The Future of Psychiatry in Ireland

This report was prepared for Comhairle na n-Ospidéal by the Irish Division of the Royal College of Psychiatrists

January 1998
THE FUTURE OF PSYCHIATRY IN IRELAND

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January 1998

This report was prepared by the Executive Committee of the Irish Division of the Royal College of Psychiatrists under the Chairmanship of Professor M.G.T. Webb.
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THE FUTURE OF PSYCHIATRY IN IRELAND

Preamble

This report is prepared for Comhairle na n-Ospidéal, which has initiated a study of consultant needs in psychiatry. The report consists of an overview, with individual reports from the psychiatric specialties.

OVERVIEW

EDUCATION AND TRAINING.

Psychiatry requires an initial general medical training at both undergraduate and postgraduate level, the latter being frequently more extensive than the intern year. Specialty training in psychiatry includes education in several basic neurosciences, in psychology and in aspects of sociology. Psychiatric training is at general, followed by higher specialist level, and includes research training. Most Irish psychiatrists take the Membership of the Royal College of Psychiatrists as their specialty degree: this is taken in two parts, the second part after three years general psychiatric training. The MRCPsych is the usual basic requirement for entry to higher specialist training. There is no exit examination following higher training.

CLINICAL PRACTICE.

Practice includes working closely with other professionals for the benefit of the patient and family. Leadership of this multidisciplinary team falls to the Consultant Psychiatrist in view of his/her wide and lengthy training and contractual responsibilities. Medical investigations and therapies encompass a wide range, from the biological to the psychodynamic, the multidisciplinary team includes medical members with colleagues in nursing, psychology, social work and occupational therapy, whose
professions have made significant strides in organisation and expertise in recent years. Clinical practice includes also contact with physicians in primary care and community care and the involvement of other disciplines - e.g. clinical speech and language therapists, physiotherapists, as well as the usual panoply of hospital departments for medical investigations.

Clinical practice in psychiatry is unusual in that it involves admitting some patients against their will, working within specific mental health legislation. A new Mental Health Act is due this year, which will bring significant changes to clinical practice in this area, including a considerable increase in paperwork and attendance at appeals tribunals and etc.

Clinical practice, in common with other specialties, is increasingly concerned about difficult ethical and medico-legal issues. Such issues include those relating to compulsory admission, to biological treatments and to the reporting of any suspicion of child abuse.

THE SERVICE SETTING

The Government blueprint for service organisation, "Planning for the Future" (1984), lays emphasis on working outside as well as inside hospitals, caring for and treating patients in residential settings, in their homes, in group homes, in supervised hostels, in day centres and day hospitals in the community. The community dimension of this plan has been embraced by psychiatrists with varying degrees of enthusiasm, leading to geographical variations in the extent of development of community psychiatric care. Administrators on the whole have adopted these opportunities presented by the plan for community psychiatry, have reduced in-patient beds by a considerable number, and have developed some community facilities.

It has become clear from experience in this country and in other countries, particularly the UK and USA, that:

(1) Where adequate resources, especially well-trained and motivated staff are provided:

(a) Many patients do well, especially long-term patients, and have an enhanced quality of life in community facilities.
(b) Some patients still need ready access to short-term or long-term hospital stays.

(c) Good community care is not a cheaper option than hospital-based care.

(2) When adequate resources are not provided:

(a) Patients are deprived of adequate care, occasionally with tragic results (as well publicised cases testify).

(b) The community comes to distrust the development of care in the community and political moves follow which prove not to be in the longer term interests of patient care.

The Child Care Act of 1991 is likely to be followed by specific mental health legislation relating to the age of childhood. This has been raised in the Child Care Act to include 16 and 17 year-olds, and this change will have significant effects on the provision of care for this age group in particular. There is agreement among psychiatrists that special facilities will be required as this age group has different needs, including security needs, to the majority of younger children. At the moment the mental health needs of 16 and 17 year olds are looked after by general adult psychiatrists in the main.

Psychiatry is now developing acute in-patient care within general hospitals. This has led to new methods of working, a wider range of patients, more medical investigation of patients, an enhanced research impetus and greater interaction with general medical and other specialty colleagues. These developments should benefit the general as well as the psychiatric patient. Such changes are seen very positively by psychiatrists, but there has developed a need for regional secure units to care for highly disturbed and aggressive patients, who formerly were contained within the old mental hospitals but cannot be managed in the more open general hospital units. A further need for secure units is envisaged should the new Mental Health Act follow the White Paper (1995) in introducing direct court referrals to the general psychiatric service. One way or another, there is a clear need for an increased forensic psychiatry service, either to cope with patients in secure units or to develop a more comprehensive psychiatric service for the prisons.
Changes in the Irish population and its expectations and demand for first class services are also likely to lead to changes in service organisation. The population is becoming better educated and more psychologically sophisticated, it is increasing in age, there is a more vociferous unemployed group, and there is increasing involvement of young people in the abuse of a wider range of substances. These changes indicate a need for more psychological treatments, more therapists time, and more specific therapies and treatment settings appropriate for the elderly and drug and alcohol misuse. Reduction in psychiatric hospital beds has led to increasing numbers of severely ill patients in the community who need constant contact and supervision.

In a recent review in the British Journal of Psychiatry, Jones (1996) points out that the community, for patients, is often bleak: “an uncontrolled and uncontrollable environment”. It is often hostile in its response to patients with psychiatric disorders, and there is a high re-admission rate to in-patient facilities among patients placed in community residences, even from those with 24-hour professional supervision. Some patients also are better managed away from their families, whose life-long maladaptive functioning may have little prospect of change. Not all families respond even to highly skilled and prolonged psychosocial intervention, although less severe family disturbance may well benefit.

Where excessive responsibilities are placed on consultants who have inadequate support in terms of facilities and staff, poor morale in the service will result and a crisis of staffing will occur, as is currently happening in the UK. A sobering description of the difficulties encountered in delivering community psychiatric care in an inner city is given in a very recent paper by Connolly and colleagues (1996). A dramatic fall-off in recruitment to psychiatry in the UK has followed changes in service conditions, and recruitment shortage at all grades is now most severe in psychiatry above all disciplines (National Association of Health Authorities and Trusts, 1996).

The Tierney Committee is likely to recommend far-reaching changes in medical manpower in hospitals, which will have its effect on psychiatry as on all other specialties. These precise recommendations are not known at the time of writing and are not directly considered in this paper.
There has developed a welcome central strategy of involvement of medical consultants in planning and development of hospital and community based services and in the financial management of local services. To an extent this has occurred also in psychiatry, but the White Paper (1995) makes no such reference and indeed seems to erode the central position in these aspects of the RMS/Clinical Director. The Irish Division has made representations to the Department of Health on this and other issues relating to the proposed new Mental Health Act.

IMPLICATIONS FOR THE WORK OF CONSULTANTS IN PSYCHIATRY

Of particular relevance to this submission to Comhairle na n-Ospidéal are:

(a) The need for appropriate education and training, including suitable higher training which will not only ensure clinical competence, but will meet the various challenges indicated above by stimulating a spirit of enquiry, adaptability and leadership, alongside management skills.

(b) The need to encourage the evolving specialties. The concept of the catch-all, general “sector psychiatrist” (frequently referred to as the “barefoot psychiatrist”) of “Planning for the Future” providing almost exclusively the consultant service in adult psychiatry, is no longer tenable.

Issues referred to above lead urgently to the need for the development of the existing and evolving specialties, within the framework of modern services which integrate care outside and inside hospitals.

THE TRAINING OF CONSULTANTS

Higher Specialist Training in Ireland recently has been reorganised to constitute a national scheme (IPTC 1995). Higher training is available in General and Community Psychiatry (formerly called General Adult Psychiatry), Old Age Psychiatry, Mental Handicap/Learning Disabilities Psychiatry and Child and Adolescent Psychiatry. Guidelines of the Joint Committee on Higher Psychiatric Training, on which the IPTC is represented, are followed. Certain posts may be shared between these specialties - e.g. training in Old Age Psychiatry.
requires considerable experience in General and Community Psychiatry, and training in Mental Handicap/Learning Disabilities Psychiatry has been required by Comhairle to include significant experience in General and Community Psychiatry or in Child and Adolescent Psychiatry.

In addition, higher specialty posts have been developed on local initiative, but within the umbrella of training in General and Community Psychiatry, in Rehabilitation Psychiatry and in Substance Misuse. Trainees in General and Community Psychiatry may also obtain some experience in one of the other specialties or in full-time research when a post is available. Flexibility in training is also demonstrated by many General and Community trainees, who take the opportunity provided by study sessions to take a degree or diploma course in Psychotherapy or in Management Studies, though often at the expense of more detailed research work. Other trainees obtain higher training credit for time spent in appropriate clinical research.

GENERAL AND COMMUNITY PSYCHIATRY
(recently renamed by the Royal College of Psychiatrists: formerly 'General Adult Psychiatry')

The general psychiatrist in the Irish psychiatric services now has in almost all instances extended his/her activity into the community. The general psychiatrist provides and is likely to continue to provide the bulk of the consultant service in the country, even with the advent of further much-needed specialisation.

Whether this service will continue to be provided according to the geographical sector model is less certain, as this model does not always suit patients or their general practitioners. Also in certain areas and in recessionary times of poor provision of support staff and facilities the sector model leaves the general psychiatrist seriously over-loaded, with heavy responsibilities for seriously ill patients in the community, but without the means to provide a safe and adequate service. This situation exists now in some parts of the country.

Comhairle needs to scrutinise submissions seeking approval for consultant posts to ensure adequate support staff and facilities for each consultant. A consultant team requires administrative and clerical back-up, and clinical support in the form of trainee medical staff, nursing staff, occupational therapy, psychology and social work staff. There may be specific
support needs in certain specialties. Usual facilities include a safe number of in-patients beds for acute and long-stay patients; day hospital; day support and sheltered employment centres; medium and high-support hostels and group homes.

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. These patients mainly are suffering from chronic psychotic disorders and severe personality disorders; a few are homeless, but they may be considered separately. A model based on GP practices alone would not support these disorganised and isolated patients who are among the most needy of the mentally ill.

It is appropriate that different styles of care within General and Community Psychiatry should evolve, provided in due course that their methods of working, efficiency and quality of outcome are assessed. Individual consultants put different emphases on the social, psychological and biological aspects of their patients' illnesses; provided these aspects are all represented, different emphases are acceptable at our present state of knowledge of the origin and course of psychiatric disorders. Research studies seeking these origins and also assessing the effectiveness of different methods of care are proceeding and should be encouraged in this country.

The general and community psychiatrist deals with all-comers who are referred to the service. He/she is 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 many types. Patients are referred by general practitioners, accident and emergency departments, and by colleagues in other departments of the general hospital and community care. Only a small proportion of these patients will be referred on for specialist psychiatric care.

Each of the services which involve more than one consultant team has a need for a clinical director. This is a responsible and time-consuming leadership and administrative position which has a major impact on the effectiveness and efficiency of the service. It carries a
personnel and service planning and development role. The new Mental Health Act is likely to designate the clinical director’s post as statutory, with particular responsibilities - e.g. for patients who are to be admitted involuntarily to hospital. Acknowledgement must be made in the structuring of the clinical director’s post for these added dimensions to the ordinary consultant’s responsibilities. Sufficient time (2-3 sessions) must be allowed for these tasks.

General and community psychiatry consultants will continue to develop special interests and responsibilities apart from the acknowledged and emerging specialties - e.g. in affective disorders, in the psychiatry of AIDS, in biological investigations, and particularly in new forms of therapy such as cognitive treatments, or psychopharmacology. This tendency should be encouraged, to the point of facilitating tertiary referral from other catchment areas and health boards, especially to academic centres, such as occurs frequently with other medical disciplines. This pattern of referral will provide better services for patients, will aid the development of new therapies and specialties over time, but will need a more flexible use of beds and other facilities than is allowed at present by the strict geographical sector model.

In this way special responsibilities within general and community psychiatry may develop. Initially these may not require sessional time, but it should be possible for a service to restructure posts over time to allow for useful special responsibility developments. The key to enabling special responsibilities, and part-time specialty work to co-exist with sector responsibility lies in protected special sessions alongside reduced sector responsibility in general psychiatry.

In other words it is envisaged that the extent of sector responsibility will vary according to the number of general sessions to be worked by any one consultant. It may then be more convenient administratively for two consultants to continue to provide for a wider sector, sharing responsibility for a defined population according to the number of general sessions each provides. Sector size need not be cast in stone.

Accepting that the standard consultant clinical responsibility is for a population of 25,000 - 30,000 (Department of Health: “Planning for the Future”, 1984), it is important that certain sessions are protected appropriately, for administration (e.g. clinical director), teaching and research (tutors, academics), and special clinical responsibilities (e.g. rehabilitation,
consultant-liaison, psychosexual disorders, neuropsychiatry, eating disorders). The standard population responsibility would then be reduced in size according to the number of special sessions worked by each consultant in general psychiatry.

The population size of a sector responsibility should also be reduced where severe socio-economic deprivation exists (e.g. centre city districts, areas of high “Jarman index”) which brings increased psychiatric morbidity, or where a widely dispersed population requires a great deal of travelling time for staff. Alternatively the general population sector size might increase where a general and community psychiatrist is working alongside two or three specialty consultants (e.g. in rehabilitation, alcoholism, old age). These specialties will take some of the clinical load from a standard sector responsibility.

Some of the potentially full-time specialties e.g. psychotherapy, liaison psychiatry in a major teaching hospital, will not significantly reduce a sector general psychiatry responsibility, although providing a very valuable and improved service for important groups of patients, and also providing valuable education for medical staff and other health professionals.

All psychiatrists should have time for planning, audit, quality control and suitable innovation, or there will be slow change in the effectiveness of the overall service.

SPECIALTIES.

The well-established specialties in Ireland: child and adolescent psychiatry, mental handicap/learning disabilities psychiatry, forensic psychiatry run in essence full-time parallel services to general and community psychiatry. In the case of substance including alcohol misuse, the general and community psychiatrist deals with many emergency and routine issues, while the specialist runs a tertiary referral service.

In theory the emerging specialties, old age psychiatry, psychotherapy, liaison psychiatry and rehabilitation psychiatry could be managed as half-time specialties alongside a general and community psychiatric commitment. Experience here and in the UK has shown, however, that these specialists are much more effective in full-time posts. This is because of the continual and urgent demands of general and community psychiatry which absorb an excessive time and energy commitment on the part of consultants, always eroding the
specialty sessions and leaving the specialty underdeveloped. This is of course is a particular problem when clinical, clerical and administrative back-up is inadequate.

In rural areas, however, the smaller numbers of patients and larger distances involved may not allow a full-time post to be a realistic option for liaison psychiatry and rehabilitation psychiatry, leaving half-time commitments by the general and community psychiatrists as the more realistic option. A psychotherapy specialist who does not have to deal with emergency work in the usual sense, could travel widely in an area to provide training and sessional commitments with patients. Therefore, even in rural areas it would be preferable for a psychotherapist to have a full-time appointment. Old Age Psychiatry likewise should be developed as a full-time specialty.

The specialties may be listed according to custom and practice and to the nature of their evolving responsibilities and state of development:

**TABLE I**

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Urban</th>
<th>Rural</th>
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<tbody>
<tr>
<td><strong>Group A  Main-stream specialties.</strong></td>
<td></td>
<td></td>
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<tr>
<td>General and Community Psychiatry</td>
<td>FT</td>
<td>FT</td>
</tr>
<tr>
<td>Child and Adolescent Psychiatry (including Infant Psychiatry)</td>
<td>FT</td>
<td>FT</td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td>FT(HT)*</td>
<td>HT</td>
</tr>
<tr>
<td>Mental Handicap/Learning Disabilities Psychiatry</td>
<td>FT</td>
<td>FT</td>
</tr>
<tr>
<td>Old Age Psychiatry</td>
<td>FT</td>
<td>FT</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>FT*</td>
<td>FT/HT*</td>
</tr>
<tr>
<td><strong>Group B  Emerging specialties within General and Community Psychiatry</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison Psychiatry (including Perinatal Psychiatry)</td>
<td>FT</td>
<td>PT</td>
</tr>
<tr>
<td>Rehabilitation and Social Psychiatry</td>
<td>FT*/HT</td>
<td>PT</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>FT*/HT</td>
<td>FT/HT</td>
</tr>
</tbody>
</table>
Group C Require development in the public services, within General and Community Psychiatry

- Eating Disorders
- Psychosexual Disorders
- Personality Disorders (including the Homeless)
- Neuropsychiatry

Group D Require development, within Child and Adolescent Psychiatry

- Psychiatry of Infancy

Group E

- Academic and Training

FT = Full-time responsibility  HT = Half-time responsibility
PT = Part-time

*Specialists may provide services for more than one catchment area.

The Royal College of Psychiatrists has provided guideline figures for England and Wales for the number of consultants and the bed requirements for the different specialties. We consider these overall guideline figures to be appropriate also for Ireland, but would emphasise that consultant manpower and in-patient bed requirements need to planned locally, after a detailed assessment of need. These requirements must take into account socio-demographic factors, including social isolation, poverty, age and gender within a population, and existing local provisions. However we consider it is valuable to provide these outline figures which may help Comhairle na n-Ospidéal to review applications from a broad perspective, in addition to looking more closely at local need.
### TABLE II: Consultant Numbers

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Wtes per 100,000 total population</th>
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<tbody>
<tr>
<td>General &amp; Community Psychiatry</td>
<td></td>
</tr>
<tr>
<td>General Psychiatrists</td>
<td>3.3</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>0.1</td>
</tr>
<tr>
<td>Perinatal</td>
<td>0.1</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>0.4</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>0.6</td>
</tr>
<tr>
<td>Liaison psychiatry</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4.9</strong></td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>2</td>
</tr>
<tr>
<td>Learning Disabilities/Mental Handicap</td>
<td>1</td>
</tr>
<tr>
<td>Forensic Psychiatry</td>
<td>6 - nationally</td>
</tr>
<tr>
<td>Psychiatry of Old Age(^1)</td>
<td>1</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>0.8</td>
</tr>
</tbody>
</table>

\(^1\) This assumes that the population served has the national average of 16% of people over the age of 65. If this is not so, consultant numbers should be based on the number of people in this age group and estimated as 1 wte/10,000 population over age 65 years.

### TABLE III: Bed Requirements for different specialties of psychiatry

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>General &amp; Community Psychiatry (Acute)</td>
<td>44</td>
</tr>
<tr>
<td>Rehabilitation and continuing care for adults(^2)</td>
<td>90</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>5</td>
</tr>
<tr>
<td>Learning Disability/Mental Handicap(^2)</td>
<td>25</td>
</tr>
<tr>
<td>Forensic Psychiatry - high security beds in CMH</td>
<td>80</td>
</tr>
<tr>
<td>- medium security beds</td>
<td>50</td>
</tr>
<tr>
<td>- low security beds should be available in each catchment area.</td>
<td></td>
</tr>
<tr>
<td>Psychiatry of Old Age - Acute</td>
<td>1.5 per 1,000 population over 65</td>
</tr>
<tr>
<td>- Continuing care for dementia</td>
<td>3 per 1,000 population over 65</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td></td>
</tr>
</tbody>
</table>

\(^2\) Many of these places should be provided outside hospitals, in the community.
CHILD AND ADOLESCENT PSYCHIATRY
(see Appendix I)

The specialty is reasonably well developed in Dublin, Cork and Galway, but some Health Boards have yet to develop adequate services. Particular problems are caused by some posts being provided within the Community Care Programme. These posts are isolated from other psychiatric services and have stimulated virtually no educational or research activity, as junior medical staff have not been appointed and the consultants are poorly supported by other professional staff. These services need the appointment also of a clinical director. Also, there are no specialised in-patient beds for children with psychiatric disorder. The Irish Division deplores this situation and insists that Child and Adolescent Psychiatric Services should be provided in conjunction with the remainder of psychiatry.

Major problems are envisaged with the inclusion of 16 and 17 year olds with the age of childhood, in accordance with the Child Care Act (1991). The White Paper on A New Mental Health Act (1995) specifically involves consultants in Child and Adolescent Psychiatry with this age group, but staff and age-specific facilities including beds do not exist at present to cope with their care. It is true that this age group does not often fit easily within the General Adult Services either, as many adolescents are still closely dependent on their own families. The best solution may be to proceed as outlined in the White Paper but to insist that the Department of Health put in place appropriate staff and facilities.

Recommendations.

• A significant increase in consultant numbers is required to provide adequate services throughout the country, as discussed in the enclosed document from the specialty. The Irish Division recommends a figure of 2 consultants per 100,000 population, although this will rise if 16 and 17 year olds are to come under the care of consultants in child and adolescent psychiatry. This age group will also need a different range of services including day programmes and dedicated in-patient beds.

• Each consultant post should carry acute beds for highly disturbed children, at a rate of 5 per 100,000 population.
INFANT PSYCHIATRY

Within Child Psychiatry a rapidly growing sub-specialty, Infant Psychiatry, is of developing importance. The relationship between abnormal attachments between parents and infant, and the emotional and personality disorders of adult life leads to hope that preventative strategies may be put in place at this early stage.

Recommendations.

- A recognition of the potential value of infant psychiatry should be made at this time.
- Sessions for child psychiatrists at neonatal clinics and paediatric units for this work should be provided.

(See also Perinatal Psychiatry).

FORENSIC PSYCHIATRY

The involvement of psychiatrists with the assessment and treatment of mentally disordered offenders is well established, the most visible manifestation in Ireland being the Central Mental Hospital, Dundrum. There are just two consultant specialists in the country, although some general psychiatrists take a special interest in medico-legal aspects of psychiatry, and become involved in assessments related to criminal cases.

There is increasing awareness also of the need for expert forensic knowledge related to Mental Handicap and Child and Adolescent Psychiatry. Disturbed young people pose particular problems which have stretched the existing services beyond their capacities to manage.

Serious psychotic disorders have been reported to occur in about 8% of our prison population (Smith, 1995), but minor affective disorders, personality disturbance and drug and alcohol misuse are much more widespread in the prisons, and also require treatment.

The proposed new Mental Health Act is likely to recommend direct court referrals to the general psychiatric services, and the Irish Division has considerable concern that people with
severe or aggressive personality disorders may be inappropriately placed in general psychiatric facilities, where effective treatment for them cannot be provided.

**Recommendations.**

- The Division recommends a more comprehensive forensic psychiatry service to provide suitable treatment in the prisons and special units. In addition, if there were to be an effective gatekeeper system and adequate numbers of beds in secure special units, then psychiatrically ill patients from the courts/prison system could be managed outside prison.

- There is a growing need for forensic psychiatrists to provide assessment and care for the increasing numbers of aggressive psychiatrically ill individuals, many with dual diagnoses involving substance misuse, and also disturbed personality disordered individuals inside and outside the court/prison system. There is an immediate need to increase the number of consultants to 6 for the country. Special provision in addition will be required for young people and mentally handicapped individuals.

**MENTAL HANDICAP/LEARNING DISABILITIES PSYCHIATRY (see Appendix IV)**

This specialty is of course well established and consultants have been to the fore in pioneering care in the community for their patients over the last few decades. Large numbers of moderately mentally handicapped patients of all ages are now living successfully in houses and hostels with varying degrees of intensity of supervision.

