. In addition, core
knowledge and skills must be gained in the specified areas. Training should be planned prospectively
and the single CSD will be awarded on completion of training.

A. GENERAL (ADULT) PSYCHIATRY

The training period for this CSD will be three years. Two years are to be spent in general psychiatry.
A third year may be spent in psychiatric research or one of the other specialties. If this year is spent
in one of the sub-specialties of general psychiatry (liaison, substance misuse or rehabilitation) then
the IPTC will recognise this special experience.

In order to obtain a CSD in general psychiatry a trainee will have gained the core skills mentioned
above. The training programme required to obtain these involves weekly supervision by a training
consultant, attendance at clinical and academic meetings and involvement in a research programme
throughout the three years. The clinical experience will be gained in the following settings: inpatient wards for acute admissions, intensive care and rehabilitation, day hospitals and resource centres, outpatient clinics and hostels, sheltered workshops, primary care and home settings. The clinical experience in general psychiatry may be supplemented with specialist training in substance misuse, rehabilitation or liaison psychiatry. Additional training, including that in a fourth year if necessary, may be required for a trainee to apply for a particular consultant post. In these circumstances, a trainee will receive a CSD in the appropriate specialty (and not a dual CSD).

B. OLD AGE PSYCHIATRY
A three year training is required in order to obtain the knowledge and skills necessary for consultant appointment in this specialty. One of these years may be spent in general psychiatry (or one of its sub-specialties) or in any other psychiatric specialty.

C. CHILD AND ADOLESCENT PSYCHIATRY
The training programme for award of a CSD in this specialty lasts for three years, all of which must be spent solely in child and adolescent psychiatry. Experience gained in other specialties during this period will not count towards training for a CSD in child and adolescent psychiatry.

D. PSYCHIATRY OF LEARNING DISABILITY
Three years training are required for award of a CSD in the psychiatry of learning disability, of which one year may be spent in general psychiatry or another appropriate psychiatric specialty.

E. FORENSIC PSYCHIATRY
The three year period required for award of a CSD in forensic psychiatry must be devoted solely to this specialty.

F. PSYCHOTHERAPY
The three year training programme required for award of a CSD in psychotherapy may not include clinical experience gained in any other specialty.

PART 2. DUAL CERTIFICATION
The IPTC and the JCHPT accept that trainees should have the option of seeking dual certification. While the minimum duration of higher training for award of a single CSD is three years there is considerable overlap between some of the psychiatric specialties so that a full six year training is not required for dual certification. Training should be agreed prospectively and the dual CSD will be awarded on completion of the full programme of training.

A. DUAL CERTIFICATION INCLUDING GENERAL PSYCHIATRY
There is considerable overlap between the core knowledge and skills required for a CSD in general psychiatry and those required for other specialties of psychiatry (as listed in Part II). The degree of this commonality varies between specialties. Accordingly, programmes for dual certification involving general psychiatry will be as follows:

i. General Psychiatry and Old Age Psychiatry: the basic skills of assessment and management of psychiatric disorders and treatment, including psychological and physical approaches, are common to these specialist areas with some variation in emphasis according to the patient group. Thus, training will be of four years duration, comprising:
- one year of training in general psychiatry or one of its sub-specialties
- two years gaining clinical experience common to both specialties, in settings which are also common to both specialties (in practice one year of common training will be spent in old age psychiatry and one year in general psychiatry)
- one year of training in old age psychiatry

ii. General Psychiatry and the Psychiatry of Learning Disability: as above, there is more than 50% overlap in the training between these two specialties. Thus the training programme will last four years and comprise:
- one year of training in general psychiatry or one of its sub-specialties
- two years gaining clinical experience common to both specialties, in settings which are also common to both specialties (in practice, one year of common training will be spent in the psychiatry of learning disability and one year in general psychiatry)
- one year of training in the psychiatry of learning disability

iii. General Psychiatry and Forensic Psychiatry: the area of commonality between these two specialties is less than 50%. Therefore, the training programme will comprise:
- two years in general psychiatry
- one year gaining clinical experience common to both specialties, in settings which are also common to both specialties
- two years in forensic psychiatry

iv. General Psychiatry and Psychotherapy: a higher training programme in psychotherapy must include 900 hours of supervised clinical experience. However the area of commonality between these two specialties is sufficient to enable training towards a dual CSD to be obtained as follows:
- two years in general psychiatry
- one year gaining clinical experience common to both specialties
- two years in psychotherapy

v. General Psychiatry and Child and Adolescent Psychiatry: dual CSDs will not be available in these two specialties of psychiatry

B. DUAL CERTIFICATION - OTHER PROGRAMMES

It is envisaged that dual certification will not be sought in old age psychiatry in combination with either forensic psychiatry or the psychiatry of learning disability. However, there are areas of commonality between a number of pairs of psychiatric specialties, for which joint training programmes may be followed, as detailed below.

i. Psychotherapy and any other specialty: a five year programme comprising two years in each specialty and a year in common training (which must include adequate psychotherapy experience).

