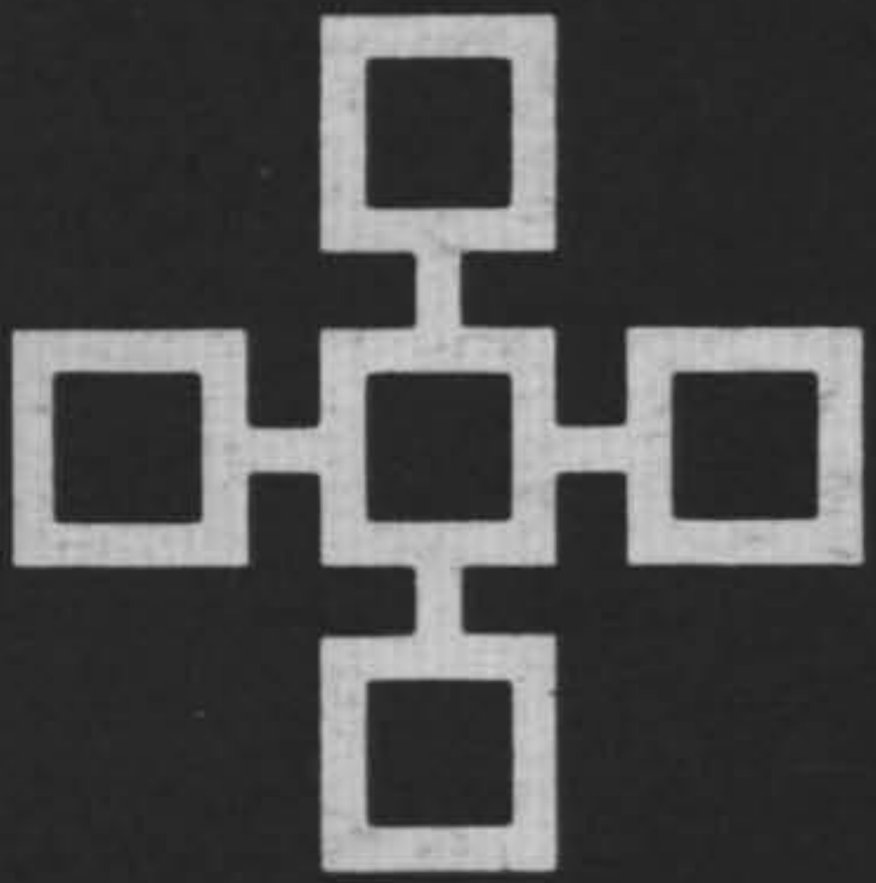
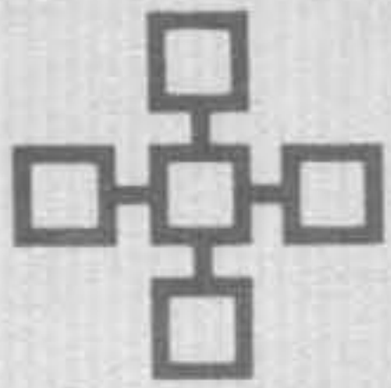
Psychiatric services at Consultant level: a discussion document



Comhairle na n-Ospidéal

Psychiatric Services at Consultant Level

-a discussion document



With compliments

Comhairle na n-Ospidéal,

Corrigan House, Fenian Street, Dublin 2.

☏ 763474/762284

Comhairle na n-Ospidéal

Psychiatric Services at Consultant Level – a discussion document

CONTENTS

1. Introduction

1.1 In pursuance of its statutory function to regulate the number and type of appointments of consultant medical staff in hospitals providing services under the Health Acts, the Comhairle has examined the question of psychiatric services at consultant level. This examination was undertaken both to aid the Comhairle in formulating policy on consultant appointments and to make recommendations to the Minister and the health boards on appropriate matters directly relating to the Comhairle's statutory role. The Comhairle wishes to emphasise that the examination does not purport to be a general review of the psychiatric services as a whole. It deals solely with those issues which are of relevance to its own statutory functions.

1.2 The Comhairle wishes to acknowledge, with gratitude, the assistance given by the following individuals who are not members of the Comhairle but who participated in the task as members of a Comhairle sub-committee on psychiatric services:–

Professor Ivor Browne,
Dr. Fergus Campbell,
Professor Robert Daly,
Professor Thomas Fahy,
Professor Thomas Lynch,
Dr. Paul McQuaid,
Mr. Donal O'Shea,
Dr. John Owens,
Dr. Patrick Power,
Dr. J. A. Robins,
Professor Noel Walsh.