In response to the requirement of Comhairle na n-Ospidéal that consultants should occupy two sessions weekly in General Adult Psychiatry, several different arrangements have been made with local services. While this does ensure closer contacts within the general services, the sessions tend to be spent in "special interest" work - e.g. Psychotherapy; Adolescent Psychiatry, because mainstream General and Community Psychiatry requires a continuity which cannot be provided in two sessions. The arrangements which have been made do, however, contribute usefully to the overall psychiatric services, and have led to more awareness by consultant colleagues of the work of mental handicap specialists.
Most mentally handicapped individuals with psychiatric disorder require separate treatment facilities than those of normal intelligence, as their assessment and treatment requires special skills and their behaviour may become more disturbed in a general setting which may not meet their needs.

There is a particular need for protection of patients with mental handicap from abuse, including sexual abuse. Mentally handicapped offenders on the other hand are presenting increasing management problems and again need specialised facilities and care.

**Recommendations**

- There should be one whole-time equivalent (WTE) consultant for 100,000 population for adult mentally handicapped patients and 0.2 WTE for 100,000 for children and adolescents. Again the latter figure may rise if 16 and 17 year olds are to be included.

- Each consultant should have access to a psychiatric unit specifically provided for those with mental handicap.

**OLD AGE PSYCHIATRY** *(see Appendix V)*

The rapid rise of the specialty of Old Age Psychiatry has demonstrated the benefits of specialisation. There are now just four consultants in Old Age Psychiatry, three in Dublin and one in the Mid-Western Health Board, whose jobs are full-time in this specialty. Their appointments have led to defined services for the elderly. These services integrate hospital and community facilities, and are clearly far more appropriate and effective for patients and their carers than those formerly provided in the old mental hospitals, which consisted largely of containment and physical care. The consultants work in close co-operation with their consultant psychiatrist colleagues in their catchment areas, as well as with the local consultants in Geriatric Medicine.

**Recommendations.**

- There is a strong case, spelled out in the document provided by the specialists in Old Age Psychiatry, for a substantial increase in their numbers throughout the country.
• Each urban catchment area should have the services of a full-time specialist in Old Age Psychiatry at a ratio of one consultant per 10,000 elderly population.

• Each consultant should be provided with the appropriate facilities to deal with both functional illness in old age and also with dementia associated with behaviour problems.

PSYCHOTHERAPY (see Appendix VI)

Psychotherapy is a well established specialty in the USA, Australasia, UK and most European countries. European training guidelines are being published which require all psychiatrists to be trained in the Psychotherapies: dynamic, behavioural and cognitive. Child and adolescent psychiatrists are also trained in family approaches e.g. systemic.

For the moment all services should have supra-catchment area specialists whose expertise is particularly available for teaching and supervision of junior medical and other staff. Psychotherapeutic understanding is a necessary part of all psychiatrists’ training, and is required for the treatment of a wide range of patients and interactions with relatives.

Although other disciplines may very effectively treat patients who are most likely to respond to psychotherapy, it is only the psychiatrist who is able to evaluate the need for complementary and alternative biological treatments. Again, medical psychotherapists are likely to develop new methods or approaches to helping the management of patients who present to our services (e.g. personality disorders) and who are not currently seen as responding well to present techniques of psychotherapy. An example is the extension of cognitive psychotherapy to the treatment of personality disorders, and the combination of such methods with pharmacotherapy.

There is no consultant psychotherapist in the Republic of Ireland’s public service, although a number of general consultants use psychotherapeutic approaches frequently in their practice. In Northern Ireland there are two half-time consultants in Belfast and one general consultant psychiatrist with special responsibility in psychotherapy. A further post is being processed. There is one SR post in the Republic and in Northern Ireland there are now Diploma and
Degree courses in clinical psychotherapy, with others being planned, demonstrating the increasing demand for higher training in the psychotherapies.

**Recommendations.**

- Four new consultant posts are recommended, two in the Eastern region, one in the West, and one in the Southern region. These whole-time consultants should be linked to University departments in order to provide for specialist psychotherapy training at both under-graduate and post-graduate level. The aim should be to create one whole-time equivalent consultant psychotherapist per 200,000.

- Following the creation of these posts, formal links should be established with some of the excellent training courses already in operation to enhance and broaden trainee psychiatrists' exposure to psychotherapy.

- Links with the established training programmes in Northern Ireland could also be developed.

**LIAISON PSYCHIATRY**

(see Appendix VII)

This specialty has developed rapidly in recent years in some of Ireland's general hospitals. The origins were laid down early in the century in the United States, the modern aim being to provide psychiatric, including psychological assessment, understanding and therapy for the benefit of patients attending the various departments throughout the general hospital, including the accident and emergency department.

Here there are two current models. The first is the consultation model, whereby psychiatrists provide assessments of patients on the general wards and in the Accident and Emergency Department, they sometimes prescribe acute treatment, but more often recommend treatment elsewhere in psychiatric facilities or recommend discharge home if urgent psychiatric treatment is not required. The consultations may be provided by general "sector" psychiatrists on patients who live within their sector boundaries.

The attraction of the consultation model is its limited cost. The disadvantages are the limited care provided (the general psychiatrist often must fit in the consultations at the end of a busy
day or week, and may not have specialised knowledge relating to the needs of medically ill patients); the uncertainties of responsibility for patients who live outside geographically defined sectors of the psychiatric service; the limited interaction between general staff and psychiatrists which allows little education on psychiatric, including psychological understanding relating to their patients; and the perpetuation in the minds of general staff of the stigma of mental disorder, as the principal issue becomes one of disposal.

The second is the liaison model, which involves a specialist who is trained in liaison psychiatry. The specialist has particular knowledge of psychological issues and reactions of staff and patients to disorders encountered throughout the general hospital, and an expert knowledge of appropriate treatments, pharmacological and psychological within the general hospital context. The liaison psychiatrist not only treats patients directly, but through frequent contacts with general consultants and staff is able to put in place suitable programmes of assessment and care for patients of the specialist departments; is able to educate general staff in psychological aspects; and can contribute to research studies which take account of psychological issues, including quality of life, pain relief, treatment compliance, communication with patients and relatives, suicidal ideation, dying and bereavement.

In practice the liaison model becomes the consultation-liaison model. Essentially this is a pragmatic approach recognising that for many patients a consultation model is sufficient whereas for the complex problems combining both medical and psychiatric dimensions then a liaison approach is more appropriate. For this model a full-time liaison psychiatrist is required who usually works with a multi-disciplinary team. The liaison psychiatrist's catchment area is essentially the hospital in which he/she works. Close links are formed with the hospital consultants as well as the community psychiatric services, primary care and community care services. As well as providing psychiatric assessments, specialised services can be developed in conjunction with the specialised services offered by the hospital, e.g. National Cardiac Transplantation Unit, National Renal Transplantation Unit, National Bone-Marrow Transplantation Unit, National Neuro-surgery Unit.

The superiority for patient care of the consultation-liaison model cannot be questioned; the apparent disadvantage is cost, but it is certain that many seriously ill patients who receive
appropriate psychiatric and psychological care recover more rapidly and need less hospital care overall.

Recommendations.

- There is an urgent need for specialist consultation-liaison psychiatry in each of the large general teaching hospitals; the specialist should be full-time, as there is more than enough work to justify a special team, and the work will not be eroded by urgent catchment area responsibilities. In smaller hospitals the consultation model may still satisfy the increasing demand, but protected sessions should be set aside for these consultations.

PERINATAL PSYCHIATRY

Liaison work at maternity units and hospitals has for long been a valuable feature of Irish psychiatry. The initiative was taken by the maternity hospitals, who recognised the major contribution psychiatrists can make to the health and psychological adjustment of pregnant women and recent mothers. The major psychiatric illnesses presenting in pregnancy and in the puerperium are an obvious target for intervention by psychiatrists, and specialised knowledge is particularly valuable in view of the many endocrine and metabolic disturbances which occur. In addition, the perinatal psychiatrist can provide advice concerning screening for psychiatric disorder, psychological and physical stresses, treatment regimes, compliance with treatment relationship issues, and so on.

Recommendation.

- Sessions for liaison work in maternity units and hospitals should be provided by liaison psychiatrists or general psychiatrists with special responsibilities.

REHABILITATION AND SOCIAL PSYCHIATRY

Rehabilitation and effective social management of patients, particularly long-term patients, are part of the task of all general psychiatrists. In the more densely populated catchment areas in particular there is a strong case for one consultant taking on the supervision of residential homes, hostels and day centres, to liaise with local rehabilitation organisations, to plan
individual programmes, to ensure fair distribution of places between the sector teams in communal rehabilitation facilities, and to oversee the day-to-day running of these facilities.

Recommendations.

- Were this consultant to take over the full care of all patients in these facilities, then this would constitute a full-time position in the more densely populated catchment areas. For the most part, however, we envisage this as a part-time responsibility, at three sessions per 100,000 population, as his/her consultant colleagues will continue the overall care of many patients in the residential homes and day centres.

SUBSTANCE MISUSE: (see Appendices IX(a) and (b))

Drug Misuse And Alcohol Dependence

In recent years separate services have developed to manage drug misuse and alcohol dependence. The Irish Division is in favour of the separate development of these specialties, as the age mix, family involvement and range of needs of these two groups of patients tend to be quite different. Certainly, abusers of illicit drugs may go on to misuse alcohol or may do so concurrently, but the life styles of such drug abusers can be very different to those of most alcoholics, and the two groups are not appropriately treated together.

Political pressure has led to funding for new appointments of consultants in drug misuse in Dublin this year, and it is likely that further such psychiatric appointments will be needed both in Dublin and in other urban centres in the coming years. Close working arrangements with medical consultants who care for AIDS patients have developed appropriately. It is essential that specialists treat or at least closely supervise the treatment of drug misusers, as general medical doctors do not have the training to manage alone the very difficult psychosocial issues involved.

Psychiatrists are also the appropriate doctors to manage alcohol dependence. Indeed the complex interplay of physical and psychosocial factors involved in the origins and effects of alcohol dependence demand the knowledge and skills of psychiatry, while the complex behaviour of alcoholics and the suitable treatment regimes call for the expert management of a specialist. Traditionally alcoholics have been managed by general adult psychiatrists, and to
an extent this practice will need to continue because of the large numbers of patients with alcohol dependence requiring treatment, but the availability of experts for the more difficult patients and to develop effective treatment programmes and conduct research is important.

Alcoholics have usually been the first group of patients to be managed mainly outside hospital (often appropriately), when in-patient beds were reduced. There has been, however, a worrying further trend to avoid treating alcoholics altogether and to divert them to voluntary or private facilities which may not be medically supervised. Alcohol manifestly has serious acute and chronic effects on the brain, as on other organs of the body. The Irish Division deplores the attitude which has been developing that such patients have brought about their own difficulties, should not, therefore, take up expensive medical time and facilities, but should find such help elsewhere as they can. Alcohol addiction in fact renders individuals poorly capable of managing themselves and their own affairs.

The psychological, physical (including the results of accidents) and social toll due to alcohol abuse and dependence among alcohol addicts, and the major long-term psychological effects on their spouses and children, cry out for the skilled intervention of psychiatrists.

It is relevant that two of the six “key areas” contributing significantly to premature mortality, identified by the Government’s health strategy for the 1990s (Shaping a Healthier Future), are Alcohol and Causes of Accidents.

Recommendations.

- Separate services for drug misuse and alcohol dependence should be developed, including provision for separate consultant specialists.

- The rising number of drug misusers require further consultant appointments and comprehensive services for drug misuse.

- The Irish Division therefore favours the appointment of specialists in alcohol dependence, to provide appropriate management, research, supervision, education and training.

- In urban areas, therefore, it is recommended that full-time consultants are appointed to each of the specialty areas. Each would provide tertiary referral services and would
also act as an advisory, educational and research resource. Each consultant would work in collaboration with colleagues in general and community psychiatry, who will have many patients with dual diagnosis of psychiatric disorder and drug or alcohol misuse.

- Specialists in drug misuse may also work with colleagues in primary care, who undertake the management of drug abusers. Although need is difficult to judge, there is probably an immediate requirement for another consultant in drug misuse in Dublin and one further in each major urban centre.

- Alcoholism is still an important reason for admission to psychiatric hospital, most general psychiatrists, forensic psychiatrists and liaison psychiatrists are involved in treating alcoholics. Many patients can be treated as out-patients with a suitable detoxification and management programme in place, or at least medically supervised psychotherapeutic programmes available.

- The number of tertiary referrals centres and consultants needed in the country depends not so much on the actual number of alcoholic patients, which is enormous (e.g. a quarter to a third of male patients in medical beds in general hospitals satisfy diagnostic criteria for alcohol dependence), but on the priority which our society may put on treating alcoholics. A start may be made by creating two dedicated units in Dublin and one each in Cork, Galway and Limerick.

In rural settings part-time specialists should be encouraged; who might assess and treat drug and alcohol misuse within their own catchment areas.

**EATING DISORDERS**

(see Appendix X)

Patients with severe anorexia nervosa, bulimia nervosa and obesity are notoriously difficult to treat. They carry a high mortality rate of between 10 and 18%. The detrimental effect of such an ill person on a family and household is enormous. The only factors correlating with outcome include early recognition, early intervention and the skill of the treatment team.
Specialists have emerged who treat these disorders as a major part of their service commitment. The sub-specialisation is recognised internationally and Dublin hosted the European Council on Eating Disorders in 1995.

The numbers of severe anorexic and bulimic patients is equal per capita to the UK. Obesity has not become the large problem it is in the United States. Anorexia nervosa and bulimia are two areas of medicine that are very well described and a very real impact can be made given specialised facilities.

Recommendations.

- Unless there is going to be one large national resource serving the country, full-time specialists in eating disorders are probably not warranted given the finite resources available. Special interest posts with one in each region are already needed in the public service. Treatment teams are multi-disciplinary and the consultant psychiatrist in charge of the unit has both a supervisory or administrative role in leading the team in addition to direct patient management. The treatment of bulimia nervosa does not require in-patient facilities. It can be managed on an out-patient basis but does require specialised knowledge.

The alternative is that health boards be prepared to send patients to the few units available in the country in voluntary and private hospitals funding treatment out of current budget rather than having initial capital expenditure.

PSYCHOSEXUAL DISORDERS

Sexual dysfunction is common, but patients are slow to come forward for treatment. Increasingly individuals who have been victims of sexual abuse, particularly in childhood, are seeking help later in life.

Many of those with sexual deviations e.g. paedophilia, would be best treated by forensic psychiatrists who have received appropriate training. The number of transsexuals seeking assessment for gender reassignment surgery is increasing.
Behaviour therapy and dynamic psychotherapy plus medical knowledge for possible physical conditions leading to sexual dysfunction form an appropriate professional background for assessment and therapy. Skills in marital therapy may often help, and trained counsellors may take on much of the psychotherapy, under supervision.

At the moment a small number of psychiatrists is providing these services in Ireland, but demand is growing rapidly.

Recommendations.

- A half-time consultant and team is likely to be needed in the next few years in each region in the public psychiatric services.

PERSONALITY DISORDERS

A major debate on the extent of psychiatry's commitment to people with personality disorders is likely in the next few years, because of the demands placed on the services by young people who repeat suicide attempts; those who have seriously disturbed relationships with others; people who have psychopathic traits and offend against society; and homeless and wandering people who live in varying unsatisfactory relationships with society but who do not seek or respond to conventional services.

All of these people with personality disorders present a formidable challenge, and all general and community psychiatrists have a number of such patients under their care. They were probably managed more effectively through the structures and tolerance provided by in-patient stays in the older psychiatric hospitals, but they do not fit easily into modern community based services, where they can be disruptive and non-compliant with treatment plans.

Recommendations.

- These recommendations are made in advance of the report of the Department of Health Working Group on the Disturbed Mentally Ill. A number of patients will benefit from special treatment approaches, including the need for institutional care and special units. These should be units of increasing levels of security, i.e. "special units" (acute and long-term), "medium secure units" (longer-term), "high security unit"
(Central Mental Hospital, Dundrum). Offenders may be cared for in all three types, but forensic psychiatrists should direct the medium and high security units. Dublin should have at least one acute special unit, one long-term special unit, and one medium secure unit, in addition to the Central Mental Hospital. Initially these units would also care for those with mental illnesses, but experience may dictate separate units for the psychotic patients. Two special units and one medium secure unit will be necessary in the rest of Ireland also. Consultants could work full-time or half-time in these units. Specialist psychotherapy skills will be essential.

**THE HOMELESS MENTALLY ILL**

The targeted group of homeless individuals constitutes a core of people who usually do not stay in touch with the health services, and perhaps 40% of whom suffer or have suffered from major psychiatric disorders. Substance misuse is a common co-morbid condition.

**Recommendations**

- This group needs an assertive, outreach approach to care which demands a specialised team approach. It is suggested that each Health Board assess the medical including psychiatric needs of its own group of homeless people and provides services accordingly.

- The one specialist in Dublin for this group, based at St Brendan’s Hospital considers that a specialist is required in each major population centre to plan and co-ordinate services, while each catchment area should have a consultant with nominal responsibility for the homeless who would liaise with the regional responsible consultant.

**NEUROPSYCHIATRY**

This speciality is due for development in Ireland. It will deal with the assessment and management of patients where frankly disordered brain function causes psychological, behavioural and cognitive difficulties, resulting in major impairment of an individual’s
function. Assessment cannot always lead to long-term provision of care, but such patients with marked behavioural disorders may require on-going neuro-psychiatric management.

Patients needing assessment include brain injured individuals (from external or internal insults), early onset dementias, some patients with epilepsy, multiple sclerosis and other neurological disorders. Many show co-morbid mood disorders and psychoses.

The neuropsychiatrist may advise and co-ordinate services for such patients who at present are found in hospital and community settings of all types. In this way there are similarities with the work of the specialist psychiatrist of old age.

Recommendations.

• The consultant neuropsychiatrist's team should include trainee psychiatrists, neuropsychologist, occupational therapist and social worker. A small number of assessment beds and out-patient assessment facilities are required, with access to appropriately staffed continuing care beds for patients requiring long-term placement, probably including a secure facility. Close collaboration with the neuro-rehabilitation service in the National Rehabilitation Hospital in Dun Laoghaire should occur.

• Because of the research and teaching potential of such work, posts should have university affiliation. Two full-time posts would be appropriate for the start-up, perhaps both in Dublin, but forming links with all the Health Boards. It is likely that a third post would be justified within 10 years.

ACADEMIC PSYCHIATRY (see Appendix XV)

Psychiatry was seen as the poor relation within medicine until very recently. Academic departments within Irish medical schools have developed only since the 1960s, and are still among the smallest clinical departments in terms of full-time academic staff and resources. Academic psychiatrists initially found it necessary to promote their discipline by taking on many administrative tasks within their universities, their hospitals, their professional bodies, particularly post-graduate training bodies, the health boards and wider national and international committees, which may not have been strictly within their required role as
university teachers, researchers and clinicians. In several instances the clinical load has been heavy and has absorbed most of the energies of academic psychiatrists.

With support coming mainly from part-time teachers there has been little time to devote to academic development and research work appropriate for full-time university staff. These young departments of psychiatry need greater support, particularly in the form of new staff, in order to provide the expert teaching and research leadership that is required to supply a comprehensive training base in this country and to attract back the brightest and best who have studied abroad. It is encouraging now, in addition, to find able young clinicians coming forward who are pursuing excellent research studies, as part-time academics, which is testimony to a developing research ethos within psychiatry in Ireland.

Full-time and part-time university posts must be developed in which their academic role is recognised more fully by Comhairle na n-Ospidéal in terms at least of sufficient protected weekly sessions to allow them to devote their energies to under-graduate and post-graduate teaching and to research.

Recommendations.

- Undergraduate and postgraduate teaching, research and associated administration need protected time. A system has evolved whereby "full-time" academic have a notional clinical commitment of 9 sessions, with 2 sessions only available for academic work. Whatever notional arrangements are made, it should be recognised that full-time academic psychiatrists need 5-6 sessions for academic work, part-time academic staff need 3-4 sessions and teaching consultants need 1-2 sessions. Post-graduate psychiatric tutors need 2 sessions for organisation and training. The notional arrangements may have to continue in the foreseeable future, as central funding for universities has been severely curtailed in recent years and the universities have not yet generated satisfactory outside sources of funds.
Specific Response To Questions In Letter From Mr Tommie Martin, Secretary To Committee On Psychiatric Services, Comhairle na n-Ospidéal, dated 10 October 1996.

(See Appendix XVI)

Most of the issues raised in Mr Martin's letter have been addressed in the body of the commentary and specialist reports. However, it may be helpful to summarise some of this information in direct response to Mr Martin's questions.

(a) There is no doubt that general adult psychiatry (now renamed general and community psychiatry) will continue to provide the bulk of the psychiatric services for the foreseeable future, and certainly in the next ten years. The precise way in which the general psychiatrist will work is likely to shift, according to local planning and opportunities, in response to the emerging specialties, in relation to the individual psychiatrist's particular interests and previous experience, and perhaps to major policy shifts emanating from the Department of Health, e.g. in response to the second Tierney Report.

(b) The increasing trend towards specialisation should continue as this is going to provide a much improved service for patients, along with the skills and knowledge deriving from the welcome developing research ethos in Irish psychiatry.

(c) Geographical sectorisation has drawbacks, but is probably the best available model at the present time which will enable all patients to receive appropriate care. What is well worth retaining is the concept that a standard geographical sector for a consultant team will service a population of about 25,000-30,000. The general sector commitment of each consultant, however, will vary according to a number of factors. His/her commitment will be to a reduced population if some weekly sessions are devoted to e.g. administration, academic work, or special responsibility sessions. Comhairle should designate the number of sessions to be so protected. Further variation in the extent of general responsibility to a population will vary according to the degree of socio-economic deprivation (e.g. according to the Jarman Index) and to the amount of travelling time which is required to service a widely dispersed
population. In addition the population to be served by any one consultant may be altered by the number of specialty sessions provided by other psychiatrists within the specific catchment area. Consultants should be encouraged to take on specialist work, and some of this might be within their overall work as general psychiatrists. It should be remembered that general and community psychiatry contains many emergencies, and the time available to specialties will be eroded where a general psychiatrist has a specialty responsibility. This fact would argue for full-time specialists in the developed and emerging major specialties.

(d) The answer to (c) supports the concept of specialisation overlaying more than one catchment area in certain specialties. (See Table on page 10).

(e) There are several implications resulting from acute psychiatry being provided in units in the general hospital.

(i) Interaction with other disciplines in the general hospital is beneficial for psychiatry and for other disciplines. The strident demand for specialist liaison psychiatrists demonstrates this point.

(ii) The availability of modern equipment for biological investigation is helpful for many patients, and also stimulates an interest in research in psychiatry.

(iii) It has become apparent that highly disturbed patients in general hospital psychiatric units cannot be contained in these open units, and special and medium secure units must be provided, mainly for short stay acute disturbance, but also for relatively few longer-stay, very disturbed individuals.

(iv) The presence of psychiatry in a general hospital does open the way for the psychiatric service to cover the whole catchment area of the general hospital. This, must be realised, will require a significantly increased department of psychiatry, including more in-patient beds in the larger general hospitals, as the large teaching general hospitals currently serve the same population as two or three psychiatric catchment area services. Such a development would enable
the emergence of most of the specialties of psychiatry within the enlarged catchment area. This could well be an efficient use of resources.