ii. Forensic Psychiatry and the Psychiatry of Learning Disability: a five year programme comprising two years in each specialty and a year in common training.

iii. Child and Adolescent Psychiatry and the Psychiatry of Learning Disability: the five year programme comprises one year in an area of commonality and two years in both child and adolescent psychiatry and the psychiatry of learning disability.
iv. Child and Adolescent Psychiatry and Forensic Psychiatry: training for a dual CSD will comprise two years in each specialty plus one year in an area of common training. NB. A four year training option remains available in forensic child and adolescent psychiatry (two years in child and adolescent psychiatry, one year in adolescent forensic psychiatry and one year in adult forensic psychiatry) but such a programme will lead to award of a CSD in child and adolescent psychiatry only.

v. Forensic Psychiatry and the Psychiatry of Learning Disability: the five year programme required for this dual CSD comprises two years in both specialties plus one year in an area of commonality.

3. THE PLACE OF RESEARCH IN HIGHER TRAINING
One year spent in relevant research may count towards training for a CSD in general psychiatry, old age psychiatry, psychiatry of learning disability, child and adolescent psychiatry, forensic psychiatry or psychotherapy. No research may be considered to contribute to higher training unless educational approval has been obtained from the IPTC. More detailed Guidance Notes on “Approval On Higher Training Gained In Research” are being prepared by the IPTC.

One year of training for a dual CSD in general psychiatry and old age psychiatry may be spent in research, provided it is undertaken with a balance of clinical experience per specialty. Where a trainee is undertaking any other combination of dual training it is unlikely that sufficient clinical experience could be gained if a year was devoted to full-time research. It is therefore anticipated that, with this single exception, programmes of higher training leading to dual certification will not include a research year.

The IPTC and JCHPT reserve the right to consider any individual training programme that varies from the above in order to allow trainees the flexibility to complete an individualised training programme to meet his/her needs.
APPENDIX F:

List of health board hospitals, general hospital psychiatric units and private hospitals as used in the report entitled “Activities of Irish Psychiatric Services 2003” by the Health Research Board.

<table>
<thead>
<tr>
<th>HEALTH BOARD HOSPITALS</th>
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| ECAHB                   | Central Mental Hospital, Dundrum  
                          | Cluain Mhuire Family Centre  
                          | Newcastle Hospital, Greystones  
                          | Vergemont Clinic, Clonskeagh |
| NAHB                    | St. Brendan’s Hospital, Dublin  
                          | St. Ita’s Hospital, Portrane  
                          | St. Vincent’s Hospital, Fairview |
| SWAHB                   | St. Loman’s Hospital |
| MHB                     | St. Fintan’s Hospital, Portlaoise  
                          | St. Loman’s Hospital, Mullingar |
| MWHB                    | St. Joseph’s Hospital, Limerick |
| NEHB                    | St. Bridgid’s Hospital, Ardee  
                          | St. Davnet’s Hospital, Monaghan |
| NWHB                    | Mental Health Services, Sligo  
                          | St. Conal’s Hospital, Letterkenny |
| SEHB                    | St. Canices’s Hospital, Kilkenny  
                          | St. Dympna’s Hospital, Carlow  
                          | St. Luke’s Hospital, Clonmel  
                          | St. Otteran’s Hospital, Waterford  
                          | St. Senan’s Hospital, Enniscorthy |
| SHB                     | Carraig Mór, Cork  
                          | St. Finan’s Hospital, Killarney  
                          | St. Stephen’s Hospital, Cork |
| WHB                     | St. Bridgid’s Hospital, Ballinasloe  
                          | St. Mary’s Hospital, Castlebar |
## GENERAL HOSPITAL PSYCHIATRIC UNITS

<table>
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<tr>
<th>ECAHB</th>
<th>St. Vincent’s, Elm Park</th>
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| NAHB  | Mater Misericordiae Hospital  
James Connolly Memorial Hospital |
| SWAHB | Naas General Hospital  
St. James’s Hospital  
Tallaght Hospital |
| MWHB  | Regional Hospital, Limerick  
Ennis General Hospital |
| NEHB  | Cavan General Hospital  
Our Lady’s Hospital, Navan |
| NWHB  | Letterkenny General Hospital |
| SEHB  | St. Joseph’s Hospital, Clonmel  
Waterford Regional Hospital  
St. Luke’s Hospital, Kilkenny |
| SHB   | Bantry General Hospital  
CUH  
Mercy Hospital, Cork  
Tralee General Hospital |
| WHB   | Roscommon County Hospital  
UCHG  
Mayo General Hospital |

## PRIVATE HOSPITALS

| Dublin Region | Bloomfield Hospital, Dublin  
Hampstead & Highfield Hospitals, Dublin  
Kylemore Clinic, Dublin  
Palmerstown View, Dublin  
St. John of God Hospital, Dublin  
St. Patrick’s Hospital, Dublin |