(f) The size of population served by consultants should vary according to their other commitments, to the socio-economic index of the population and by the distances to be travelled. The existing catchment areas have not we think developed on any very logical pattern, and could well be examined as a separate task, along with a more rational decision as to the ideal size for a catchment area. Present thoughts are that an ideal size may be about 150,000 population.

(g) This question is covered essentially by answers to (c) and (f). The new Mental Health Act, recent legal decisions and the changing attitudes of the population are all likely to increase the burden of administration and time required for clinical activities over the coming years. This argues for a reduction in population:consultant ratio in the coming years.

(h) It is difficult to answer this question without being more aware of the changing role of general practice. Our experience with general practitioners is that they vary enormously in their interest in psychiatry and in their preparedness to spend time with patients with psychiatric disorders. We would hope that the enlarging size of shared general practices, the increased number of other health professionals working in general practice and the improved education in psychiatry which is now available would all lead to a situation where more psychiatric patients had genuinely shared care between GP and psychiatrist and more patients with minor psychiatric disorders would be managed in general practice. This would allow the psychiatrist to provide a true consultancy service for mild to moderate severity disorder, while probably needing to retain the major share of care for the more severely affected patient. It is worth recording that the fund-holding GPs in the UK are spending more on patients with minor psychiatric disorders (of whom they have many) and very little on those with severe psychiatric disorders (of whom they have few, but who have great needs). Those with severe disorders need protected time, money and specialist care.
Position paper on Child and Adolescent Psychiatry in Ireland.

Report from the Child and Adolescent Section of the Irish Division of the Royal College of Psychiatrists.

June 1997
INTRODUCTION:

The purpose of this position paper is to review the present status of the specialty of Child and Adolescent Psychiatry in Ireland.

1. The need for the specialty of Child and Adolescent Psychiatry.
2. The extent of present services.
3. Recommendations for development of future services.

SECTION 1

NEED FOR CHILD AND ADOLESCENT PSYCHIATRY:

1.1 Definition of Childhood Psychiatric Disorder

Psychiatric Disorder has been defined by Professor Michael Rutter as: “Abnormalities of emotions, behaviour, relationship or thinking which are inconsistent with the patient’s intellectual level and of sufficient duration or severity to cause persistent suffering or handicap to the person and/or distress or disturbance to those in daily contact with him”.

These are disorders that are defined by the World Health Organisation and compiled along with other medical disorders into a manual entitled ‘The International Classification of Diseases - 10th edition’ (ICD.10).

They are usually classified on a multi-axial classification system. The purpose of this is to take into account the many different factors that are significant in understanding the reasons as to why a child presents with certain difficulties. The axes that are considered are as follows:

**Axis 1**

Refers to psychiatric disorders diagnosed within the child.

**Axis 2**

Refers to specific developmental problems within the child, e.g. Reading Retardation.

**Axis 3**

Refers to the child’s overall development level, i.e. I.Q.

**Axis 4**

Refers to any known medical conditions.

**Axis 5**

Refers to the child’s psycho-social environment including family factors and the wider environment of the child’s school and community.

1.2 Prevalence Figures

Epidemiological studies suggest that there is an overall prevalence of psychiatric disorder of up to 20% in the general population of children under 16 years of age. Moderate to severely disabling conditions are estimated at a prevalence of 10%. A prevalence of 2% is estimated for severe disabling problems. When considering an Irish population, it is important to note that 29% of our population are younger than 16 years with 33% being younger than 18 years.
1.3 Role of the Consultant Psychiatrist

The Child Psychiatrist is a Medical practitioner who has completed general psychiatric training and specialist training at a higher level in Child Psychiatry. Child and Adolescent Psychiatry is a recognised specialty within the Royal College of Psychiatrists of Great Britain and is also a recognised medical specialty in the European Union of Medical Specialties (UEMS).

Irish Child Psychiatry has representation on the Central Committees of the UEMS and ESCAP (European Society of Child and Adolescent Psychiatry).

The role of the Consultant Child and Adolescent Psychiatrist may be summarised as follows:

(a) Promotion of the mental health of children, adolescents and their families.

(b) Assessment, diagnosis and treatment of the psychiatric disorders of childhood and adolescence.

(c) Management and development of services.

(d) Training and education of junior medical staff and para-medical specialties, e.g. nursing, psychology, social work, etc.

(e) Research and development of the specialty of Child and Adolescent Psychiatry.

(f) Consultation and advice to policy makers and agencies involved in child care.

(g) Prevention of psychiatric disorder.

The roles and responsibilities of a Consultant Child Psychiatrist are comparable to that of other hospital consultants. Consultant Child Psychiatrists are employed under the same common contract as other hospital consultants.

1.4 Assessment, Diagnosis and Treatment of Childhood Psychiatric Disorder.

Assessment, diagnosis and treatment in Child Psychiatry is multidisciplinary. The concept of multidisciplinary work stems from the multi-axial description of disorders. Practitioners carry out an assessment which produces a broad description of the child’s situation in a biopsychosocial context. Normally treatment in Child Psychiatry occurs on an out-patient basis in the context of the family. Parents are essential to the treatment and frequently are required to be co-therapists along with the treatment and frequently are required to be co-therapists along with the treating team. Often treatment involves the parents, child and/or the whole family with frequent reference to the wider environment, e.g. school, community, etc.

(a) Out-Patient Treatment:

Out-patient treatments available in Child Psychiatry are largely psychotherapeutic and include:
(i) Family therapy
(ii) Therapy with parents, e.g. behaviour management, parental training.
(iii) Individual therapy with the child, e.g. psychotherapy, play therapy, cognitive therapy.
(iv) Pharmacotherapy is not infrequently used, either alone or as an adjunct to the other therapies.
(v) Group treatments such as group psychotherapy.

(b) Day Treatments

Treatment may take place in a number of day treatment settings such as specialist preschool groups, adolescent groups, parent groups and day hospital programmes.

(c) In-Patient Treatment

It is estimated that 0.5% of children require in-patient treatment. Children who require inpatient psychiatric treatment are usually those who present with psychotic illnesses, major depression or manic depressive psychosis, attempted suicides where suicide is still thought to be an ongoing risk, severe eating disorders, disabling neurotic conditions, e.g. obsessive compulsive disorders, severe separation anxiety, etc. In-patient settings are also used for further assessment of children who present with complex disorders where diagnosis is unclear and requires clarification.

SECTION 2

THE EXTENT OF PRESENT SERVICES:

2.1 Child and Adolescent Psychiatry is a relatively new specialty in Ireland. Services are provided by Consultant led multidisciplinary teams which are largely community based. The 1990s have seen substantial developments in Child Psychiatry particularly outside the main urban areas of population. This has been a very welcome development, but the consultant ratios per head of population are extremely variable.

In areas outside the Eastern Health Board and the Western Health Board treatment teams been for the delivery of out-patient services are still incomplete.

In-patient services are available in the Eastern and Western Health Boards only.

Specialist services for child sexual abuse assessment, adolescent psychiatry, liaison child psychiatry, autism are available in the Eastern Health Boards are alone. (See Appendix I).

2.2 Team Structure

The essence of Child Psychiatry is multidisciplinary work. Child and Adolescent Psychiatric Services are staffed by multidisciplinary teams with a Consultant Child Psychiatrist as team leader who retains overall clinical responsibility for treatment of children attending the service.
In all areas outside the Eastern Health Board and Western Health Board areas the core team is still not complete. The concept of the core team must take into consideration the skills necessary for the treatment of the various childhood psychiatric disorders and the core team must include other professionals in addition to the essential trio of Child Psychiatrist, Psychologist and Social Worker. See Section 3.2.

2.3 Organisation of Services

The Child Psychiatric Services at present vary from area to area. A large number have community based Child and Adolescent Psychiatric Clinics. Many of these services are under the direction of the Community Care programmes. In other areas Consultant Child and Adolescent Psychiatrists are hospital based with links to the Paediatric Department and are administratively a part of the hospital programme structure. In the Eastern Health Board area, the Child Psychiatric Service is part of the Special Hospital Programme which caters for all psychiatric services.

The differing organisation of services within different Health Board programmes has led to variations in development of services around the country with emphasis and priorities given to different aspects of the services. This organisational variation has not been in the best interest of the developments of Child and Adolescent Psychiatric Services and the population they serve.

2.4 Consultant Numbers

There are presently 35 consultants (32.0 WTEs) in the Republic of Ireland. This number is insufficient for clinical needs.

To date it has been based on norms recommended by the Royal College of Psychiatrists. These norms are based on British demographics where children and adolescents under the age of 18 years form 20% of the population. This is marked contrast to the Irish population structure where 33% of the population are under 18 years of age.

The norms therefore provided by the Royal College are clearly irrelevant to the requirements of the Irish population.

The Royal College recommendations for the supporting team for a consultant include non consultant hospital doctors of both senior and ordinary level registrar grade in addition to the wider multidisciplinary team. The inclusion of such posts in the team of the Child Psychiatric Service have implications for the training of adult psychiatrists as well as for the provision of services for the Child Psychiatric Service. Given the increase in consultant posts over the last 4-5 years in Ireland, there are clearly inadequate numbers of senior registrar posts. It is essential that in the planning of new Consultant child and Adolescent Psychiatric posts, that an NCHD post should also be included as part of the multidisciplinary team. To date, the provision of registrar and senior registrar posts in Child Psychiatry have been very variably acknowledged in the different health board areas outside the Western Health Board and Eastern Health Board region.

2.5 Existing Shortfalls in Child and Adolescent Psychiatry

Gaps and shortfalls in existing services that have been identified are as follows:
1. **Consultant numbers** are too few to meet identified needs of the population, particularly outside of the Eastern Health Board area.

2. Teams are not adequately resourced in terms of:
   (a) **Personnel resources**; Most teams have insufficient support staff both medical and non-medical.
   (b) **Material resources**; Accommodation, furnishings, equipment, etc, are not always available to an acceptable standard.

3. **Information Technology** is not established in Child Psychiatry. This is a very necessary pre-requisite for audit of services, outcome evaluation and subsequent planning and development of services.

4. **In-Patient Needs**: In-patient treatment units are only available in the Eastern Health Board and Western Health Board areas. Existing bed numbers are inadequate to serve the needs of the defined catchment areas. Outside of these areas, some limited services are offered through the private sector. On occasions, it has been necessary to admit children to adult psychiatric hospitals which is inappropriate.

5. **Liaison Child Psychiatric Services** are not fully developed and are unevenly distributed throughout the Paediatric Departments of the country.

6. **Adolescent Services**: Specialist services for adolescent disorders are only available in the EHB area.

7. **Autism**: There is a very uneven and patchy distribution of services for autistic children.

8. **Forensic Services**: There are no services available to children who come in front of the courts as a result of offending behaviour, as the subjects of custody and access disputes, or care proceedings.

9. **Substance Abuse**: There is growing concern about psycho-active substance misuse. Child Psychiatric has a role in the treatment of psychiatric disorders that arise as a result of substance misuse. The specialty also could usefully be employed in an advisory and consultation role in the development of particular services for this group.

10. **Learning Disability**: Psychiatry of learning disability is long recognised as a sub-specialty of psychiatry. Child Psychiatrists with a special interest in learning disability are not available in many health boards.

11. **Children at risk**: Children who have been abused or neglected are a particular group who are known to have a higher incidence of psychiatric disorder that the general population. Access to Child Psychiatric Assessment and treatment is essential for this vulnerable group. These children often present a complicated picture and require additional services such as appropriate child care facilities (e.g. group homes, crisis intervention facilities, fostering) and alternative education
programmes. The relative shortage of appropriate services at primary care level impinges on child psychiatry services in terms of increased demand, for all aspects of out-patient and in-patient treatments.

12. **Academic Departments:** Academic departments are an essential pre-requisite to the fostering of research and development of a specialty. For many years, the Irish Division of the Royal College of Psychiatrists has recommended that the development of a Professorial Chair in Child Psychiatry. A welcome development has been a recent appointment to Trinity College, Dublin.

13. **Tertiary Referral:** All existing Child Psychiatry Services are organised on a catchment area basis which requires each Consultant Child Psychiatrist to provide generalised treatment for all types of psychiatric disorder. There is very little scope for the development of specialist services, e.g. in the areas of hyperkinesis, attention deficit disorder, eating disorders, autism, etc. The development of tertiary referral services could be used as a backup to existing catchment area consultants for diagnostic problems, etc.

2.6 **Teaching and Training**

Once a doctor has completed basic specialist training in psychiatry (which usually includes a period working in Child and Adolescent Psychiatry) and passed the Membership examination of the Royal College of Psychiatrists, a period of higher training of four years duration is undertaken as a Senior Registrar. The principal aim of higher training is to provide such a doctor with an education programme which will fit him/her for the independent practice of Child and Adolescent Psychiatry, whether as a Consultant in the health service or as a senior member of an academic department.

During higher training the Senior Registrar develops and deepens diagnostic, therapeutic and management skills, and moves to increasingly independent practice so that he/she is able to assume a Consultant role on the completion of training. The achievement of these aims requires that training occurs in well organised schemes which offer a variety of training posts under the supervision of skilled and interested Consultants/Trainers. Each scheme operates under the direction of a scheme organiser and is overseen and approved by the Joint Committee of Higher Psychiatric Training of the Royal College of Psychiatrists. The number of Senior Registrar should be related to the likely number of Consultant vacancies in the immediate future both in the local region and at a national level.

At present, training at Senior Registrar level is only available in the Eastern and Western Health Boards in four separate training schemes. The total compliment of just six Senior Registrar posts is insufficient to fill projected Consultant posts in the future.

2.7 **Continuing Professional Development (CPD)** Continuing medical education is an essential part of any consultant's work. It is absolutely essential for the maintenance of professional standards and development of the specialty. Excessive workloads in many areas and poorly resourced teams often preclude consultants from partaking in a desirable number of sessions.
SECTION 3

RECOMMENDATIONS:

3.1 Consultant Numbers

The norms that have been previously quoted are now out-dated and inapplicable to the Irish situation for reasons previously detailed (Section 2.4).

This Section recommends that the norm of two wholetime equivalent (WTE) Consultant Child Psychiatry posts per 100,000 of population be adopted in the Irish situation (See Appendix II).

This norm applies only to general Child Psychiatric services which excludes specialists posts, teaching posts and other responsibilities. Recommended number of consultant posts are detailed in appendix 1.2. It should be noted that these recommendations apply to the 0-16 age group. It should also be noted that these norms are less than that applicable in most European services.

It should be noted that a separate needs analysis is required for the 16-17 year old age group.

3.2 Team Structure.

As with all specialist consultant posts, each consultant child psychiatrist should be supported by non-consultant hospital doctors with at least one Registrar and one Senior Registrar in training.

With regard to the wider multidisciplinary team, the concept of the three member core team is now outdated. When taking into consideration the concept of the wider multidisciplinary team, it is recommended that consideration be given to the skills mix required to provide a comprehensive Child and Adolescent Psychiatric Service. The types of treatment skills that should be available to such a team are as follows:

(a) Medical skills related to the assessment of complex cases and development of complex treatment packages to mental illness, to physical symptoms and illness, and to medication.

(b) Counselling and Observational skills: Assessment and treatment interviews with parents, children, married couples and whole families.

(c) Psychotherapy, family therapy, behavioural, cognitive and activity based treatments (play, dance, art, music or occupational).

(d) Knowledge of child development (normal and abnormal), of disorders (causes, natural course, prognosis), of treatment strategy (including prognosis), of resources in other services and of relevant legislation.

(e) Handling of aggression, withdrawal and other extreme behaviours.
(f) Psychological tests and their interpretation.

(g) Assessment of risk (e.g. of abuse, violence or suicide) and appropriate actions.

Managerial, organisational and secretarial skills are also essential to the team.

Composition of the team should include the following disciplines. The numbers and ratio of different disciplines should be dictated by local needs.

(a) Consultant Child and Adolescent Psychiatrist with Senior Registrar and Registrar.

(b) Clinical Psychologist.

(c) Psychiatric Social Worker.

(d) Psychiatric Nurse.

(e) Child Psychotherapist.

(f) Child Care Worker.

(g) Secretary with information technology support.

(h) Speech and Language Therapist.

(i) Occupational Therapist - where day programmes are involved.

3.3 Organisation of Services

(i) It is recommended that the present mix of hospital based and community based services should certainly continue but that it should be more evenly balanced. These services operate as secondary or specialist services accepting referrals from professionals in primary care. These services may then refer to tertiary level services as will be described in the following sections.

(ii) **Day Hospital Services** should be widely available.

(iii) **Specialist pre-school programmes** should also be developed in all areas.

(iv) **Rights of admission to in-patient services** should be more accessible and more equitably distributed throughout the country. This should be planned on a national basis, taking geographical factors into account.

(v) **All paediatric hospital departments should have formal links with the local Child Psychiatric Services**, i.e. specified numbers of sessions to be determined by local need.

3.4 Individual regional Child Psychiatric Services should be requested to consider the needs of their own area and provide plans for future service development.
3.5 **Clinical Director Posts**

The posts of Clinical Director in Child Psychiatry should be maintained. This could be either a permanent post or one that rotates on a periodic basis. There should be a minimum of one Clinical Director per Health Board area, whose job description allows specifically allocated time for administrative tasks. The Clinical Director post gives an opportunity for significant linkage with management. This person should retain overall responsibility for management and co-ordination of services and plans for future development.

3.6 **Adolescent Psychiatry**

The present Child and Adolescent Psychiatric Services retain an upper age limit of 16 years in line with the Mental Treatment Act, 1945. There is a large group of 16-18 year old young people with psychiatric disorder who, it is commonly agreed, represent an area of unmet need.

We recommend that a new Special Interest layer of Adolescent Psychiatry be developed in line with new Mental Health legislation.

One model of service could be that services could develop for the 13-17 year old age group with out-patient adolescent Psychiatry multidisciplinary teams linked to the Child Psychiatric Service and specifically appointed in-patient units. These in-patient units could be based close to general hospital adult psychiatric units which would allow for administrative ease in terms of out of hours cover, etc.

3.7 **In-Patient Services for Younger Children**

Children from the age of 5-12 years require facilities for in-patient assessment and therapeutic milieu type treatment. There is a need for the development of specialist units which will have facilities for admission of children alone and also a facility for admission of families. These units should be run by a Consultant Child Psychiatrist, supported by a specialist team. This would be regarded as a tertiary specialist area which would require full time consultant allocation per unit.

3.8 **Sub-Specialisation**

Consideration should be given to the creation of hospital based posts which would allow for the development of special interests and tertiary referral. This could be modelled along the same lines as that which exists in the paediatric specialty at present.

Particular areas which require more specialist development at present are forensic services, autism, substance abuse, eating disorders, attention deficit disorder, etc.

3.9 **Training**

We recommend that the number of Senior Registrar posts be increased to a minimum of 12. They should also be distributed across all Health Board areas.

Duration of training at present is four years,
however, this should be reduced to three years of specialist training in order to align higher child psychiatric training with that in place in the UK and the European context.

3.10 Information Technology

The degree of computerisation varies markedly between and even within Health Board areas in Child Psychiatric Services. To facilitate the demands of audit, service planning, outcome evaluation research, all child psychiatric services need to have computerised patient records, computerised administrative systems. These processing systems need to be designed in such a way that they would be compatible with each other so that data on a national basis can be collected. This would greatly facilitate inter-professional communication and provide national epidemiological data, regional needs assessments, rationale for regional service provision and development, resource management, standardisation of treatment, and expand research opportunities in Ireland.

3.11 Continuing Professional Development (CPD)

Official recognition of the importance of CPD must be given in the development of the new consultant posts, with allowance for CPD time in job descriptions.

3.12 Consultant Job Descriptions

Job descriptions for Consultant Child Psychiatrists should be in standard format and in accordance with model job descriptions approved by the Royal College of Psychiatrists.

Membership of Committee.
Dr C Halpin
Dr M Doyle
Dr B Dowling
Dr F O'Leary
Dr M Lawlor
Dr B Doody
## APPENDIX I

### EXISTING CONSULTANT NUMBERS

<table>
<thead>
<tr>
<th>HEALTH BOARD</th>
<th>POPULATION</th>
<th>W.T.E.</th>
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</tr>
<tr>
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<td>2</td>
<td>0</td>
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32.0 W.T.E.
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<tr>
<td>POP: 1991 (100,000 units)</td>
<td>Realistic Teaching Adolescent Specialist Services Child 0 - 12Y Adol 12 - 16Y</td>
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<td>Rep of Ireland</td>
<td>3526000 - 34 units</td>
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<td>38 + (6 x 0.8) = 43</td>
<td>24 beds</td>
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<td>24</td>
<td>38</td>
<td>38 + (6 x 0.8) = 43</td>
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<td>342000 - 3 units</td>
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<td>9.5</td>
<td>9.5 + (1.5 x 0.8) = 10.5</td>
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<td>6</td>
<td>6 + (1.5 x 0.8) = 7</td>
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<td>6</td>
<td>6</td>
<td>6 + (1.5 x 0.8) = 7</td>
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</tr>
<tr>
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<tr>
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<td>4</td>
<td>4 + (1 x 0.8) = 5</td>
<td>4 beds</td>
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<td></td>
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<td>105</td>
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</table>
Child and Adolescent Consultant Norms for the Republic of Ireland. 0 to 16th Birthday, Normal to Borderline Intellectual Ability.

REFERENCES:


COLUMN 4.: Purchasing Psychiatric Care - Contribution from the Child and Adolescent Psychiatric Section, Royal College of Psychiatrists (1994).


INFANT PSYCHIATRY

Infant psychiatry is a relatively new, but rapidly growing, sub-specialty in child psychiatry dealing with children up to 36 months. There is a wealth of recent texts on the subject, as well as international journals and organisations which deal with the emotional problems of infants and their families.

Clinics that have a special interest in infant psychiatry tend to have infants and their parents referred to them with a variety of attachment disorders, sleep disorders, oppositional aggressive disorders, pervasive developmental disorders, failure to thrive, and many others.

As the direct relationship between the attachment disorders of infancy and the emotional and personality disorders of adult life become more apparent, increasing attention is being paid to the intra familial relationship dynamics that evolve for infants, and the development of services in this area promises to be possibly the most rewarding of all the preventive strategies now presenting to mental health professionals.

The circumstances of a child’s birth, e.g. born after three miscarriages, born after death of husband, born to puerperal psychotic mother or depressed mother, may critically effect the type and quality of the attachment formed. The grieving of parents of a “Down’s Syndrome” or other physically unusual child, over the loss of an “anticipated” normally healthy baby, again effects the relationship formation. The increasing numbers of children of extremely low birth weight who require months in incubators present us with another group who are at great risk of developing attachment disorders.

The combination of the developmental paediatrician and the child psychiatrist attached to neonatal clinics and paediatric units is increasingly being used to enable parents resolve the complicated feelings and developing attitudes to their baby that may otherwise be pathogenic. Such psychiatric intervention is different to that of a psychiatrist attached to maternity hospitals who essentially works with maternal illness.

The Irish Division recommends the creation of child psychiatric sessional appointments to such developmental paediatric units.
FORENSIC PSYCHIATRY

Forensic psychiatry is psychiatry practised at the interface of psychiatry and the law and work locations include the Central Mental Hospital, Dundrum, the courts and prisons. Increasingly the service is asked to give specialist opinions on illness-related dangerousness residing in general psychiatry settings and this type of consultation is both welcome and appropriate. The forensic service is based mostly at the Central Mental Hospital, Dundrum and there are two Consultant's based there, the Medical Director, Charles Smith, and Dr Art O'Connor. A third Consultant was assigned to the service up to ten years ago, until Dr Smith agreed to drop the post at that time, a time when service demand was low.

There is evidence that existing prison populations harbour substantial psychiatric morbidity. A recent randomise survey of Mountjoy prisoners uncovered 5% with major psychiatric illness and another 8% with substantial psychiatric morbidity, requiring ongoing psychiatric attention. These percentages excluded the much higher numbers of alcohol and drug dependent prisoners. For those judged to be majorly ill, prison was seen as an inappropriate location and extrapolating from these figures it would seem that nationally at least another 100 medium secure psychiatric beds might be needed to house this illness group. While existing rehabilitation programmes work well for those involved and follow up locally and in the UK indicates that none of these rehabilitated patients end up in prison, nevertheless there is a genuine concern that illness which formerly found admission and asylum in psychiatric hospitals, is no longer able to access general psychiatric beds and is finding it's way, after minor charges into the prison system. This is unacceptable and it has to be challenged with either a diversion system or early recognition and transfer system from prison to ordinary psychiatric or secure psychiatric accommodation.

Forensic psychiatry is increasingly called upon to help with aggressive disturbance in hospitals that have no locked wards and with the validation of Section 208 transfers, Dundrum itself is now being regularly asked to address problems that remained and stayed contained in the hospitals of the past. Increasingly, for medico-legal purposes, opinions on dangerousness are required of the forensic psychiatric service. It all adds up to increasing demand and shifting need.

Almost certainly there is a requirement in each health board and in the Eastern Health Board in particular, for a medium secure unit to which dangerous and/or aggressive patients can be admitted using existing mental health legislation. There is currently a Department of Health Committee looking at this mentally disordered patient group and it’s needs. A de-designated part of the Central Mental Hospital could fill this function, certainly as an interim measure but it would carry substantial capital and revenue costs.

It does seem as if there is immediately a need for a third full-time consultant to the existing forensic psychiatric services. It seems reasonable also to try to address problems outside the Dublin area with local specialist inputs and for that reason Cork and Limerick with their
existing prisons could do with a Consultant Psychiatrist who had a special interest in forensic psychiatry to address local problems there.

Child and adolescent psychiatry and mental handicap have their own special needs and relevant psychiatric inputs for these groups are clearly a new requirement that has to be addressed.
THE PSYCHIATRIC NEEDS OF PEOPLE WITH MENTAL HANDICAP

SECTION I: INTRODUCTION

1.1 Services for people with mental handicap in Ireland have changed radically in recent years. Formerly people with mental handicap predominantly resided in medium to large sized institutions away from their family or origin, a significant number residing in mental hospitals. At present the services are community orientated with most people living either with their own families or in supervised group homes in the community. Furthermore, the services now cater for an increasing number of elderly people with mental handicap.

1.2 The Census of 1981 indicated that there were 22,979 people with some degree of mental handicap (administrative prevalence rate 6.7/1000). It is generally agreed that these numbers have significantly increased since that time.

1.3 It is now 6 years since the publication of the document “Medical Aspects of the Mental Handicap Services” (Comhairle na n-Ospídéal 1988). There have been radical changes since then in that Consultant Psychiatrists now only practice psychiatry as a specialty within the mental handicap services - the general medical needs usually being met by primary care physicians. This practice is well established in many services and should be adopted by all. In view of this a committee was appointed by the Mental Handicap Section of the Irish Division of the Royal College of Psychiatrists to look at the psychiatric needs of people with mental handicap with special reference to:

(i) The Psychiatry of Mental Handicap
(ii) The Role of the Consultant Psychiatrist
(iii) Models of Services and Implications for Treatment
(iv) Training
(v) Recommendations.

1.4 The membership of the sub-committee was as follows:

- Dr Colette Halpin - Chairperson
  Consultant Psychiatrist, Stewart's Hospital, Dublin 20

- Dr Patricia MacCarthy
  Consultant Psychiatrist, St Vincent's Centre, Navan Road, Dublin 7
1.5 For the purpose of this paper we propose to use the WHO Definition of Mental Handicap which is "Mental retardation is a condition of arrested or incomplete development of the mind which is especially characterised by impairment of skills manifested during the development period, which contribute to the overall level of intelligence i.e. cognitive, language, motor and social abilities." (World Health Organisation, Geneva 1992).

1.6 Mental Handicap is not synonymous with psychiatric disorder though psychiatric disorder is frequently seen in the person with mental handicap. We will use Rutter’s definition of psychiatric disorder which is: "Abnormalities of emotions, behaviour, relationship or thinking which are inconsistent with the patient’s intellectual level and of sufficient duration or severity to cause persistent suffering or handicap to the persona and/or distress or disturbance to those in daily contact with him".

SECTION 2: THE PSYCHIATRY OF MENTAL HANDICAP

This section explains the relevance of psychiatry to the field of mental handicap under the following headings:

(1) Prevalence of Psychiatric Disorders.
(2) Why do we need psychiatrists with specialist training in mental handicap?
(3) Other issues relevant to the psychiatry of mental handicap.

2.1 Prevalence of Psychiatric Disorders in People with Mental Handicap

Recent epidemiological studies indicate that approximately 50% of mentally handicapped people in hospital and in contact with services in the community have suffered at some time from psychiatric symptoms or behaviour problems sufficient to require a specialist service (Royal College of Psychiatrists 1986). International studies have revealed a very high prevalence of psychiatric disorders in people with mental handicap when compared to the normal population. (Corbett, 1979; Bouras and Drummond, 1992; Gilberg et al, 1986; Gath & Gumley, 1986; Day, 1985). Irish studies support the high prevalence of behaviour and psychiatric disorder in people with mental handicap (Conlon, 1987; Lister & Kinsella, 1989; Keane et al in Press).

2.2 Why do we need psychiatrists with specialist training in mental handicap?

"People with mental handicap are entitled to the same range and quality of service as are available to other citizens and to services designed to meet their special needs." National Development Group for the Mentally Handicapped 1980.

We in Ireland agree with this philosophy as shown by our signatory to the United Nations Declaration on the Rights of Mentally Retarded Persons 1971.
Experts in the field of mental handicap view people with mental handicap as a distinct group in our population who have special needs. This is especially highlighted when mental health issues are examined.

As previously mentioned people with mental handicap are more susceptible to mental health problems than the general population (Corbett 1979, Lund 1985, Gostason 1985, Reiss 1990, Rutter et al 1976, Gilberg et al 1986). Psychiatric disorder increases as the degree of mental handicap increases and up to 50% of the psychiatric disorders present as behaviour disorders many of which are unique to mental handicap. There are also unique features attending the occurrence, nature, diagnosis and treatment of the psychiatric disorders. (Royal College of Psychiatrists 1986).

People with mental handicap are a heterogeneous group who can present with a multiplicity of mental health problems, often of a chronic nature. Mental Handicap Psychiatry constitutes a distinct body of knowledge and practice that is continually evolving, for example, the recent work on behaviour phenotypes and the increasing evidence of the neurological neuropsychiatric and socio-communicative basis of many behaviour disorders. (Lund, 1985, Reid et al 1984, Reid 1972, Hucker et al 1990; Reiss 1988, Coyle 1988, Hunt and Cohen 1988; Berg and Gosse 1990; Fraser and Rao 1991).

A specialist psychiatric service is required to ensure that developments in the area of mental handicap psychiatry occur, to ensure that the best quality psychiatric service is delivered to people with mental handicap who are psychiatrically disordered, and to promote research and training.

It is well documented that the generic psychiatric services are unlikely to be able to provide and offer the expertise and facilities necessary to effectively treat people with mental handicap who are psychiatrically disordered. Attempts to provide for the mental health needs of mentally handicapped people within generic psychiatric services have been unsuccessful (Jacobson and Ackermann 1988; Gold et al 1989; Marcos et al 1986; O'Brien 1990; Day 1992; Newman and Emerson 1991).

Specialist skills are required to diagnose psychiatric disorder accurately in patients whose communication abilities are severely limited. Assessment and diagnosis is more difficult than in general adult psychiatry. In mental handicap psychiatry the only history may be the collateral from the family or carer. The questions used to diagnose psychiatric disorder in mental handicap psychiatry and general adult psychiatry are different. Greater attention is given to non-verbal communication and behaviour assumes a much greater place in the assessment. This behaviour then has to be decoded and understood e.g. is it indicative of psychiatric disorder? The psychiatrist in mental handicap at all times has to be aware of unusual developmental disorders (e.g. Autism, Asperger's Syndrome) which can present with disruptive behaviour. In addition, more attention has to be directed at the environment in which the behaviour is exhibited.

In recent years certain groups in our society have been identified as requiring specialist psychiatric services because of their special needs e.g. the elderly, children and adolescents. Historically, a specialist psychiatric service has been available to Irish people with mental handicap. However, it is disappointing to note that the recent Green paper on Mental Health omitted the sub-specialty of the Psychiatry of Mental Handicap in it's list of recognised sub-specialties (Section 10.12 Green Paper on Mental Health). Thus people with mental handicap who are psychiatrically
disordered may be at risk of being denied a specialist psychiatric service. An integral part of any mental handicap service is the psychiatric component as psychiatry is an integral part of any health service.

(vi) People with mental handicap are a vulnerable group who are unable to make their demands and needs known. They are dependant on society to be caring and to put checks in place to ensure their rights are met. We believe that a specialist psychiatric service for people with mental handicap would go some way to ensuring that this marginalised group in our society would have the full benefits of modern psychiatry.

(vii) In summary the arguments for specialised psychiatric services are well documented and can be summarised as follows:

(a) The diagnosis of psychiatric disorder in mentally handicapped people requires special expertise and experience in the face of atypical presentation, communication difficulties and often the absence of subjective complaints (Reid 1972; Hucker et al 1979; Wright 1982; Reiss and Szyszko 1983; Sovner 1986; Menolascino et al 1986; Fraser and Rao 1991).

(b) Specialised assessment and treatment techniques, and facilities are required for the management of behaviour problems, many of which are unique to mentally handicapped people. (Day et al 1988).

(c) Mentally retarded offenders differ significantly from other mentally disordered offenders, both in the nature and origins of their offending behaviour and their treatment needs and require specialised services (Day 1990).

(d) Therapeutic interventions, including counselling and psychotherapy, require modification in their application to take account of intellectual and other limitations (Levitas & Gilson 1989).

(e) Special regimes and careful monitoring of drug treatment is necessary because of the high frequency of side effects and unusual responses in mentally handicapped people (Snaith et al 1979; Day 1990).

(f) Treatment, rehabilitation and aftercare must take account of co-existing physical disabilities, including epilepsy, which frequently complicate mental retardation as well as the requirement for general habilitative measures (Day 1984, 1990).

(g) Specialised services increase staff competences and skills, bring benefits of cumulative experience, ensure ownership of the task in hand and increase the probability of effective and successful treatment (Clements 1987, quoted in Newman & Emerson 1991).

(h) Specialised services provide an essential base for teaching and research (Day, K. 1993).
2.3 **Other Issues relevant to the Psychiatry of Mental Handicap**

(i) **Family Issues**

(a) The care of the person with mental handicap places additional stress on the family. These stresses include difficulties in accepting diagnosis, inappropriate or dysfunctional handling strategies, chronicity of the problem etc.

(b) The assessment and treatment of people with mental handicap who also have a psychiatric disorder must pay particular attention to family issues. This always requires a great deal of time from the psychiatrist.

(ii) **Abuse and Neglect including Sexual Abuse**

(a) People of all ages with mental handicap are vulnerable to all types of abuse. Recent Irish studies concur with this and indicate that it occurs in both sexes. (Dunne and Power 1990, Sexual Offences and the Mentally Handicapped, Law Reform Commission, 1990). Sexual abuse has been found to be 2.6 - 4 times more common in mentally handicapped children than children of normal intelligence. (Child Sexual Abuse in Northern Ireland 1990).

(b) Abuse of mentally handicapped adults is believed to be quite prevalent and concern has been expressed about widespread professional ignorance of the matter (Cooke L.G. 1990).

(c) It is well documented that abuse and neglect result in secondary psychiatric disorder.

(d) There is an increasing awareness of sexual abuse in people with mental handicap. Diagnosis and treatment is very time consuming and difficult because of communication problems. There currently is not the manpower to carry out this work.

We would recommend that additional resources should be made available to meet these needs.

(iii) **Mentally Handicapped Offenders** - there is emerging concern about this group (Needs & Abilities 1990). The current reluctance of the Irish Courts to sentence any offender who has a diagnosis of mental handicap has increased the demand for community based psychiatric services for this category of person.

(iv) **Additional Handicaps**: - Sensory impairments, epilepsy and other medical conditions are common in people with mental handicap. These conditions and their associated treatments often add to the complexity of psychiatric disorders in this group.
SECTION 3: THE ROLE OF THE CONSULTANT PSYCHIATRIST

3.1 The diagnosis and treatment of psychiatric illness in a child or adult with mental handicap.

This may involve the treatment of the individual alone but also because of the complexity of mental handicap and the dependence on key carers, it usually requires the key workers, families or others to become involved in the assessment process and in the supportive and therapeutic work; it often involves collaborative work and liaison with other medical and paramedical professionals, for example, psychologists, social workers, speech and language therapists, paediatricians, neurologists, etc.

3.2 Prevention of psychiatric and behaviour disorders.

(i) Early Intervention.

(ii) Family therapies and support.

(iii) Development of good standards and policies.

3.3 Intervention re forensic and medico-legal matters.

(i) The provision of medico-legal and forensic reports on patients under their care.

(ii) The provision of advice on medico-legal matters.

(iii) Liaison with the legal profession as necessary.

3.4 Liaison with other medical specialists both in primary and secondary care.

This includes collaborative clinical work with other medical specialists, research and teaching.

3.5 Rehabilitation including transfer of residents from long-stay placements to the community.

3.6 Research: Consultants have a contractual obligation to encourage, support and carry out ongoing research in order to continue to broaden knowledge of psychiatric disorder in mental handicap, its causes, treatment and outcome.

3.7 Audit: Consultants have a contractual obligation to carry out audit research and to monitor their own work practices.
3.8 **Leadership of the multi-disciplinary team**, that is, co-ordinating the work of multi-disciplinary teams which exist for the benefit of the handicapped person for whose care the psychiatrist has clinical responsibility.

3.9 **Teaching**: The consultant psychiatrist has an obligation to teach and supervise the work of:

(i) registrars in training who work in mental handicap as part of their general psychiatric rotational scheme.

(ii) senior registrars who are in training to become consultants in the psychiatry of mental handicap.

The consultant psychiatrist is also expected to become involved in the teaching and training of other professionals involved in mental handicap, for example, nurses, social workers, psychologists, general practitioners, other doctors, etc.

3.10 **The Consultant Psychiatrist has a Management role**

(i) They have specific training in management.

(ii) They have special training in team work and collaborative work with other professionals.

(iii) Due to their broad base of knowledge and expertise they are in a position to understand the complexity of the various psychological, social and medical factors that exist in relation to people with a mental handicap which are of utmost importance when planning services.

(iv) The Consultant Psychiatrist has a pivotal role in the overall planning and development of mental handicap services.

(v) The Consultant Psychiatrist as a Clinical Director co-ordinates the delivery of all types of clinical services to people with mental handicap.

**SECTION 4: MODELS OF SERVICES AND IMPLICATIONS FOR TREATMENT**

4.1 A psychiatric service for people with mental handicap must be directed at the needs of the people it serves. It must recognise that:

(i) the reduction of in-patient beds in the psychiatric services has resulted in people with mental handicap with a psychiatric disorder having great difficulty in obtaining psychiatric admission when appropriate.

(ii) most people with mental handicap no longer live in large residential units but now live in domestic type houses.

(iii) that adult mentally handicapped people have not for some considerable years, and are not being admitted to psychiatric hospitals for provision of residential care. This
contrasts with the finding of the report of the Committee on Medical Aspects of the Mental Handicap Services in 1988 “Mentally handicapped people especially those requiring a significant level of care have been and continue to be sent to psychiatric hospitals when they reach adult level”.

(iv) Children and adolescents are now only admitted to long-term residential care in cases of extreme need. This has created a necessity for greater support for families at all professional levels if integration into family and community is to succeed.

(v) Psychiatric disorders in people with mental handicap include the full range of psychiatric disorders seen in the general population. For the purpose of this report it is useful to consider the following sub-groups:-

(a) acutely and chronically mentally ill;

(b) mildly mentally handicapped people with maladjustment, emotional problems and social inadequacies;

(c) mentally handicapped offenders.

(d) severely mentally handicapped people with behavioural problems;

(e) the elderly mentally handicapped with psychogeriatric problems;

(f) mentally handicapped people whose epilepsy poses special problems;

(g) mentally handicapped children and adolescents of all intellectual levels with psychiatric, emotional and behavioural problems.

4.2 A specialised psychiatric service for mentally handicapped people and their families should have the following as their main functions:-

(i) Prevention of psychiatric and behaviour disorders;

(ii) Diagnosis and treatment of psychiatric and behaviour disorders;

(iii) Counselling, psychotherapy and support for families and other carers;

(iv) Diagnosis and treatment of physical/sexual/emotional abuse and neglect;

(v) Provision of advice on the legal aspects of mental handicap including issues of consent.

4.2 Service for people with mild mental handicap: The decision of where a person who has a mild mental handicap who also has a psychiatric illness should be treated is particularly problematic as people with a mild mental handicap prefer to identify with the normal population. The generic psychiatric services as now constituted are frequently unable to meet their needs. This appears to be largely due to a lack of appropriate resources.
4.4 The model of service must recognize the legal difficulties involved in the treatment of people with mental handicap particularly the issue of consent. The person with mental handicap frequently is unable to give informed consent. Under existing legislation a person can only be treated without consent if admitted to a psychiatric hospital or unit and detained without his or her consent as a temporary patient or as a person of unsound mind. The legislation as it pertains to psychiatric treatment of people with mental handicap requires urgent updating.

4.5 Proposed Model of Service:

Having identified the psychiatric needs of people with mental handicap and the current legislative difficulties we would propose a model of service along the following lines:

(i) **It should be community based with good backup resources:** These including;

   (a) psychiatric out-patient facilities;

   (b) domiciliary visits;

   (c) staff allocation for home intervention in times of crisis. This type of service is particularly important for children with mental handicap who have a psychiatric, emotional or behaviour disorder.

(ii) **It should have a mental treatment unit** as proposed in the Green Paper on Mental Health with full legislative safeguards present in psychiatric hospitals. These mental treatment units should cater for those with acute and acute on chronic mental illness. The structure for these units can be located in one of 3 ways:

   (a) A mental treatment unit on a mental handicap site;

   (b) A mental treatment unit for people with mental handicap co-located with mental illness services;

   (c) The integration of mental illness and people with mental handicap into mental illness services where due regard is taken of the needs of the person with mental handicap.

We recommend that these units should have a multi-disciplinary team attached to them and should be largely staffed by nurses with training in both mental handicap and psychiatry. These should provide for a given catchment area and the location of these treatment units should be determined by the local needs of the services.

(iii) **Specific treatment provision is required in the treatment of the following groups:**

   (a) mentally handicapped children and adolescents with psychiatric disorders.

   (b) mildly mentally handicapped people with maladjustment, emotional problems and social inadequacies.
(c) severely mentally handicapped people with behavioural problems/autism.
(d) the elderly mentally handicapped with psychogeriatric problems.
(e) mentally handicapped people whose epilepsy poses special problems.
(f) mentally handicapped offenders.

(iv) Secure Units

There is a need to have a small number of more secure units on a regional basis which would provide for the small numbers of mentally handicapped people who require conditions of security beyond that which can be provided in psychiatric units for the mentally handicapped.

We recommend that treatment units should have a multi-disciplinary team attached to them and should be largely staffed by nurses with training in both mental handicap and psychiatry. These should provide for a given catchment area and the location of these treatment units should be determined by the local needs of the service.

SECTION 5: TRAINING REQUIREMENTS

5.1 (i) The Higher Psychiatric Training Committee is a sub-committee of the Irish Psychiatric Training Committee (IPTC) which has a specific role in the training of Senior Registrars.

(ii) The IPTC is one of a number of professional bodies and the only psychiatric body recognised by the Postgraduate Medical and Dental Board as filling a major role in programmed training for doctors - the Postgraduate Medical and Dental Board having statutory functions as defined in Section 40 of the Medical Practitioners Act 1978. It endorses the training requirements as set out by the Royal College of Psychiatrists. The Higher Psychiatric Training Committee is a sub-committee of the Irish Psychiatric Training Committee and has responsibility for overseeing all aspects of senior registrar training in Ireland.

5.2 The Royal College of Psychiatrists is the professional body for psychiatrists in Ireland and the United Kingdom. It upholds a very high standard of psychiatry that is recognised worldwide. It recognises mental handicap psychiatry as a sub-specialty of psychiatry and has specific requirements for Specialist Training in Mental Handicap Psychiatry. It recognises 3 categories of consultant psychiatrists working in the field of mental handicap psychiatry -

(i) Full-time Consultants in Mental Handicap Psychiatry. These Consultants to be considered trained by the Royal College of Psychiatrists must spend 3 -4 years at Senior Registrar level in Mental Handicap psychiatry.

(ii) Consultant Adult or Child Psychiatrists with special responsibility in Mental Handicap Psychiatry. These doctors spend a minimum of 2 years at Senior Registrar
level training in Mental Handicap Psychiatry. As expected from their title the other two years are spent either in Adult or Child and Adolescent Psychiatry.

(iii) The third type of Consultant working in Mental Handicap Psychiatry is one who is deemed to have a special interest in Mental Handicap Psychiatry. To be trained adequately for this post the Royal College of Psychiatrist requires that at Senior Registrar level one year is spent in Mental Handicap Psychiatry.

An outline of the training programme by the Royal College of Psychiatrists is included in Addendum A.

5.3 Comhairle na n-Ospídeal is the statutory body for approving Consultant posts in Ireland. The consultant posts in the psychiatry of mental handicap recently advertised have required that the doctor is qualified for 7 years with 5 years in psychiatry, one of which should be in the psychiatry of mental handicap.

5.4 We note that there is a discrepancy between the training requirements of Comhairle na n-Ospídeal and the Royal College of Psychiatrists for consultant appointments in the psychiatry of mental handicap. The Mental Handicap Section of the Irish Division of the Royal College of Psychiatrists has made the following recommendations:

(a) Wholetime Posts (W.T.) - 3 years irreducible minimum of Higher Training in the Psychiatry of Mental Handicap.

(b) Special Responsibility Posts:

   - **Adult Psychiatry**
     2 years higher training Mental Handicap
     2 years higher training General Adult Psychiatry

   - **Child Psychiatry**
     2 years higher training Mental Handicap
     2 years higher training Child Psychiatry

5.5 The European dimension: In the European Union at present there is an on-going revision of medical training with the aim of unifying training throughout Europe. This may effect the training requirements for psychiatrists working in the Psychiatry of Mental Handicap.
SECTION 6: CONSULTANT PSYCHIATRIST MANPOWER IN MENTAL HANDICAP

For the purposes of this paper we carried out a census of all Consultant Psychiatrists working in the field of mental handicap.

6.1 There are presently 20 permanent Consultant Psychiatrists employed and 2 posts are filled on a temporary basis - one at St Ita’s Hospital, Portrane, Co. Dublin and one at St Mary’s, Drumcar, Co. Louth. This corresponds to 17.4 Whotetime Equivalents.

6.2 Two health boards i.e. the Midland Health Board, and North Western Health Board do not employ Consultants in the Psychiatry of Mental Handicap.

6.3 It is to be noted that 10 of the posts are wholetime. The other posts give at least 2 sessions per week to generic child or adult psychiatric services.

6.4 Of the 20 permanent consultant posts in the psychiatry of mental handicap 10 are clinical directors, thus further eroding the sessional psychiatric services available to people with mental handicap.

6.5 Sessional psychiatric services are also provided in some areas e.g. Moore Abbey.

6.6 Appendix B lists the present consultant manpower status in the psychiatry of mental handicap. This is expressed in terms of wholetime equivalents (WTEs). This clearly illustrates the discrepancy between the recommendation of the Royal College of Psychiatrists and the present provision.

SECTION 7: RECOMMENDATIONS

7.1 Psychiatric services for people with a mental handicap should be provided as a specialist service.

7.2 Those services should be provided by a consultant psychiatrist who has specialist training in the psychiatry of mental handicap. He should have available to him a multi-disciplinary team and adequate resources to provide this service.

7.3 Psychiatric services for people with mental handicap should be community based and operate on a catchment area basis.

7.4 Appropriate admission facilities should be available for the mentally ill mentally handicapped. These should ideally be provided in specialised units either within the mental handicap services or in a general psychiatric hospital which takes due account of the needs of people with mental handicap. Patients admitted in this mode should be treated by consultant psychiatrists who have specialised in the psychiatry of mental handicap. Nursing staff should have a background in both mental handicap and psychiatry. People with mental handicap who are admitted for psychiatric tretment should receive the safeguards of mental health legislation in the same way as the general population, regardless of the location of the treatment unit.
7.5 Consultant manpower numbers should be brought into line with norms recommended by the Royal College of Psychiatrists i.e. 1 whole time equivalent per 100,000 population (Ref Mental Health of the Nation. Royal College of Psychiatrists 1992) for adults and 0.2 whole time equivalents per 100,000 population for child and adolescents (Ref. Royal College of Psychiatrists 1992). Existing consultant numbers indicate a shortfall in many areas. Most notable are:-

(i) That some health boards do not employ consultant psychiatrists in mental handicap psychiatry at all.

(ii) Psychiatric services for children and adolescents with a mental handicap are not separate from adults in many areas. Many consultant psychiatrists in mental handicap are presently treating both adults and children.

(iii) There still exist 2 temporary posts.

These areas should be addressed as a matter of urgency. Detailed recommendations regarding the manpower required in each area are given in Addendum B.

7.6 Clinical Directors should be employed in each service. It is appropriate that Consultant Psychiatrists be employed as clinical directors. The administrative demands on clinical directors must be considered when structuring consultant posts. Allowance must be made for this in terms of extra sessions over and above those required for clinical psychiatry.

7.7 We recommend that there continue to be a number of whole time consultant posts in the psychiatry of mental handicap depending on the local needs of an area.

7.8 Consideration will need to be given to setting up specialist services for particular groups.

7.9 We would recommend that the minimum requirements change from one year to the following:-

(a) Whole time Posts (W.T) - 3 years irreducible minimum of Higher Training in the Psychiatry of Mental Handicap.

(b) Special Responsibility Posts:

- **Adult Psychiatry**
  2 years higher training Mental Handicap
  2 years higher training General Adult Psychiatry

- **Child Psychiatry**
  2 years higher training Mental Handicap
  2 years higher training Child Psychiatry
SECTION 8: REFERENCES


Child Sexual Abuse in Northern Ireland (1990) by the Research Team from the Departments of Child Psychiatry, Royal Belfast Hospital for Sick Children, Northern Ireland and Epidemiology and Public Health of the Queen's University of Belfast, Northern Ireland. Greystones Books Ltd.


Joint Committee on Higher Psychiatric Training (1990) Requirements of Specialist Training in Mental Handicap psychiatry. Royal College of Psychiatrists.


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Report of the Sub-Committee from the Mental Handicap Section of the Irish Division of the Royal College of Psychiatrists. February 1995.
ADDENDUM A

Requirements for Specialist Training in Mental Handicap Psychiatry

1.0 Organisation of training programme

1.1 A comprehensive training scheme may often require the collaboration of two or more centres. Each scheme should have a committee concerned with the planning and review of training. It should appoint one of its consultant members as scheme organiser. This organiser must have the necessary authority and time to undertake the task efficiently and the person should organise regular meetings with trainees and trainers to review their progress. He should be able to give career guidance.

1.2 In the organisation of training, a balance has to be struck between the need for a variety of experience on the one hand and for continuity of clinical care of patients on the other. Training should contain an element of clinical responsibility, often increasing towards its conclusion. All trainees should have the experience of working with more than one consultant. Major placements should last at least one year and some patients and their families should be seen over a prolonged period to provide experience in the chronicity of certain clinical problems. There should be opportunities for each trainee to meet regularly with peers.

1.3 Schemes may be providing joint training with other specialties or sub-specialties of psychiatry, the time spent within each specialty determining the nature of consultant post qualified for. The recommended period of higher training for a consultant post in mental handicap psychiatry is four years. The recommended period of training for a consultant post with a special responsibility to mental handicap psychiatry is two years, with an irreducible minimum of 18 months.

2.0 Resources

2.1 Senior Registrars should have a room of their own at each point in training. The use of modern aids to teaching and the development of clinical skills is highly desirable (e.g. video and one-way screens). It is essential that there is ready access to adequate and up-to-date library facilities, which should include relevant journals. There should be access to all necessary types of special investigation. Adequate secretarial services are essential.

3.0 Clinical experience and teaching.

3.1 Range of experience

3.11 Core clinical experience.

The trainee should have a minimum of 2 years core experience of assessing and treating patients who present with the range of problems likely to be encountered in a comprehensive service for people with mental handicaps. The range of problems must include emotional and behavioural disorders, psychoses and other psychiatric disorders arising in the whole range of mental handicaps from profound to borderline intellectual dysfunction. There should be exposure to children with educational difficulties and developmental disorders, and the child psychiatric problems associated with these. There should be experience in working with families who have a mentally handicapped member; this should involve attention to family structure, development and dysfunction around the problems of the new-born, child, adolescent, and adult member and should include both coping and non-coping families. There should be exposure to normal child development and the full range of disability seen in mentally handicapped people who do not have a psychiatric disorder.

3.12 Special clinical experience.

Individual trainees will vary in their needs for specialist experience and schemes should allow trainees to develop their own individual special clinical interests and skills. There should be opportunity for further experience in forensic psychiatry, child psychiatry, psychotherapy, paediatrics, neurology, genetics and other areas of medicine as they relate to mental handicap.
3.2 Types of treatment

All trainees should have experience in the various types of treatment for psychoses, emotional and behavioral disorders, epilepsy, family distress, sexual and other disorders encountered in a comprehensive psychiatric service. The range of treatments should include use of appropriate medication, individual and group psychotherapy, behavioural psychotherapy and family therapy. There should be the opportunity to manage psychiatric emergencies. There should be experience in the presentation and management of physical illness in profoundly and multiply handicapped people. There should be exposure to the field of prevention including clinical genetics, exposure to relevant paediatric treatments and an understanding of the measure taken to prevent a deterioration in the degree of handicap. There should be knowledge of the types of treatment available from other professional groups. There should be experience in rehabilitation and resettlement.

3.3 Treatment settings

Trainees should have the experience of working in a variety of settings and with the full range of related disciplines. A balance must be struck between hospital and community work, both being necessary to qualify for a full-time role. Within the hospital this should include experience of working in an admission and assessment unit, units for disturbed patients, including secure units; there should be limited experience in other settings found within large hospitals. In the community this should include working within a multidisciplinary team, out-patient departments, education and social service establishments, the courts and patients' own homes. There should be the opportunity to participate in the work of departments of child health, child psychiatry, forensic psychiatry and the other related disciplines.

3.4 Consultation work

Trainees should provide a consultative service to other professionals and agencies caring for the handicapped. This experience could be provided by attachment to statutory and non-statutory day and residential services.

3.5 Supervision of clinical experience

Supervision is essential on all aspects of a trainee’s clinical experience. Supervision by the trainee’s consultant should include both the overall planning of treatment and detailed discussion of individual treatment sessions. It should be available at a regular designated time for at least one hour per week if on an individual basis, and for longer if there is group supervision. Trainees should be able to discuss with their consultants whether they require additional help to deal with any conflict or personal difficulties that arise from treating patients and from working within multidisciplinary teams. Supervision should also attend to personal and professional development and to relevant aspects of organisational management.

3.6 Clinical teaching

There must be regular clinical teaching the consultant undertaking joint work with the trainee, e.g. case conference, out-patients, clinical audit meetings, etc. This should include interviewing techniques and differing styles of therapeutic approach as well as diagnosis and clinical management.

4.0 Academic teaching

4.1 Academic meetings

Regular academic meetings must be held. The minimum amount of time should be the equivalent of one session per week throughout the university term. Such occasions should take the form of seminars, lectures, academic case conferences and journal clubs. The consultant responsible for these should have a link with a university or teaching hospital department. The person must have adequate time and resources for teaching. Such teaching may require collaboration between several centres. The necessary expertise for some specific treatments may be provided by senior non-medical members of staff.

Academic case conferences should allow time for discussion on conceptual issues as well as clinical management matters and will necessitate discussion between two or more consultant. The equivalent of at
least one such case discussion per fortnight should be provided during university terms. There must be opportunities for an exchange of ideas with psychiatrists and others who hold varying views and have different clinical approaches. Peer group experience is very important and Senior Registrars should meet regularly together. This will be partly for the purpose of academic meetings.

4.2 Content of teaching

The major part of the academic teaching will cover the psychiatrically ill mentally handicapped. This would also involve the study of child development and of the appropriate areas of psychology, social sciences, medical biology, neurosciences and the care of the elderly. It must give the trainee opportunity for discussion with a variety of teachers whose viewpoints cover the main approaches to mental handicap psychiatry.

4.3 Supplementary experience

Trainees should be expected to attend College meetings and other conferences and courses. Deficiencies in previous training or special clinical interests should be met by periods of attachment to other units and courses. Visits to other services for the mentally handicapped, both within and outside the Health Service, should be encouraged. This should include liaison with voluntary agencies.

5.0 Research

5.1 Research methodology

The training programme should provide the trainee with knowledge and understanding of research methodology so that he is able to evaluate critically the literature.

5.2 Original work

Any approved programme must provide the opportunity, time and supervision for trainees to undertake an original piece of work. The original piece of work could be a research project, a review of a particular topic or issue for publication, or a study of some clinical innovation. It will often be appropriate for the project to be a collaborative one and the possibility of working with an established research team is highly desirable. Supervisors experienced in research must be available. In schemes approved for full-time training in mental handicap the research undertaken should be in this field.

5.3 Research time

The equivalent of two half days per week throughout the year must be available to the trainee for research. In all training schemes it should be possible for selected trainees to spend up to 12 months of their training in full-time supervised research, and this should be encouraged.

6.0 Teaching experience

The experience of teaching registrars, medical students and students from other disciplines, particularly from those represented in multidisciplinary teams, is a valuable part of training. This should include both clinical supervision and academic tuition. Supervision and some help with the skills of teaching should be available to the trainee. Organising an academic programme is an important experience.

7.0 Management and administration

Many consultant posts in mental handicap psychiatry include a large element of administration. To prepare for this work trainees should have the opportunity to share in the administration and decision making machinery of their service. They should be given a working knowledge of Health Service and Local Authority management structures and related financial issues. This should be encouraged through supervision by their consultant and attendance at management courses.
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*Recommended consultant wholetime equivalents in the psychiatry of mental handicap includes both child, adolescent and adult posts, the number of each depending on local requirements.*
THE PSYCHIATRY OF OLD AGE

Specialist Psychiatric Services for Elderly People - A Proposal for the Development of Services in Ireland.

Introduction

The Psychiatry of Old Age is a recognised psychiatric speciality which is concerned with mental disorders arising anew in people over the age of 65 years. Broadly, it deals with two groups of people:

1. Elderly people developing functional psychiatric disorders for the first time over the age of 65 years.

2. Dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.

The Psychiatry of Old Age is a relatively young psychiatric speciality. The first services developed in the early 1960's in Great Britain as a response to the increasing recognition of mental health problems in elderly people. At that time there was also an appreciation that most elderly people with such problems were living in their own homes (approximately 95%) and so the thrust of such services has been to provide a community oriented approach offering domiciliary assessment and treatment where practical. Experience with these services over the years has shown that it was essential that the services should focus on both functional psychiatric illness as well as dementia in old age. It has also become apparent that such conditions are very amenable to treatment. Treatment has been evaluated and refined by the development of academic centres in Psychiatry of Old Age such as the Institute of Psychiatry in London and the highly regarded units in Liverpool and Nottingham.

Interestingly, in sharp contrast to developments in Psychiatry of Old Age in Great Britain, the United States initially focused on research into ageing and brain changes particularly with regard to dementia and the affective disorders of old age. Research has been fruitful in illustrating that such problems can be helped by appropriate treatment in its broadest sense to include biological as well as social and psychological techniques and from this has developed Psychiatry of Old Age Services, which are commonly referred to as Geriatric Psychiatry Services, in the United States of America.

In Ireland, it is increasingly becoming apparent that specialist psychiatric services are required for elderly people for a number of reasons. These include:

- changing demographic factors - more people are surviving to old age and therefore more at risk of developing dementia. 5% of people aged over 65 years are likely to suffer from dementia and this increases to 20% of those aged over 80 years.

- the special needs of elderly people with psychiatric problems - these include the increased likelihood of co-morbidity in terms of co-existing medical problems and the
often atypical presentation of depression in old age. Likewise the identification and treatment of psychiatric and behavioural disturbance in dementia sufferers requires specialist skills.

- changes in family structures - families are smaller so fewer children are available as carers. The increasing trend for women to work outside the home again reduces the number of available carers for elderly people with mental illness.

- emigration - again reducing the pool of potential carers.

The Service Philosophy

It is important that Psychiatry of Old Age services develop in conjunction with services for Medicine for the Elderly particularly because of the co-morbidity of medical and psychiatric problems in old age. However, it is equally important that Psychiatry of Old Age should be grounded in psychiatry so that skills in treating psychiatric disorders and behaviour problems are retained and, indeed, enhanced by adopting any new treatments developed in General Psychiatry. These can then be used, albeit sometimes in a modified form, in Psychiatry of Old Age. To quote the Joint Report of the Royal College of Physicians and the Royal College of Psychiatrists on the care of elderly people with mental illness “Psychiatry of Old Age belongs to the family of psychiatry but is married to geriatrics”.

Close relationships with both Medicine for the Elderly and General Psychiatry can best be maintained by siting the Psychiatry of Old Age services in general hospitals. General hospitals should be the base for the team, the site of the acute beds, the day hospital and outpatient clinics. Furthermore, general practitioners are familiar with making referrals to general hospitals and this will facilitate their referrals to Psychiatry of Old Age when necessary.

Close relationships with general practitioners are crucial. This involves frequent liaison, particularly by phone, so that general practitioners became familiar with the mental health problems in elderly people which are appropriately referred to the service and the benefits of making an early referral but at all times emphasising the role of the general practitioner as the doctor primarily caring for the patient. This close liaison would educate general practitioners in the recognition and treatment of depression in old age and, likewise, the management of dementia. Whilst they are very aware of both these problems, research shows that often awareness does not lead to treatment. The liaison would, of course, work both ways with the Old Age Psychiatry Service becoming aware of the needs of general practitioners and their patients in a particular area and then developing services which respond best to these needs.

Service Model

As already stated, Old Age Psychiatry Services should be developed in conjunction with pre-existing Geriatric Medicine services or simultaneously with such services taking into account regional, geographic and demographic factors in individual cases. The population of elderly people for which such a psychiatrist is responsible must be kept to a reasonable number. To fail to do so would limit severely the effectiveness of the psychiatrist to the detriment of patients and their families. In practice, this means appointing one whole time equivalent consultant in Psychiatry of Old Age per 100,000 population assuming 10% of the population will be over 65 years.
Service organisation.

It is essential that the organisation of the service is clear. This includes clear guidelines on the relationship between Psychiatry of Old Age and General Psychiatry in terms of both clinical responsibility, administrative interaction and resource allocation.

Clinical Responsibility: The groups of patients appropriately dealt with by Psychiatry of Old Age Services have already been listed i.e.

1. Elderly people developing functional psychiatric disorders for the first time over the age of 65 years.

2. Dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.

Despite the apparent clarity of this, misunderstandings may occur. In particular, chronic schizophrenia is dealt with by General Psychiatry services - such patients on reaching the age of 65 years are not automatically transferred to Psychiatry of Old Age. Delirium is a medical problem even when it occurs in the setting of dementia and, therefore, requires assessment and treatment in a medical or surgical setting depending on the underlying physical cause of the delirium.

Administrative Interaction: This is a complex area. Psychiatry of Old Age must look in two directions. Whilst clinically it makes sense for the Psychiatry of Old Age consultant to relate closely to colleagues in General Psychiatry in his/her catchment area to ensure a comprehensive psychiatric service is provided, Psychiatry of Old Age services must also relate closely together in geographic regions for the purposes of service delivery, sharing clinical experience and, crucially, for resource allocation. The latter will be dealt with later.

In terms of out of hours cover, practice indicates that the Psychiatry of Old Age consultants and their NCHDs should take part in the General Psychiatry rota because numbers would make it impractical for separate Psychiatry of Old Age and General Psychiatry rotas to operate.

Resources: Resources always seem insufficient in psychiatry and experience shows that when specialities advocate for themselves they are more likely to be successful in obtaining adequate resources in terms of both personnel and facilities. It is, therefore, strongly recommended that the resource requirements of Psychiatry of Old Age are considered separately from those of General Psychiatry and to facilitate this it would be necessary for the consultants in Psychiatry of Old Age in individual health boards to form administrative groups to deal with resource allocation in particular. This should not detract from their role in catchment area teams.

In general, special interest posts in the Psychiatry of Old Age have been found to be an unsatisfactory method of service delivery particularly for elderly people. Experience in Britain particularly has shown that with special interest posts consultants become overly involved in the General Psychiatry moiety where problems tend to be more robust in their presentations, more chronic and where patients have greater numbers of advocates to support them. Many mental health problems in elderly people present quietly with the person involved being the last to complain and so it is very important
that the consultant psychiatrist should be in a position to devote all his/her clinical time supervising and providing a service for this vulnerable population. This often means being proactive in seeking out sufferers rather than waiting for them to come for assistance.

(b) Service delivery

Domiciliary Assessment: Domiciliary assessment has been described as the lynch pin of Psychiatry of Old Age Services. Its particular advantages are that it ensures assessment is provided for the many elderly people who are reluctant to avail of psychiatric services or who by reasons of their abnormal mental state (e.g. if they suffer from dementia) are not able to keep an outpatient appointment. It means that a very comprehensive assessment of the person to include their social as well as their psychiatric status is possible. It ensures that comprehensive information is obtained from informants as well as the patient and also that one is aware of the other people involved with the patient. This is essential knowledge in dividing a care plan. Specifically in the case of people who suffer from dementia, it means a more valid assessment of their mental state is obtained since they will be at their best cognitively in the familiar surroundings of their own home. However, for domiciliary assessment to be an effective form of assessment it must be readily available and flexible in its approach.

The Day Hospital: The day hospital plays an important and, indeed, pivotal role in Psychiatry of Old Age Services. Its role is assessment and treatment of those with both dementia and functional psychiatric illness. It means a rapid response to referral is possible. It provides an alternative to inpatient admission in many cases and it also facilitates discharge. The day hospital should be sited on a general hospital so that physical screening, which is essential in this age group, can be carried out efficiently. It also assists in administration of the service particularly where charts are concerned.

In very thinly populated rural areas a mobile day hospital model, whereby particular days are spent in different locations, may be a more practical method of providing access to a day hospital.

Out-patient Clinics: Like day hospitals, it is essential that out-patient clinics for Psychiatry of Old Age are based in the general hospital as this will facilitate easy access to hospital and community referrals. Out-patient clinics are particularly useful for follow up of elderly patients with functional psychiatric disorders such as depression who do not require the intensive treatment modalities available in the day hospital setting.

Consultation Liaison Service: This is an integral part of any Old Age Psychiatry Service. The rationale for this is that it permits specialist psychiatric liaison with geriatricians and other consultants in the general hospital. Since a substantial number of admissions to general hospitals are of elderly people this is a valuable contribution to the general hospital. It also permits the development of a seamless service whereby patients are followed into and out of hospital and whatever support services are required for management of their psychiatric problems can be arranged by the service.
Medical: All Old Age Psychiatry services should be led by a consultant with appropriate training in this speciality. As in General Psychiatry, the consultant should be hospital based but community oriented and service delivery should be based on a well trained multidisciplinary team with appropriate resources.

The level of NCHD underpinning required by individual consultant will depend both on the catchment area for which he/she is responsible and also other commitments. These may involve teaching, training and research. It is important that there is flexibility to accommodate these other requirements but each consultant in Psychiatry of Old age should have at least one NCHD. Such NCHD placements are important, indeed essential, training placements for them particularly now that we are confronted with a rapidly ageing population and, therefore, and increasing need for specialist Psychiatry of Old Age services.

Nursing: The community psychiatric nursing ratio recommended for the population over 65 years is 1 CPN:4,500. The importance of the role of CPNs is Old Age Psychiatry cannot be described adequately. The majority of the patients seen are home based and often reluctant to leave their homes so monitoring by CPNs ensures the smooth functioning of the service and a rapid response to problems. A response which ensures that crises are kept to a minimum.

Nursing staff for the day hospital and acute and long stay in-patients beds must be psychiatrically trained and adequate in number to deal with the often frail elderly people with whom they are working.

Other disciplines: As in General Psychiatry, essential disciplines in the multidisciplinary team include occupational therapy, psychology and social work. These are required not only in in-patient settings but also in the community and day hospital aspects of the service.

(d) Facilities

Day hospital: As already described, it is essential that day hospitals in Psychiatry of Old Age are based on the general hospital campus both for ease of access to the general hospital and the community and to ensure that the physical aspects of assessment can be carried out. Day hospitals should be sufficiently spacious to provide room particularly for those who suffer from dementia who may be restless or aggressive. Their staffing should be multidisciplinary and include psychiatrically trained nursing staff, the number required include an occupational therapist, psychology and social work sessions and last but not least a receptionist to ensure both good communication with carers and that therapy sessions are not constantly interrupted by the telephone. The receptionist would also ensure that the administrative work of the day hospital is kept up to date.

Acute in-patient beds: The acute beds for Psychiatry of Old Age should be an integral part of the acute psychiatric unit ideally with a separate or designated area.
within the unit for Psychiatry of Old Age. Such a unit should be based in a general hospital.

**Long stay beds:** It is crucial that there is easy access to different levels of long stay care for the patients seen by Old Age Psychiatry Services.

Ideally long stay care should be provided within the person's community so that links with family and friends are easily retained and maintained thereby improving the quality of life of residents, particularly those who suffer from dementia.

The range of care required by dementia sufferers include welfare, general nursing and psychiatric care. Welfare and nursing care is required by those with personal care needs, who also require 24-hour care and a safe environment so that habits such as wandering can be managed. Psychiatric long stay care is required for people with dementia who have severe behavioural problems such as aggressive. However, it would be anticipated that people would be able to move once their behaviour problems have settled provided that the move is within the same area. There is also a requirement for psychiatric beds for elderly people with treatment resistant depression.

Again taking the pragmatic approach to long stay care, private beds funded by nursing home grants, where appropriate, should be used by health boards.

The Eastern Health Board proposes to develop Community Care Units in a various areas around it's region. There are four modules planned for each unit: one for the physically infirm, one for respite, one for people who suffer from dementia and one providing day care. This seems to be an excellent concept because it would permit people to move between different modules depending upon their different care needs whilst remaining in the same unit. Also the units would be developed to serve particular catchment areas which would enable people to remain integrated within their communities. This is a significant advance on the previous model of using large geriatric hospitals or asyla for continuing care.

It is of the greatest importance that there should be equality of access to all long stay facilities.

The personnel and facilities required for an Old Age Psychiatry Service are summarised in Appendix I.

**Training.**

It is essential that training is provided within Old Age Psychiatry Services for medical and non-medical specialities.

**Training in Old Age Psychiatry**

(a) **Medical Students**

Given our ageing population an appropriate emphasis must be given to exposure of medical students at both pre-clinical and clinical level to Psychiatry of Old Age. All students should have access to a didactic module in Psychiatry of Old Age in the clinical medical school curriculum and, where possible, clinical experience should also be available. This should cover both functional and organic mental illness in old age.
(b) General professional training in psychiatry
Each psychiatric trainee should have a minimum of six months training in Psychiatry of Old Age. They should gain experience in several aspects of Psychiatry of Old Age particularly domiciliary, day hospital and acute in-patient work as well as continuing care.

(c) Higher professional training in psychiatry
The Royal College of Psychiatrists recommends that trainees in Psychiatry of Old Age at higher professional level spend two years in Old Age Psychiatry ideally in two different services. The other two years are spent in General Psychiatry. The College also recommends that there should be access to other relevant experience such as Medicine for the Elderly, neurology and consultation liaison psychiatry.

It is important to develop a number of senior registrar posts to meet the need for consultants in this country and also to provide general psychiatry and mental handicap trainees with experience in this speciality. However, the number of posts should be monitored carefully as we are very aware that in Ireland a certain proportion of our trainees travel abroad to train at higher level and we consider such experience gained elsewhere a valuable contribution to psychiatry in Ireland.

(d) Trainees in general medicine.
There should be reciprocity in training by which is meant that registrars and senior registrars in medicine for the elderly should obtain some training in Psychiatry of Old Age. This may be done by means of exposure in consultation liaison settings, combined clinics or accompanied domiciliary assessments.

(e) Training in research relevant to mental illness in old age.
Recent advances in the assessment and treatment of mental illness in old age are significant and have contributed to our ability to maintain people in their homes and improve their quality of life and those of their carers. For these reasons it is essential that academic centres providing training in research in mental illness in old age are developed and that interested trainees in psychiatry and other disciplines should have the opportunity of working in such centres.
APPENDIX I

PSYCHIATRY OF OLD AGE SERVICES
RESOURCE REQUIREMENTS 1, 2, 3.

(1) Personnel Requirements:

Consultant 1 : 10,000 pop over 65 yrs.
Secretary 1 per consultant
C.P.N.s 1 : 4,500 pop over 65 yrs.
minimum of 1 per consultant
N.C.H.D.s
Occupational Therapist 1 per service
Psychologist .5 - 1 W.T.E. per service.

(2) Structural Requirements:

Acute Beds
(i) dementia 1 : 1,000 pop over 65 yrs.
(ii) functional illness .5 : 1,000 pop over 65 yrs.
Day Hospital Places 2 : 1,000 pop over 65 yrs
Continuing care places 3 : 1,000 pop over 65 yrs.
for severe dementia

The number of acute beds can be reduced if an active day hospital programme together with a rapid, flexible response to referrals and active follow up of people in their homes is available.
REFERENCES

1. Care of Elderly People with Mental Illness - Specialist Services in Medical Training. A joint report by the Royal College of Physicians and the Royal College of Psychiatrists. 9th February 1989.


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PSYCHOTHERAPY

Proposals for the Development of Psychotherapy Services in Ireland

1. Psychotherapy as a Sub-Specialty; Background:

A training in psychotherapy encompasses two main aspects. The first is a training in the discipline of a psychological approach to the patient. The second aspect is in the effectiveness of psychotherapy as a clinical tool. By separating these two aspects, social pressures have led to different emphases on psychotherapy training in different countries.

In North America and some European countries, where only physicians were registered to practice as clinicians, training in psychotherapy has been integrated within psychiatry. In other countries where psychotherapy was practised by those without medical qualifications, there developed a greater disparity in psychiatry. The highest level of psychotherapy training includes personal therapy, theoretical and clinical supervision and is compulsory training for psychiatrists in the Netherlands. In Switzerland, Finland and Germany, intensive theoretical and clinical training is compulsory and personal therapy only highly recommended. In countries, which were more influenced by biologically trained psychiatrists, it was only more recently that the lack of psychotherapy training was recognised as a problem. In the 1970s, it was recognised in the UK and Ireland that there was a shortfall in training and services in psychotherapy that could only be addressed by creating a sub-specialty.

Regarding the effectiveness of psychotherapy as a separate clinical tool, it was only in the 1970s that outcome research was beginning to be taken seriously. The first influential work was in Germany when private insurance companies were convinced that it was more cost effective to pay for psychotherapy, as it reduced the cost of psychiatric services. An extensive body of research has now been produced to argue the case for psychotherapy on purely economic grounds. The case has been put to the Voluntary Health Insurance in Ireland that psychotherapy reduces general medical service demands by 20% and reduces in-patient hospital stays.
2. Training Needs of the Psychiatrist.

In May 1996 the European Board of Psychiatry prepared a draft document of requirements for specialist training in psychiatry. It puts forward minimal standards of training to encompass a variety of approaches and degree of input in terms of time spent with patients and in supervision. In the UK, psychotherapy training has become compulsory before the membership examination as a step towards higher specialist training.

There has always been a practical difficulty in developing training resources outside of large centres. In the late 1980s in the UK, the problem of unequal distribution of training and experience was addressed and major efforts made in finding ways to help development in the peripheries.

3. Existing Resources in Ireland.

In 1993 attention was drawn by the Royal College of Psychiatrists to the lack of any specialist training in Ireland and considered a serious gap in the provision of service and training. In addition there has been dissatisfaction by patients with the lack of psychotherapy services being provided by the medical and psychiatric profession. Patients have become more psychologically aware and realise the limitations of drug therapy.

In the private sector major developments have occurred over the past two decades in the provision of psychotherapy services. In 1990 the Irish Standing Conference for Psychotherapy was founded. It embraces all the major psychotherapy training organisations and has links with the European Association of Psychotherapy. While the training provided by these bodies is recognised as appropriate for the needs of the psychiatrists, only a proportion of trainees take it seriously. The main problem is the lack of any sub-specialty and the career implications for those in training. Despite the requirements for training, they are not fully implemented without leadership.

The situation can be illustrated by the different developments North and South of the border. In the North, the development of the specialty was enabled by the funding of higher training posts in Adult Psychotherapy. The trainees travelled to use resources in Dublin and London until a minimum number of specialists could develop training and services locally. This has led to major developments within the National Health Service. In the Republic of Ireland, where such training is available, it has not been taken up by the public sector in adult psychiatry. On the other hand there is much greater development in the field of Child Psychiatry where the influence of consultant psychiatrists trained in psychoanalysis and various psychotherapeutic approaches has been greater.

4. The Role of the Consultant Psychotherapist.

The Consultant Psychotherapist is trained to a high level of expertise in at least one specialised branch in psychotherapy. He or she also has a working knowledge of other psychotherapy fields. The responsibilities of the consultant include:
4.1 Clinical function: Assessment of patients regarding suitability for various forms of psychotherapy, treating patients presenting special difficulties, and acting as a leader of therapeutic communities.

4.2 Teaching function:
(a) Teaching medical students and non-psychiatric doctors communication and interview skills.
(b) Providing the basic training required for all psychiatrists.
(c) Other disciplines; contribution to the psychotherapeutic skills of a wide range of professionals; nurses, psychologists, social workers, occupational therapists and those of other disciplines such as art and music therapy.
(d) Voluntary agencies; counsellors and other supportive agencies rely heavily on teaching and supervision from specialists in psychotherapy. (Traditionally, in many psychotherapy centres, the services are maintained by voluntary trainees working the consultant and carrying out the clinical work in order to get the training and supervision available.)

4.3 Management function: The development of services and advice to managers.

4.4 Consultative function: To institutions within the public health sector the consultant psychotherapist provides expertise at times of crisis, e.g. where there is a high level of staff illness or conflicts occurring in multidisciplinary settings.

5. The Range of Psychotherapeutic Treatments.

5.1 Psychotherapy as a main treatment method. Increasingly the general psychiatrist's case load involves patients who present with interpersonal dysfunction, mental conflict and behavioural disorders. Psychotherapy is 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.

5.2 Psychotherapy in conjunction with other treatments: Psychotherapy used in conjunction with pharmacological approaches has been demonstrated to be particularly effective. It is used as a component in the treatment of a wide range of major mental illness, including psychosis. It provides a treatment model in the context of larger therapeutic programmes such as those for severe personality disorders, and contributes to the management of severely disadvantaged groups such as the mentally handicapped or chronically mentally ill.

6. Proposals for Development.

The Royal College of Psychiatrists has recommended that (as a first step) in the provision of psychotherapy services there should be one whole-time equivalent consultant psychotherapist per population of 200,000. A post-membership training of at least three years must be completed before appointment as a consultant psychotherapist. As an interim measure it might be helpful to provide appointments for consultant psychiatrists with special responsibility for psychotherapy.
allocating a minimum of 6 sessions a week to psychotherapy with a responsibility of 4 sessions to general psychiatry or another specialty within psychiatry. The training resources already exist in Ireland to set up such posts. It has been found however, that 'Special Interest' posts do nothing to contribute to development of services, for the psychiatrist cannot devote the time to the teaching, training and development of services.

There is a serious need for the setting up of higher specialist training in psychotherapy. Each main centre should provide such posts to enhance the training of the general psychiatrists, for the trainee contributes to the overall development. Although higher training cannot be organised until specialists are appointed, there are possibilities which have been successful in Northern Ireland, using resources from other centres. While those in the North were funded to travel to Dublin and London, services have developed enough in the North to provide a training experience within the country. There exists a useful opportunity for attracting European funds for such a joint co-operative venture as well as enhancing the cross border co-operation which is already being developed in other medical specialties.
LIAISON PSYCHIATRY

Background

Psychological disorders are significantly more prevalent in general hospital in-patients and out-patients than in the general population. These disorders are often not recognised leading to expensive, technological investigations being carried out before psychological issues are considered. Many hospital doctors have not received adequate training or developed sufficient skills to diagnose and manage complex psychological disorders or know when to refer patients to a consultant psychiatrist.

Nature and role of a liaison psychiatry service.

Liaison psychiatry is essentially psychiatry in relation to general hospital patients. The term described the arrangements whereby hospital physicians and surgeons have access to mental health professionals in order to assess and treat patients presenting with psychiatric or psychological as well as organic symptoms. Both a 'liaison' model and a 'consultation' model have been described but the joint report of the Royal College of Physicians and the Royal College of Psychiatrists published in April 1995 recommend a consultation-liaison model.

Evidence as to benefits of liaison psychiatry.

Epidemiological considerations.

Liaison psychiatry is concerned with situations where physical and psychological disorders overlap. This occurs when an individual has a psychological reaction to physical disease or when psychological disorders cause physical symptoms. Anxiety and depressive disorders occur in 12-15% of medical patients. Failure to recognise and treat these conditions may impair the patients' quality of life, delay recovery or increase mortality. Studies indicate that between 25-50% of new medical out-patients experience physical symptoms that cannot be explained on the basis of organic disease. If undetected, multiple physical investigations are conducted to eliminate organic disease and significant costs are incurred. Alcohol and drug misuse are widespread among hospital in-patients and are responsible for many admissions. Liaison psychiatry is also involved with patients who require medical assessment for treatment...
following deliberate self-harm. This group is particularly at risk of completed suicide.

Benefits of liaison psychiatry.

An effective liaison psychiatry service leads to earlier detection of psychological problems and hence reduce disability and distress with improved quality of life for patients. At a practical level, this leads to reduction in length of stay in hospitals for medical and surgical patients as well as a reduction in the number of medical out-patient attendances. Studies have indicated that effective liaison psychiatry leads to avoidance of inappropriate hospital admissions of patients with chronic multiple unexplained disorders. It also leads to a reduction in the number of tests performed and a decrease in medical service utilisation. Liaison psychiatrists also accurately identify and treat anxiety and depressive disorders in patients with organic disease. This impinges not just on quality of life but also on mortality rates.

Components of a liaison psychiatry service:

The joint report of the Royal College of Physicians and the Royal College of Psychiatrists recommend the creation of a generic liaison psychiatric team. The team should consist of a full-time consultant psychiatrist, one or more psychiatrists in training, 2 clinical nurse specialists, a social worker and a clinical psychologist. The minimum consultant input to liaison psychiatry is seen as 5 sessions.

The model of service delivery is the consultation-liaison type. The consultant regards the hospital, including the Accident and Emergency Department, as his catchment area. Special expertise is developed particularly in the area of Deliberate Self Harm and Suicide.

Specialist services can also be provided where there are particular needs in general hospitals. National centres (cardiac, renal) have specific needs and a liaison model is appropriate to meet those needs. Similarly, liaison psychiatrists are frequently involved with pain clinics where a psychological input is so vital.

Conclusion.

A liaison psychiatry service is a cost effective way of improving the treatment of general hospital patients with psychosocial problems. Quality of life is enhanced and healthcare utilisation is reduced.
General Principles

Psychiatric Rehabilitation amalgamates in different measure components of treatment, enabling and caring to allow individual patients to achieve maximum independence. Whilst rehabilitation considerations form part of all aspects of psychiatry, specialist rehabilitation services are an essential component of comprehensive psychiatric services. The variable disability created by chronic mental illness, brain injury, severe neurotic disorder and personality disorder forms the remit for that rehabilitation specialty. Within that spectrum, it is likely that the consequences of chronic mental illness will be the major consideration.

The aim of rehabilitation is to enable people with a disability to function as independently and as effectively as possible.

In psychiatry, the focus is on social disability. Here 'disablement' is defined in terms of the degree to which an individual falls short of the performance that is generally expected within a given society, as interpreted by the individual or those closely connected with them.

It is caused by the intrinsic impairments of the illness, social disadvantage and the personal distress or reaction of the person to these. Rehabilitation ideally works to the person's own priorities and within the context of their own environment.

The process of rehabilitation involves making a detailed assessment of patient’s social and personal skills, their social role performance and the effect their clinical symptoms have on this. It also involves assessing the social environment and their families and carers, and examines the range of resources in the local community.

Then, in partnership with the patient, a detailed individual programme is drawn up, and long-term and short-term goals are defined, as are the methods and intervention resumed to bring these about. A time schedule is set. The outcomes are reviewed and evaluated at agreed intervals.

The most common structured interventions are skills training, behaviour analysis and modification, and counselling, but social learning takes place from the general milieu and the relationships formed.

The Role of a Rehabilitation Consultant with a Special Interest in Psychiatry in the Psychiatric Service

The Manpower and Training in Psychiatry document, as published by the Irish Psychiatric Training Committee in May 1995, said it was essential that there be a special interest
commitment in the part of one psychiatrist in each psychiatric service to rehabilitation. The extent of this commitment would necessarily vary with the extent of each catchment area but, in general terms, approximately three sessions per 100,000 of population appears appropriate. The reason for such a requirement is that many rehabilitation facilities, such as workshop places, hostel places, day centre places, etc. are communal to the service and are not sector-based and so it must be ensured that each of these facilities is being used to its maximal potential and that each individual is appropriately placed i.e. not receiving care above or below his or her needs. This, in principle, requires the recognition on the part of the consultant team of each service that a rehabilitation place belongs to the service as a whole and not to an individual consultant. The knowledge of what places and facilities are available in the service as a whole and the distribution of these appropriately between patients becomes the responsibility of the rehabilitation psychiatrist who is seen as the "proprietor" of places while the patient remains the responsibility of the sector psychiatrists for his or her clinical management. Alternatively, it may well be that the rehabilitation psychiatrist might take on responsibility for all these patients. There must, of course, be close liaison between the rehabilitation and sector psychiatrists both for the patients' and the service's best interests. This requires considerable skills on the part of the rehabilitation psychiatrist. The rehabilitation psychiatrist will also have the responsibility of networking with the various rehabilitation organisations such as the NRB and Rehabilitation Institute in the catchment area and with their integration and co-ordination for the benefit of patients and the services as a whole. This requirement will, nationally, involve approximately ten whole-time equivalents.

The consultant team must be multidisciplinary to include at least nursing, social work, occupational therapy and clinical psychology components.

Community Psychiatry

There is a need for community approaches to rehabilitation. Whilst there is much work to be completed in the long-stay hospitals, an even greater need is arising for the majority of disabled people who live in the community.

The rehabilitation approach to this group is different from that for hospital patients, for whom much emphasis is placed on return of competence and the promotion of independence; the focus for patients in the community is on the maintenance of competence and preservation of independence.

Active community rehabilitation is best implemented from a day hospital. Social factors are significant in the outcomes of severe psychotic disorders. Many deficits are resistant to intervention and, to enable the highest level of functioning, the social environment has to be manipulated. This may involve family interventions, provision of supported residential and day-care facilities, and intervention with staff of these units.

Family work is an essential component of and resource in community rehabilitation. Families need support, counselling and education, as they can suffer from stress and reduced psychosocial adjustment themselves.

A rehabilitation co-ordinating committee researching local needs liaising with housing and interested voluntary bodies and other professional representatives in a health service area can be of immense advantage.
Overall, there have been significant developments since the publication of *Planning For The Future*. At that stage, there were 11,906 patients in Health Board hospitals and units. In 1994 there were 5,568 residents in such units. 226 people became ‘new long-stay’ patients in 1994. This is still unacceptably high. There has been a marked increase in the provision of day-care places from 1,300 in 1990 to 3,447 in 1994 and in residential accommodation outside the hospital from 1,797 in 1990 to 2,370 in 1994.

There has been one consultant appointment in hospital and community rehabilitation, but many services have a consultant with special responsibility for rehabilitation.

Throughout the country, in 1994, there were approximately 175 training units for vocational skills training. These are mainly operated by voluntary organisations, but some are operated by Health Boards. Of these centres, 61% accept people with all types of disability but 23 of these are specifically for people with disability due to mental illness. Alongside these services, there are around 50 vocational officers working through the National Rehabilitation Board, co-ordinating the placements of trainees.

In recent years, the National Rehabilitation Board has developed the Skill Base Programme which is now being used in the basic training units. This innovative, trainee-centred approach incorporates modules in new technology, remedial education, social and cultural development as well as enterprise work experience in an integrated programme of basic training and development. This is a welcome addition to the rehabilitation services.

**Present Extent of Service Need**

There remains over 4,082 long-stay patients in public psychiatric hospitals and 186 patients in private psychiatric hospitals; a total of 4,268. They require considerable resources for their rehabilitation.

In the community, around 1% of the population suffer from long-term mental illness. Despite treatment advances, most of those suffering from schizophrenia require help. Almost 50% of these will continue to live with their families. Of those suffering from affective disorders, 12-15% have persistent mood abnormalities and high levels of disability.

Almost 8% of patients attending primary care are disabled by chronic mental disorder and its sequelae. It has been estimated that 250 per 100,000 will be long-term users of psychiatric services, while 50-60 per 100,000 (the high-dependency group) will require care in residential settings. Long-stay hospital places are required for 8-9 per 100,000.

Failure to identify and prioritise for this group can lead to services selectively providing for those with low levels of illness while under-providing for and under-treating those with the most need.

**Problems**

There has been a marked failure to recognise and appreciate the importance of rehabilitation in psychiatry in general, but particularly in resettlement, for activation in long-term units, in secure units, and as a prerequisite in the management of long-term illness in the community.
There is also a lack of appreciation of the needs of the long term mentally ill, in both the hospital and community. As the services are increasingly devised the community, there are not yet in place the resources and the approaches to management to ensure continuity and appropriate acceptable and effective forms of reprovision and care for this vulnerable group.

Many of the consultants who have a special responsibility for rehabilitation in their services are also expected to deliver a full-time general service. They also lack basic resources.

Many rehabilitation units are expected to function with just the two disciplines of nursing and medicine. This is not acceptable. Clinical psychology and occupational therapy are essential components of this service.

The nursing staff assigned to work in rehabilitation in the main have had no specialised training. The need for residential facilities far outstrips the provision. Overall, the services are still far removed from the position of being the resource and support to the primary care team.

Recommendations

(1) **Consultant post in Hospital and Community Psychiatry**

The Royal College of Psychiatrists recommends that it is vital that each service has a consultant who has a designated responsibility for rehabilitation. The Manpower and Training in Psychiatry document proposes that there are approximately three sessions per 100,000 population allowed. These consultants should have an advisory role to other parts of the service and to the voluntary agencies, as well as being involved in teaching and training of staff.

(2) **Training**

Psychiatrists in training require experience in the rehabilitation and management of long-term mental illness. This should include clinical involvement in long-stay hospital wards and clinical experience of progressive rehabilitation programmes, spanning hospital, statutory, voluntary and independent agencies linking with primary care. Rehabilitation is part of the training of all general psychiatrists and should be undertaken both during general professional/higher professional training, such training may be arranged on a part-time/sessional basis or through a period of full-time experience.

Approval teams should confirm that training and rehabilitation is a sub-specialty commitment. Training needs to ensure that there is a practical link between general adult acute services in the specialty rehabilitation team.

MRCPsych training courses should include specific teaching on rehabilitation. The MRCPsych examination should test knowledge in this area. Senior registrar posts in rehabilitation need to be created and those who wish to become a consultant with special responsibility for psychiatric rehabilitation should undertake a minimum of two years approved higher training in general psychiatry and one in rehabilitation. Experience must include the assessment of psychiatric disabilities and the use of planned programmes to minimise these. This involves work with a multi-disciplinary team, offering a specialised rehabilitation service for patients with chronic mental illness. The experience of in-patient workshops, hostels, group homes and other supervised accommodation. Senior registrar experience should include involvement with and
providing advice to local authorities, independent and voluntary agencies. The training experience should offer opportunities to take part in service planning and in the further development and management of community provision. Opportunities for attachment to another rehabilitation team or to carry out a supervised research project are additional valuable experiences. Training in management skills is particularly necessary.

Appointments of new consultants with special responsibility for rehabilitation should be conditional on that senior registrar experience.

(3) General Treatment Approaches for People with Long-Term Mental Illness

All treatment programmes should include a rehabilitation approach. (not all will require specialist rehabilitation input).

Case Register: Each sector service should elicit the names of their psychiatric patients with high levels of disability. These names should be on a case register and they each should be assigned a case manager from the sector team.

Case Managers: Case Managers should work with family and primary care teams in monitoring, assessing and arranging for services to meet the needs of their group.

(4) Rehabilitation Committee

Each area should have a rehabilitation committee, to research local needs, to produce a plan, and to negotiate for resources.

(5) Special Interest Group

A special interest group in social psychiatry and rehabilitation has been set up in Ireland. The World Federation of Psychiatric Rehabilitation Meeting was held in Trinity College, Dublin in September, 1993.

(6) Audit and Quality Evaluation and Research

All parts of rehabilitation services should be involved in audit, as there should be ongoing evaluation of quality of service provision and quality of life of those who receive the service.

Research is of vital importance in rehabilitation.

Conclusion

Rehabilitation is an essential component of psychiatric management. People with long-term mental illness continue to suffer disability, but rehabilitation can greatly improve their quality of life and that of their relatives and carers.
SUBSTANCE MISUSE
General Guidelines

The appointment of two new consultants with a special interest in substance misuse is to be welcomed. Given the present escalation of the problem and that it is much to the fore in the media and elsewhere, perhaps it is surprising that various figures are bandied about ranging from four to ten - twelve thousand addicts in Dublin along. Many of these claims are made without any scientific basis whatever. Of note are the Health Research Board’s figures, and indeed those from Trinity Court - the National Drug Treatment Centre.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>New Patients</th>
<th>Return Patients</th>
<th>Total Patients</th>
<th>Attendances</th>
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<td>1992</td>
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<td>851</td>
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<td>1785</td>
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</table>

Needs Assessment

It is difficult to get an indication of the extent of the pattern of drug misuse, particularly as there is not a mandatory reporting system in place. Neither is there a regional or national database. Enforcement data which include seizures of controlled drugs and arrests and convictions from drug related offences, can be useful.
Activity data: Existing agencies should be monitored, different systems should be compatible and outcome measures should be agreed.

**Appropriate Services:**

**Advice:**

Advice to drug misusers particularly their relatives, friends and indeed other professionals is an essential part of any service. Whether a telephone helpline should be staffed on a 24 hour basis and by whom would need to be examined.

**Psychotherapy:**

Both individual and group psychotherapy are central to treatment. Initially to facilitate the development of insight and motivation and later emphasis is on relapse prevention.

**Management of Physical Complications:**

The management of acute intoxication, overdose and other medical complications is primarily dealt with at the Accident & Emergency Department and general medical wards. Close liaison between the drug treatment and the surgical services is essential as it is with G.U.M. Given that the number of pregnant addicts has increased substantially in the past 2 years closer ties with the maternity hospitals is of paramount importance.

**Withdrawal:**

Facilities should be provided for both out-patient, Day hospital and in-patient withdrawal. Longer term treatment plans should be required for those who are more entrenched in their addiction and may also have concurrent psychological or medical problems.

**Facilities for this group includes:**

- **Residential rehabilitation** with a view to a more intensive and prolonged period away from a drug taking environment. These facilities are often provided by non-statutory organisation.

- **Stabilisation** of long-term substitute prescribing e.g. structured Methadone maintenance programmes combined with regular reviews and goal setting as an integral part has a very useful and beneficial role as repeated studies have shown.

- **Needle exchange** facilities to prevent the spread of HIV infection should also be provided. However they need to be monitored closely, to ensure ‘leakage’ is minimised.

- **Shared Care** with the general practitioner: GPs are able to assist in the care of such patients, thereby relieving the specialist services which can concentrate on the care of more difficult patients or more specialist treatments. In many districts there are now community drug teams which may include staff from various disciplines for example a community psychiatric nurse, a social worker, and a psychologist. These staff will
often be able to provide practical advice and assistance in the identification of an appropriate care plan and its subsequent implementation and monitoring.

It is essential that regular reviews are undertaken by specialist staff to ensure that extended withdrawal and stabilisation regimes have not become by default indefinite maintenance prescribing. The model of 'shared care' as implemented in obstetrics would be the ideal.

- **Drug Diversion.**

If a decision is made to prescribe for the long longer-term or chronic (and often self-labelled as hopeless) drug addict who is heavily involved in the illegal drug scene then supervised consumption of medication will have to be considered, with due attention to the need for security of drugs and for ensuring the safety of supervising staff.

- **Prison/Remand.**

The consultant psychiatrist, should review the facilities needed to provide reports for people remanded by the Courts on drug related charges. Consideration, in consultation with probation and prison authorities, should also be given to input both by the consultant or by other drug personnel to the education and counselling needs of drug offenders held in prisons. This is particularly relevant to HIV harm reduction strategies, to pre-discharge advice (including caution of the danger of renewed high drug intake following loss of tolerance during custody), and to continued aftercare.

**Practical Considerations - Organisational**

**Scale of Services Required:**

Given that a proper assessment as to the extent of the drug problem has never been undertaken, it is difficult to quantify the true extent on a national basis. However anecdotal evidence indicates that other major urban areas have increasing drug problems particularly regarding MDMA (Ecstasy).

Future consultant appointments in these areas should stipulate at least sessional commitments to substance misuse. The prospective applicants having spent at least 18 months in the specialty as part of their senior registrar rotation.
In recent years separate services have been developing to manage drug misuse and alcohol dependence. The Irish Division favours the separate development of these specialties. The age mix, family involvement and range of needs of these two groups of patients tend to be quite different. Abusers of illicit drugs may go on to misuse alcohol or may do so concurrently, but the life styles of such drug abusers can be very different to those of most alcohol abusers and the two groups are not appropriately treated together.

Political pressure has resulted in funding for new appointments of consultants in drug misuse in Dublin in the last year and it is likely that further such psychiatric appointments will be needed both in Dublin and in other urban centres in the coming years. Close working arrangements with medical consultants who care for AIDS patients have developed appropriately. It is essential that specialists are intimately involved in the treatment of and service planning for drug misusers. General physicians and general practitioners do not have the training nor the time to manage alone the very difficult psychosocial issues such patients almost invariably pose.

In 1996 a National Alcohol Policy was published which requires what are termed “individual and environmental initiatives” and which includes amongst its ten strategies for alcohol action the need to “Ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families”. (Annex 3). The Irish Division recognises the important role played in the management of alcohol problems by voluntary and statutory organisations, general practitioners and general physicians but believes that psychiatrists are the appropriate doctors to manage alcohol dependence. Indeed, the complex interplay of physical, psychological and social factors involved in the origins and effects of alcohol misuse and dependence demand and require the skills of psychiatry while the complex behaviour of alcohol abusers and the development of suitable treatment regimes call for the expert management skills of a specialist.

Traditionally alcohol abusers have been treated by general adult psychiatrists. The extend to which at the present time the psychiatric hospital services have provided the bulk of the treatment provided thus far can be assessed by reference to the report “Irish Psychiatric Hospitals and Units, 1995” (Keogh and Walsh, 1996) which shows that in 1995 the category “alcoholic disorders” accounted for 20% of psychiatric discharges and 11% of in-patient days. One in every five patients admitted for the first time for diagnosis and treatment were judged to be suffering from an alcoholic related disorder. Between different kinds of psychiatric facilities and between public and private hospitals there was no significant difference - 20% of admissions to health board hospitals, 19% of admissions to psychiatric units in general hospitals and 21% of admissions to private psychiatric hospitals were for alcohol-related disorders. For the most part, such services have found it difficult to provide little more than
detoxification. Community based services are patchy. Resources for after-care are scarce. The Irish Division agrees with the National Alcohol Policy's endorsement of the efficacy of brief and community based interventions in the treatment of many abusing and dependent patients but would caution that the research findings for the most part indicate that such interventions are particularly effective in moderately heavy drinkers and those who are in the early stages of developing dependence. The need for appropriately qualified professionals and a wide range of facilities, including residential facilities, for the diagnosis and treatment of the more severely dependent alcohol abusers and those with significant co-existing physical and/or psychiatric morbidity remains pressing throughout the country.

Alcohol abusing individuals have usually been the first group of patients to be managed mainly outside of hospital (often appropriately) when in-patient psychiatric beds were reduced. Nevertheless, as the figures quoted above indicate, psychiatric hospitals still carry a significant proportion of the treatment of such patients. The two major private psychiatric hospitals also provide treatment programmes which include in-patient and out-patient components and supportive after-care programmes. The Irish Division is concerned, however, about a tendency to disparage the close integration of residential, out-patient and community based psychiatric approach to the detection and management of alcohol problems in favour of a policy of diverting such individuals and their families to voluntary facilities which are often not medically supervised, which are under strain and which, in some areas, exist only in skeletal form. The Division is concerned too by a growing tendency to suggest that such patients have brought about their own difficulties, should not take up expensive medical time and facilities and should be largely left to find such help elsewhere as they can. It should be noted that alcohol dependence often renders individuals poorly capable of managing themselves and their own affairs.

Alcohol manifestly has serious acute and chronic effects on the brain as well as upon other organs of the body. Alcohol dependence is closely linked with serious physical and psychiatric ill-health and psychosocial morbidity. Its impact on marital and family life is immense. In addition, psychiatrists specialising in the psychiatry of the elderly are encountering increasing numbers of alcohol abusing and dependent patients, some of who require referral to specialist services.

Recommendations.

1. The Irish Division recommends the appointment of specialists in alcohol misuse and dependence to provide appropriate management, research, supervision, education and training. The Irish Division strongly supports the recommendation is the National Alcohol Policy to the effect that where the alcohol service is part of the psychiatric services (and the Division recommends that it should always be so) “one consultant in the catchment area should be assigned overall responsibility for the development of services and treatment of the most complicated areas” (para 5.4.1). Such a consultant would provide tertiary referral services and would also act as an advisory educational and research resource. Such a consultant would work in collaboration with colleagues in general and community psychiatry, in liaison psychiatry and in general medicine who currently encounter many patients with dual diagnoses involving psychiatric and physical disorder or psychiatric disorder and drug or alcohol misuse. Many general hospital in-patients (estimates suggest that they may constitute up to 20% of the total) who have alcohol-related problems including cirrhosis, gastrointestinal cancers, hypertension, cerebrovascular accidents and injuries, require an appropriate treatment response involving close collaboration between general medical and psychiatric
specialists. In this regard, it is relevant that two of the six “key areas” contributing significantly to premature mortality, identified by the Government’s health strategy for the 1990s (Shaping a Healthier Future) are Alcohol and Causes of Accidents.

2. The Irish Division recommends that a catchment area with a population in excess of 100,000 should have a consultant psychiatrist with a special interest in alcohol abuse and dependence. Such a special interest should be reflected in a sessional allocation to the area of alcohol abuse and dependence of not less than 4 sessions.

3. Alcohol abuse and dependence remain important reasons for admission to psychiatric hospitals and most general psychiatrists, forensic psychiatrists and liaison psychiatrists are involved in the treatment of alcohol abusing and dependent patients. The Division concurs with the opinion expressed in the National Alcohol Policy that many patients can be treated as out-patients and accepts too that detoxification “can take place successfully on a day basis in a clinic or in a person’s home under the supervision of a doctor and/or nurse”. However, such a policy requires a suitably designed and staffed detoxification and management programme in place and medically supervised psychotherapeutic and support services available. The development of such programmes would be greatly accelerated by strengthening the consultant contribution.

4. The Irish Division recognises that the required number of tertiary referral centres and consultants with a special interest in the problems associated with alcohol use and misuse depends not so much on the actual number of alcohol abusing individuals, which as have been indicated above is considerable, but on the priority which Irish society places on treating individuals who are misusing and/or dependent on alcohol. However, a significant commitment to implementing any national policy on alcohol would be the creation of specialist units comprising residential, out-patient and after-care facilities - two such units in Dublin and one each in Cork, Galway and Limerick.
Appendix X

EATING DISORDERS

ANOREXIA NERVOSA

Introduction

Anorexia nervosa has been called the most severe of psychiatric morbidities (Crisp). Its impact on the individual and family is not always recognised in studies of the community as numbers are small (1:150 girls secondary school age. 7% of anorexia nervosa patients are male). Apart from morbidity, mortality rates have ranged from 18% (Theander) to 10% (Crisp). Paradoxically, severity of presentation does not correlate with outcome (Russell). The only factors correlating with outcome include early recognition, early intervention and skill of the treatment team (Slade).

The disorder can be summarised as a phobic avoidance of weight gain. Somehow and for some reason, the patient develops fear amounting to terror of taking part in the normal maturation process and out of that fear, resists attempts to force them into doing so. The origins of that fear are likely to be related to the interplay between dynamic factors, i.e., requirements of maturity, family strengths and weaknesses, social environment and ambitions, etc., and the patients ability to measure their environment. The patients ability to measure their environment is hampered through cognitive deficits which appears to be quite a real inability to measure body size, body feelings, judge relationships and problem solve. (Body image distortion, lack of interceptive awareness, personal ineffectiveness and alexithymia - Bruch, Garner, Bourke and Taylor).

The reason for this preamble is that in understanding the origins and requirements of the disorder, emerges an appreciation of what is required in the treatment.

The following opinion would, in addition to my own experience, be influence by the treatment units of Crisp and Russell: London, Halmi; New York, Freeman; Edinburgh, Touyz and Beaumont; Sydney, Garfinkel; Toronto and Van der Eyken: Belgium, among others. Dublin hosted the prestigious European Council on Eating Disorders when Ireland held the Chairmanship in 1995.
**Team Membership**

Treatment is psychotherapy rather than organic/pharmacological. Knowledge and experience are essential and as mentioned previously correlate with outcome.

In my experience, one consultant can manage ten eating disorder in-patients beds in a service split 50/50 with general psychiatry. While the treatment area of unit for eating disorders benefits from creating it's own therapeutic milieu, it is better for the psychiatrist to be involved in general psychiatry as co-morbidity is becoming increasingly recognised and a knowledge of general psychiatric treatment requirements are necessary.

**Family therapy** is essential especially in the younger age group (18 and under). This can be carried out by a consultant psychiatrist with a background in family psychotherapy or therapist of any other discipline, suitably trained. The family therapist would also double as marital therapist given that the effects of such a disorder when a marriage is involved can be significant.

**Cognitive/behavioural therapies** are fairly central to any treatment programme. This very often falls to the psychologist or nurse therapist and involves developing programmes for working with body image distortions, social skills and interpersonal skills.

On the understanding that this disorder includes a fear of body size with a built in inability to measure it, the use of physiotherapy with education and controlled exercise, massage and swimming exercises have been found useful to therapy. Each of these disciplines would have their specialised techniques familiar to eating disorder programme managers.

The interpretation of emotions and the ability of the patient to describe their feelings is invariably compromised. **Occupational therapy** with art therapy has been found useful in helping move the patient towards an understanding of their fears.

Nutrition or diet is the medium through which the patients fear is initially expressed. Guidance and reassurance in introducing the patient to normal eating is essential. Many units have the attachment of a dietician for this purpose although the skills are in the main psychotherapy based and other units have used designated nursing staff on the assumption that they develop the necessary skills.

Nursing skills are as for normal intelligence, psychologically intact (non psychotic) but often terrified individuals who because of difficulty measuring their environment, needs extra support, guidelines, limit setting and encouragement. Based on a three shift system, each shift should have an experienced staff nurse supervising nurses on a normal general psychiatric nurse patient ratio. An alternative is to have a designated nursing sister on a daily 9 to 5 basis who acts as co-ordinator/therapist during that time when most therapies take place.

**Treatment Settings**

There are no figures to support the siting of eating disorders units in either freestanding psychiatric units or general hospital psychiatric units as regards outcome. Many of the world's leading centres have been based in one or the other settings. Siting the unit in a general psychiatric hospital has the benefit of available staff with a psychiatric background while general hospital settings have the availability of medical backup, investigation techniques and physiotherapy departments. There is a trend to site new psychiatric units in general medical
hospitals especially as regards the management of non-high risk/disturbance disorders (psychosomatic disorder, anxiety disorders, phobias and depression) and therefore is one had to make a decision on the siting of a new unit, attachment to a general hospital would be first choice.

Given the numbers involved, it would not be necessary to have a unit or team available in each catchment area setting. Regional treatment units would be sufficient to cover an area of reasonable travelling time for relatives, family, etc. Such centres derive much of their momentum not only from direct clinical care but also research and international contact as the management of eating disorders is an ever changing subject. Greater knowledge leads to increasing understanding of the disorder and changes in treatment methods. For this reason units were often sited with an association to academic departments although internationally, with the increasing recognition of the disorder and the need for treatment units this is no longer an essential trend.

Four units for southern Ireland to provide care on a regional basis. For example and for discussion, East, West, South and Central each with seven to ten beds would be adequate.

Anorexia nervosa treatment units for children, i.e., without the expectation of having past puberty and following the example of Great Ormond Street Hospital, London, having catered for patients age 8 and up to puberty onset, requires a different and more child based therapeutic milieu. It is also more family oriented and is better catered for through child psychiatric services. National requirements would be less and for the present I would expect one national unit to be sufficient.

Out-patients

Anorexia nervosa can often be dealt with very adequately on an out-patient basis. As a guide figure, an expectation for admission at a 1:20 ratio can be made. Cross referral between disciplines to make use of the treatment team on an out-patient basis is necessary allowing family sessions, cognitive behavioural and social skills sessions along with dietary counselling and dynamic therapy to take place as required.

Day patient programmes

These programmes are under current investigation. Treatment team staffing is similar to in-patient units. The population served is of necessity more local and treatment times are longer. On a day patient basis they are cheaper but total patient treatment cost is not correspondingly so due to the increased treatment time. Any new unit should have a parallel day patient programme. A possible progression for treatment resistance being from out-patient to day-patient and finally in-patient care.

Bulimia nervosa differs from anorexia nervosa in that whereas anorexia nervosa is a fear of normal weight, bulimia nervosa is a fear of loss of control and becoming overweight. This disorder is best dealt with on an out-patient basis. The management makes more use of cognitive behavioural techniques although dynamic factors remain essential. Training and experience in the management of personality formation, primitive personality development and modified psychotherapy to cater for these factors are important attributes in treatment staff (Lacey, Kohut, Kernbur, Masterson). Co-morbidity is also becoming increasingly recognised in this disorder.
and so expertise in general psychiatry is necessary. Admission for this disorder tends to be rare but if required, the skills would be found in the treatment unit described under anorexia nervosa.

**Obesity**

Treatment programmes for obesity tend to be ignored in general psychiatry. The psychopathology lies at the opposite end of the spectrum to anorexia nervosa where anorexia nervosa is over control, obesity is lack of control and bulimia is in the middle. Obesity traditionally presents when it has been established for some time and physical consequences bring the patient to the attention of physicians or surgeons, i.e., vascular, cardiac, respiratory or endocrine problems. At present there is an increasing awareness of the need to tackle the problem before this stage which brings it into the realm of psychological medicine or psychiatry.

The different sub groups of obesity include addictive eating with dysphoria when the compulsion to eat is prevented; reactive hyperphagia, where bingeing takes place in response to depression, anxiety, frustration or boredom; counter regulatory eating where eating is a reaction to attempted restraint; and unconscious eating, nibbling and night bingeing.

The morbidly obese patient has a body mass index of 40 plus (weight (kgs.)/height squared (metres)). These patients are at risk of developing hypertension, coronary artery disease and diabetes mellitus. In terms of health care economics, tackling the problem before morbid obesity is established has found support.

70% of obese patients manage to reduce their weight without professional help. Medicine has a role in the 30% where this cannot be accomplished.

As with bulimia open ended dynamic psychotherapy alone has not shown good results and while it is an essential component of treatment, a structured or cognitive/behavioural input is required. Perhaps the greatest fault of the profession is to treat the symptom alone with dietary counselling. Unless the issues underlying the eating behaviours are tackled, results are poor.

Management is based on an out-patient programme, if even one centre with a specialist interest was in place, then there would be a national resource for this often forgotten disorder.
PSYCHOSEXUAL DISORDERS
Manpower Needs

Introduction

Estimates of the prevalence of psychosexual disorders vary. The consensus among workers in this area is that 20% of the population suffer from sexual dysfunction at some stage in their life. Unfortunately, due to embarrassment regarding the problem, affected individuals are unwilling/embarrassed to seek help. This is reflected in the considerable time delay which we have noted in our clinic. For example, where non-consommated marriages are concerned, the average delay between getting married and presenting at the clinic is 3.5 years, with a range of between 1 and 20 years. This condition provides reliable data (in that you have the two fixed points) but we have no reason to believe that other sexual dysfunctions present for help with a shorter time frame. Given the reluctance to seek help for the condition, estimates of prevalence must therefore remain provisional.

Existing Services

Psychosexual counselling is provided by a range of therapists. The widest network is probably the Catholic Marriage Advisory Council, which provides both marital therapy and psychosexual counselling, as patients frequently need both approaches. In these organisations, psychosexual counselling is provided by trained volunteers.

A number of social workers operating from psychiatric facilities also have acquired expertise in this area - this varies from region to region and I do not have the exact figures to hand.

Finally, psychosexual counselling has been provided by medical practitioners. A service by psychiatrists is provided for by Dr Tony Cranny in Galway, Dr Michelle Cavil in Naps and myself in St Patrick’s Hospital in Dublin. Again, I am not too sure of the numbers that Drs Cranny and Cavil would see but our clinic would have seen approximately 2,200
patients since 1978. Also, Dr Tom Kelly provides a similar service in the Dublin area.

From the above, it can be seen that services have evolved in a somewhat patchy and haphazard fashion, depending more upon the particular therapists involvement than an organised attempt to ensure an even spread of services throughout the country. For example, I am not too sure what services are available in the Southern Health Board region, but given the fact that I get referrals from that Region, can only presume that the services there are somewhat limited.

Future Needs.

Given the philosophy expressed in planning for the future, it would seem reasonable to attempt to provide each Health Board with at least one psychiatrist who can take referrals for psychosexual counselling. Ideally, such an individual should work from a general hospital psychiatric unit, with access to a gynaecology and also a genito-urinary specialist. It is particularly important that there be close liaison with the latter, as the number of cases of male sexual dysfunction thought to have a psychological basis has dropped from 90% down to 50%, with the advent of better investigative methods. In this regard, it is worth mentioning that non-medical counsellors be made aware of the possibility of a physical causation. Frequently, I have seen patients who have been in treatment with a non-medical counsellor, where the dysfunction ultimately turned out to have a physical basis. In this regard, it is fair to say that psychosexual dysfunction represents an extremely good example of a psychosomatic disorder and that psychiatrists are, therefore, the best equipped to deal with it.

Obviously, the Health Boards with large populations such as the Eastern Health Board and the Western and Southern Health Boards would need a greater number of psychiatrists offering this service. I should say that it need not be full-time; indeed, it is doubtful if anybody would wish to practice this specialty full-time. I would see it developing more along the lines of someone with a special interest in the area who could provide 2 or 3 clinics per week to a given Health Board.

I would also be important to have a psychiatrist assess those individuals who have been sexually abused. Studies by JEHU and others have shown an extremely high rate of sexual dysfunction in such individuals but, in addition, quite high rates of depression as well. With the rapidly increasing numbers of such cases now coming to light, careful thought will have to be given to what type of service needs to be provided for the victims of such abuse.

Closely allied to sexual dysfunction is, of course, sexual deviation. While you have not asked me to address this my personal feeling is that sexual deviants should be catered for by the forensic services. There is frequently a legal aspect and I believe that they need the expertise of specialist units who can liaise with victim support agencies where necessary.

Finally, some thought will also have to be given to providing a service for those individuals seeking gender reassignment surgery. As far as I am aware, I am the only one running such a service. this is a programme whereby patients attend me for a period of at least one year, both individually and in a group setting, prior to going abroad for gender reassignment surgery. Over the last few months, I have had to limit the group size to 10, as otherwise it becomes unmanageable. Patients attending this group come from as far a field as Clare, Donegal and Cork. I have written to the Programme Manager in the Eastern region asking that he puts some treatment programme in place for such individuals as a matter of urgency. Likewise, some services should be made available in perhaps Sligo, Galway, Limerick and Cork to facilitate
these patients. because of increased media publicity, the numbers of patients requesting gender reassignment surgery is constantly growing and the St Patrick's Hospital Service has already reached saturation point.

Training.

Where sexual dysfunction is concerned, it is generally accepted that treatment along cognitive behavioural lines offers the best chance of recovery. This is not to say that other techniques such as an analytical approach will not yield results - Dr Maeve Daly uses such an approach successfully. If a more comprehensive service is to be provided nationwide, senior registrars should, as part of their psychotherapy training, spend a 6-12 month period under the supervision of somebody with a special interest in this area. I feel it would be appropriate for people who have an interest in this area to apply for recognition as specialty tutors to provide such training.

Summary

1. The prevalence of sexual dysfunction is not known with certainty.
2. By extension, an exact estimate of manpower needs cannot be made.
3. Increased numbers of patients are seeking help, particularly child sex abuse victims.
4. Such treatment is best carried out by a consultant psychiatrist, with access to medical/surgical specialist colleagues.
5. Regionalisation/sectorisation is highly desirable, to avoid extensive travelling by patients.
6. Training should be carried out during the senior registrar phase of training.
Appendix XII

SERVICES FOR PERSONALITY DISORDERS

Current Services

At present there are few facilities for treating those with personality disorder. Inevitably the substance misuse service see many patients in whom this is an associated diagnosis, although, the focus of treatment is the substance misuse rather than the personality disorder.

The Central Mental Hospital, Dundrum, receives people from psychiatric hospitals whose behaviour constitutes a risk to others such that they cannot be managed on an open ward and are transferred under Section 201. A secure ward in St Brendan’s Hospital contains a number of personality disordered patients who cannot be contained within the traditional psychiatric services. They are, therefore, sent to this ward when their behaviour constitutes a risk to themselves or to others. The purpose of this is for containment rather than treatment.

Most patients with personality disorder are treated by the general sector services along with all other diagnostic groups. Because they are demanding of time and resources they are often disliked by mental health professionals who feel that the severely mentally ill are the group most deserving of scarce resources. Treatment is thus haphazard. A further limiting factor in the provision of treatment for those with personality disorder is the availability of suitable expertise and facilities. The treatment of this group of patients requires a major psychotherapeutic input (with cognitive/behaviour therapy the preferred choice at present) and many psychiatrists may not be suitably trained in this modality of therapy.

In summary patients with personality disorder are not adequately catered for by the existing services and input is often for containment rather than treatment.

Who is likely to benefit?

Personality disorder is present in about 15% of the general population and 4% meet the criteria for severe personality disorder e.g. anti-social or borderline personality disorder. These patients present to the community services often in the context of repeated parasuicides and threats of aggression. This places a great strain on the open ward system and the community based services. This severely personality disordered group
falls into 2 categories i.e. offenders and non-offenders. The latter group in particular often comprises of women with a history of sexual abuse and eating disorders who resort to self-destructive behaviour with repeated wrist cutting, burning and attempted hanging etc. Such patients often remain as in-patients for several months at a time in acute psychiatric units because of the non-availability of more appropriate treatment settings and because of their continuing dangerousness. In view of their unsuitable placement in these settings, there is a strong case for dedicated units to treat these people. The second group, the offender group, is scattered throughout the prison service and the Central Mental Hospital. This group is less urgently in need of dedicated treatment centres since they are already catered for in the Central Mental Hospital.

Diagnostically, the groups most likely to benefit from any developments in the services for the treatment of personality disorder are those who have anti-social personality disorder or borderline personality disorder with or without ancillary conditions such as eating disorders.

**Recommendations for the way forward:**

The creation of purpose built medium/high secure units should be considered as a priority. These would be developed on a Health Board basis and located on grounds belonging to the Health Boards. In this way controversy about their location would be avoided. Patients whose personality disorder placed themselves or other people at risk would be considered for treatment and the duration of stay would be medium term i.e. ordinarily 6 to 18 months. Referrals would be from psychiatrists, generally where there is a history of failed attempts at out-patient and/or in-patient treatments. Specifically patients would not be accepted on an emergency basis where short term containment was required since facilities already exist for the management of such patients and the therapeutic ethos of the units would be undermined.

One of the advantages of the specialist in-patient treatment unit lies in its power to select its patients and to deploy a coherent and co-ordinated treatment strategy via staff who have become experts in the particular method.

It is arguable whether these units should consider patients who are on probation or who are sent by the courts or whether they should exclusively deal with the non-offender population. On balance the more homogenous the population the greater the likelihood of therapeutic effectiveness. The presence of an offending patient population may impinge negatively on those who are conviction free. Consideration would also have to be given to whether these should be mixed or single sex units.

As well as providing in-patient treatment, out-patient treatment would also be offered to those deemed suitable. Supervision would also be offered to those working sector teams who provide treatment for those with severe personality disorder - in this way expertise will be expanded.

Finally these units would be centres for research into relevant aspects of personality disorders including treatment, risk assessment and indicators of response to treatment.

**Staff**

Each unit would have a medical director trained in forensic psychiatry and (ideally) psychotherapy. A multi-disciplinary team would consist of staff members similarly trained
including non-consultant hospital doctors, social workers, psychologists, occupational therapists and psychiatric nurses.

**Strategy for progressing this proposal:**

In order to progress this proposal further the following is recommended:

1. 'Needs Assessment' of those with personality disorder currently being treated within the psychiatric services should be undertaken focusing on those with severe personality disorder.

2. Assessment of needs in the prison and probation services should take place in parallel with this to ascertain the proportion likely to benefit from such an initiative.

**Implications for Mental Health Legislation**

If this proposal is adopted then consideration must be given to including personality disorders as grounds for compulsory treatment under the proposed new Mental Health legislation. Since the group of patients considered for treatment in these units have severe difficulties placing either themselves or others at risk many are unlikely to accept treatment on a voluntary basis. Moreover therapeutic engagement with such patients can take several months, a process not possible under the envisaged legislation.
THE HOMELESS MENTALLY ILL

The term 'homeless' will be taken to refer to heterogeneous groups of individuals (i.e. men, women, youths and families) who, in the absence of a stable base and supportive social networks, have peripatetic lifestyles characterised by poverty, by a lack of privacy, possessions and personal relationships, and by a tendency to poor physical health, psychological distress and psychiatric dysfunction.

In a proportion of cases, mental illness antedates, contributes to and is exacerbated by homelessness. In other cases, mental health problems are a consequence of homelessness and are exacerbated by the harshness of this imposed lifestyle. A common finding in homeless populations is comorbidity, namely the co-existence of multiple psychiatric disabilities and concomitant physical disabilities. Likewise, morbidity and mortality rates are known to be significantly higher than those of domiciled individuals. A number of factors conspire to make this group inordinately dependent on casualty services in general hospitals for their health needs and a district subgroup is known to make disproportionate demands on psychiatric treatment facilities.

Currently in the Eastern Health Board the psychiatric needs of the homeless are addressed by a special programme which has three hospital based and three community based components. In the past, these services focused on homeless males but more recently, have been extended to homeless females. A major source of discontent in the Eastern region is the problem posed by homeless individuals who repeatedly cross catchment area boundaries to St Brendan's Hospital, or to direct-access hostels and night shelters in this hospital's catchment area, leaving the services there over-stretched and under-resourced.

Day-to-day hazards of a homeless lifestyle are known to contribute to chronic organic impairments in many individuals, often at relatively younger ages, with the result that a disproportionate number of this group cannot conscience be discharged to extramural care of any description. A further non-compliant group of individuals who are persistently lost to follow-up, and who in consequence pose a serious risk to themselves or to others following their discharge, often have to be kept in hospital beyond the point of medical necessity. It is felt that both these developments are likely to ensure that the demand for in-patient accommodation for new long-stay patients below the age of 65 in this group, will inevitably exceed the guideline of 0.2 beds per 1,000 total population proposed in Planning for the Future, especially in urban centres where the homeless are known to congregate.
Other shortcomings relate to the range, the availability and the quality of accommodation deemed necessary to cater for existing demands. Night shelters and direct-access hostels offer a necessary though temporary solution to the problems of individuals who insist on asserting their autonomy in a palpably destructive fashion. Voluntary organisations which provide and staff the above facilities would be among the first to acknowledge that, as things stand, such hostels are part of the problem of homelessness and not one of its solutions. Nor for that matter does the solution to the problem lie in the provision of unsupervised accommodation, helpful though this option may be for a minuscule number capable of independent living. For the majority, it is felt that graded, supervised, sheltered community settings are necessary, with access to day facilities where appropriate. Regrettably, policies aimed at dismantling institutions ensure that positive bias is exercised in making available such sheltered or supervised accommodation as exists to the 'new deserving poor', namely those old, long-stay patients who are deemed capable of being relocated outside hospital.

If one excludes members of travelling community, approved applicants on housing lists and their single dependants; long-stay psychiatric in-patients who meet the criteria for homelessness laid down by the Housing Act 1988, and an unquantifiable number of ‘hidden’ homeless, e.g. single adults working as live-in domestics or in the armed forces and penal institutions, one is left with a core of homeless individuals whose number, nationwide, is believed to hover round a conservative estimate of 4,000 adults and 750 children (below the age of 18 years). We are quite satisfied that their medical needs, including their psychiatric needs, are not being met.

We recommend that each health board should: (1) determine local needs and resources, (2) decide whether these needs can be met by existing generic services with or without modification to cater for the special needs of the homeless, or (3) whether specialist psychiatric services need to be established, working in tandem with other statutory and voluntary agencies. We do not accept that the homeless choose to live precariously and disadvantageously. We accept that many in this group who are psychiatrically ill will be hard to engage in treatment, but we feel strongly that the efforts, particularly in the Eastern Health Board, should be better resourced, broadened and replicated elsewhere.
NEUROPSYCHIATRY: Development of the sub-speciality in the Irish psychiatric services

Note: This paper is concerned primarily with ideas for neuropsychiatry service development for patients under 65 years of age at onset. It assumes that those over 65 years at onset would come under the aegis of old age psychiatry services.

Neuropsychiatry: definition

Neuropsychiatry may be defined broadly as that area of psychiatry dealing with the assessment and management of patients where frankly disordered brain function causes psychological, psychiatric, behavioural or cognitive difficulties, resulting in major impairment of an individual’s function (physical, psychological and social), and, on occasions, compromising the safety of the individual patient or, rarely, of those around him. Psychiatric syndromes such as dementia, and/or behavioural disturbances such as impulsivity, aggression, wandering, incontinence, would be common features in patients with neuropsychiatric disorders. (Simplistically, neuropsychiatric services properly deal with patients suffering gross brain dysfunction - where macroscopic or microscopic changes in structure can be seen. It is now recognised that the major ‘functional’ psychoses are actually rooted in subtly impaired brain system function, only barely detectable even with current research sophistication - and these are managed with general psychiatry services).

Patient Groups

Patient groups falling clearly into this category include brain-injured patients (post-head injury, subarachnoid haemorrhage, hypoxic brain damage, etc), early onset dementias, diagnoses such as epilepsy, multiple sclerosis; some neurosurgical patients; patients with psychiatric sequelae of conditions such as Huntington’s disease, Wilson’s disease, Creutzfeldt-Jakob disease and prion diseases, HIV-associated illness, post-encephalitic stases, inter alia.

Neuropsychiatric disorders may manifest as or co-exist with all categories of ‘functional’ psychiatric disorder (mood disorders, psychotic disorders, schizophrenia), and often will be associated with unusual or atypical features in the functional disorders.
Patient Needs

Almost no curative treatments are available or in prospect for neuro-psychiatric conditions. Many such patients will be young (perhaps teens) and have a long life span; they may have stable, non-progressive conditions such as head injury; or progressive, degenerative conditions, e.g. dementia. The nature of the illness, with coarse brain disease, means that responses to conventional psychiatric/psychological interventions may be lacking or unpredictable. Clearly, these patients' needs differ from those of patients with functional psychosis; and from those of psychogeriatric patients.

There are similarities between neuropsychiatric patients' needs and those of psychogeriatric patients - a core group of patients will need long term continuing care, perhaps with specialist staff, but a majority of cases will be manageable in community settings of one kind or another, with access to and support from an appropriate specialist neuropsychiatric service.

Current Healthcare Service Usage by this Patient Group

Up to the 1980s, patients with major behavioural disturbance arising from neuropsychiatric conditions were generally admitted to long-stay beds in back wards of mental hospitals throughout the country. With the shift in the delivery of mental health services of the last two decades - away from the institutions and towards provision of appropriate care to patients in their local community, or in small, local units of supported accommodation - specialist services geared to the delivery of care appropriate to specific patient groups with specific needs have been developed. Thus, patients with mental handicap, psychiatric disorders of the elderly, disorders arising from substance misuse, and forensic psychiatric problems are now treated in appropriate sub-specialty branches of psychiatry; and patients requiring mainly physical care are properly managed within community care services. The adult general psychiatric services focus mainly on the management of patients with functional psychoses, affective disorders, and neurotic disorders, interlinking with the sub-specialty psychiatric services where appropriate. No specialist service for patients with neuropsychiatric conditions exists.

As the number of beds available in mental hospitals has declined, placement of patients with neuropsychiatric conditions has become steadily more difficult. Community services often are reluctant to accept patients as they may be too young, funding may be uncertain, and their behaviour may be too challenging (and, with major pressure of numbers on any facility for 'young, chronic sick', 'quieter' patients sometimes are more easily placed). Many beds in occupied ('blocked') by patients with neuropsychiatric disorders - bed use which is inappropriate, very costly, and not in any way geared to the needs of the patient. It is likely that some patients with neuropsychiatric conditions are detained in custodial settings, reflecting the difficulty in containing their behaviour in non-specialist settings.

The Neuropsychiatrist

The consultant neuropsychiatrist offers expert medical/psychiatric skills in patient assessment and management, and co-ordinates and leads a specialist multi-disciplinary team aiming to formulate individually tailored management plans after detailed assessment.

The neuropsychiatrist also has a key role in co-ordinating with and advising medical colleagues, within psychiatry, within the general hospital, and in the community, on the management of
patients with neuropsychiatric conditions; and in developing and consolidating links with staff in all settings involved with the care of this patient group, whether run by Health Board, voluntary sector or community organisation. A useful analogue here is the co-ordinating role of the specialist old age psychiatrist.

The consultant neuropsychiatrist would have a key role in planning the services required in the future, and in service development.

**Functions of Neuropsychiatric Service**

Comprehensive assessment of problems - physical, psychiatric, psychological, behavioural, cognitive. This will involve medical assessment, including investigations where appropriate (laboratory, radiology, electrophysiology); neuropsychological testing; occupational therapy and social worker evaluation, so an intervention list aimed at maximising the patient’s function is drawn up.

Treatment of psychiatric and psychological disorders specifically.

Liaison with physicians, neurologists, neurosurgeons, geriatricians on treatment of other physical conditions.

Neuropsychiatric syndromes (indicating brain dysfunction, gross or subtle) may arise in the course of general medical or surgical conditions, and will be managed by the general hospital liaison psychiatry service. Occasional advice on specific cases may be provided by the specialist neuropsychiatry service.

Provision of a specialist diagnostic service. Provision of advice on management to local mental health teams, geriatrics etc.

Research into better techniques of assessment, better understanding of pathology, remedial strategies, psychological and pharmacological; development of behavioural neurology; links with clinical genetics.

Liaison with centres of excellence in the UK and Northern Ireland, European centres, possibly North America.

**Requirements for the service to run.**

A small number of assessment beds; out-patient assessment facilities; support for visits to patients for assessment ‘in situ’.

Access to appropriately staffed continuing care beds for patients requiring long-term specialist placement, probably including a secure facility.

Initial brief might be to provide assessment to the backlog of cases in all acute hospitals and in long-stay facilities all over the country as well as provision of assessment service for new cases.
Setting up the service.

Numbers are difficult to predict as no accurate figures are available yet (efforts are under way to get this data).

Very close collaboration is needed between the neuropsychiatry service, the neuro-rehabilitation service (National Rehabilitation Hospital, Dr Mark Delargy, consultant in rehabilitation), and neurological services, both medical and surgical, and the neuropsychiatry service should be Dublin (and University) based.

Looking at comparable population sizes, two full-time posts would be appropriate for the start-up, perhaps one north and one south of the Liffey, working closely together, and setting up links with all the country’s Health Boards. Appointing both posts at the same time would allow the service to be set up with maximum efficiency and efficacy. It is likely that a third post would be justified within 10 years.

Whether coupling of a special interest in neuropsychiatry to a (reduced size) sector general psychiatry commitment is feasible is questionable - to get 2 whole time equivalents with a 5 session sector commitment each would require an initial complement of 4 individuals, scaling up co-ordination difficulties. And as yet relatively few people are in training in the specialty.
ACADEMIC PSYCHIATRY

Some of the Problems

Compared to other academic medical specialties, psychiatry has been a late developer. Some chairs have been established only in the past ten or twenty years, and the development of adequate resources has been correspondingly slow.

A major problem facing psychiatry is the paradox of inadequate recruitment to psychiatry against a background of adequate output from Irish medical schools of doctors in general.

One of the possible contributors to this problem (of diminishing attractiveness of a career in psychiatry) is the undergraduate exposure to Institutional Psychiatry dealing with patients who are severely impaired (particularly with schizophrenia and Alzheimer’s Disease), and who have a poor prognosis.

One reason for teaching on this population is that it is one which comes easily to hand for an understaffed and under-resourced academic psychiatry department. There is a need to teach the full range of psychological medical problems in psychiatry. But to bring about teaching of Liaison Psychiatry, Psychotherapy, treatment of Personality Disorders, Anxiety and ‘problems of everyday life’ such as Sexual Dysfunction, Marital Disharmony, Disabling Phobias, Substance Abuse etc. etc., requires considerably more resources in an academic department.

An additional problem is the confusing image of the role of the psychiatrist, which is brought about not only by students’ limited experience during training but also by the public perception through the media etc., of the relative roles of Psychiatrists, Psychologists, Social Workers, ‘Counsellors’, etc.

Another problem is the lack of research production overall within psychiatry, which is if course related to having inadequate protected academic time as opposed to service responsibility. Most Irish academic psychiatrists have to take on as heavy a case load and catchment area responsibility as their non-academic counterparts.

A minor difficulty in the Department of Health’s policy on ‘inspection’. Inspection reports fail to highlight the academic work carried out in teaching hospital, and tend to cast Academic Departments in a peculiar and adverse light in reports made public and protected from legal remedies by parliamentary privilege.

An additional burden on academic departments is the need to form the teaching base for regional post-graduate psychiatric training schemes. With the further emergence of Continuing Professional Development (CPD), additional severe demands will be made on the time of the academic psychiatrist.
Proposed Solutions

1. Academic manpower resources devoted to purely academic work (Teaching and Research) should be increased by allowing for an increased percentage of protected academic time. It is unreasonable to expect a full-time academic psychiatrist to take on a full sector responsibility. One possible solution is that, where sectors are assigned, academic psychiatrists should be matched in an appropriately sized sector with a non-full-time consultant. There should of course be an adequate number of academic psychiatrists employed ‘full-time’, to include Head of Sub-Specialty Departments particularly:

(i) Child Psychiatry;
(ii) Psychotherapy;
(iii) Liaison Psychiatry;
(iv) Forensic Psychiatry (where appropriate).

Chairs should be established in these specialties in some academic departments.

2. Job descriptions for all academic posts should clearly delineate a need for teaching and research experience along with a corresponding guarantee of allocation of time for these roles.

3. All recognised teaching hospital posts should have university participation in their recruitment. This is presently, in theory at least, guaranteed by the Health Act. Unfortunately, job descriptions of psychiatrists having community responsibilities have enabled Boards to exclude academic input in certain posts despite being in recognised teaching hospitals.

4. In setting up academic departments of psychiatry adequate provision must be made for academic paramedical posts i.e. Clinical Psychologists, Social Workers and Academic Psychiatric Nursing Posts linked within an overall Department of Psychiatry, which reflects clinical practice realities.

5. Adequate material resources must be made available to Academic Departments to deal with undergraduate and postgraduate teaching, and CPD. It is unreal to detach undergraduate and postgraduate teaching from one another as these responsibilities are clearly united and the resources of the Universities are required for all aspects of psychiatric teaching.

6. The inspection process should be brought up to date to include the full range of specialties including Academic Psychiatry, Liaison Psychiatry, Psychotherapy, Child Psychiatry etc. This might overlap or parallel the College’s accreditation process using a specialised panel of visitors taking an in-depth view of the quality of services available to patients.
Dear Professor Webb,

I refer to the meeting last June between representatives of the Irish Division and the Comhairle's committee on psychiatric services during which we discussed your document which was a preliminary overview of forthcoming developments in psychiatry and contained individual reports on three specialties of psychiatry.

At its meeting on the 30th September, the committee reviewed the Irish Division's document, the report on Manpower and Training from the Irish Psychiatric Training Committee and the minutes of our meetings with the two bodies in June.

You indicated at our meeting that the Irish Division would be preparing a revised and more comprehensive document representative of the views of the profession as whole. The committee regards such a document as a vital input to its deliberations. In this context it has asked me to mention a number of broad issues it would like the Irish Division to address such as

- the development of specialisation (i) within and (ii) separate from general adult psychiatry with particular reference to

  (a) the future role of the general adult psychiatrist

  (b) should the increasing trend towards specialisation continue

  (c) if yes, how will a service now based on sectorisation fit in with the increasing trend towards specialisation

  (d) could sectorisation be retained and overlaid with specialisation on a wider catchment basis
The impact on the practice of psychiatry arising from the location of acute psychiatric units in the general hospitals.

- variations in the size of populations served by existing psychiatric catchment areas throughout the country.

- variations in consultant population ratios throughout the country.

- is the changing role of general practice likely to impinge on the role of the general psychiatrist and on the delivery of psychiatric services?

I understand from our recent telephone conversation that you anticipate that the Irish Division will be in a position to submit the promised comprehensive document by mid-November.

Yours sincerely,

Tommie Martin,
Secretary to Committee.