In recording its appreciation for their contribution to this examination of the psychiatric services at consultant level, the Comhairle wishes to stress that the comments and conclusions contained in this discussion document do not necessarily represent the views of the persons named.

1.3 The sub-committee presented a report to the Comhairle in September 1975. When it came to consider this report, the members of the Comhairle, the great majority of whom are not directly involved in psychiatric services, felt the need to familiarise themselves more thoroughly with these services and to enquire further into the problems raised by the sub-committee. It was decided, therefore, to set up a study group of Comhairle members to visit appropriate psychiatric institutions and to discuss the problems locally with the health board officials and consultants concerned. The following served as members of the study group:–

Dr. A. Kennedy (Chairman),
Professor J. N. P. Moore,
Sister Bosco McNamara,
Mr. E. Browne,
Mr. B. Herlihy.

They were assisted in their task by Dr. J. A. Robins of the Department of Health and Dr. Dermot Walsh of the Medico-Social Research Board. The study group undertook a series of visits to a selected and representative number of hospitals providing psychiatric services, namely:–

St. Loman's Hospital, Dublin,
St. Ita's Hospital, Portrane,
St. Patrick's Hospital, Dublin,
St. James's Hospital, Dublin,
Mater Misericordiae Hospital (Child Psychiatric Unit),
Jervis Street Hospital (National Drugs Advisory and Treatment Centre),
St. Dympna's Hospital, Carlow,
St. Otteran's Hospital, Waterford,
Ardkeen Hospital, Waterford,
St. Luke's Hospital, Clonmel,
St. Brigid's Hospital, Ballinasloe,
Our Lady's Hospital, Ennis,
St. Stephen's Hospital, Cork,
Our Lady's Hospital, Cork.

The Comhairle wishes to express its appreciation to the members of the study group and to the many individuals who participated and facilitated the extensive visits and local discussions. In particular, the Comhairle is grateful to Mr. Brendan Herlihy (who recently retired as a member of the Comhairle) for his endeavours in analysing statistical information relating to the demand for psychiatric services.

2. Grading Structure for Consultant Posts in Psychiatry

2.1 There is a large number of medical grades of consultant status in the psychiatric services, viz:

Chief Psychiatrist,
Resident Medical Superintendent,
Clinical Director,
Clinical Director (Professorial Unit),
Director of Child Psychiatry,
Clinical Director (Forensic Psychiatry),
Senior Psychiatrist,
Senior Psychiatrist (Forensic Psychiatry),
Consultant in Child Psychiatry.

The Comhairle considers that there is a need to cut down and rationalise the multiplicity of titles currently in use. The differences between them relate to administrative responsibility, for all consultant posts are of equal status so far as clinical responsibility for patients is concerned. The Comhairle accepts that it is of particular importance in the field of psychiatry that there should be consultant posts with administrative responsibility at area and local level to plan, organise and manage the service for patients but it sees little advantage in a variety of titles. It has decided to adopt the following two titles for all future appointments in lieu of the existing titles set out above:–

(a) Consultant Psychiatrist in . . . (particular sub-specialty in psychiatry to be named as appropriate).
(b) Consultant Psychiatrist/Director of . . . (the second part of the title will reflect the administrative responsibility).

The different degrees and levels of administrative responsibility of posts designated as "Consultant Psychiatrist/Director . . ." can be clearly laid down in the statement of duties and should not necessitate the continuation of the present multiplicity of titles which are confusing and perhaps misleading in some instances. (For example, the title "clinical director" literally taken, seems to suggest that the holder directs the clinical work of fellow-consultants which is not the case).

2.2 The Comhairle thinks that administrative responsibility and leadership are closely allied. In modern psychiatry the emphasis is on a team approach rather than an individual one. In this situation, leadership qualities, particularly at resident medical superintendent/chief psychiatrist level, are of paramount importance. In the course of their visits to the various institutions, the members of the Comhairle study group were struck by the strong influence for the better

which a consultant with good leadership qualities can have on the overall standard of the service, even where physical facilities are poor. The Comhairle considers that the importance of this aspect of the job requirement should be a vital factor in the selection of consultants at the higher administrative levels – if necessary, even at the expense of technical ability. Unfortunately, in some instances, leadership ability, or lack thereof, may not emerge until an individual has been in office for a period. In view of the fact that appointments are on a permanent basis, the Comhairle recommends the setting up of formal medical committees at local catchment area and health board area levels to advise and assist the permanent directors of psychiatric services on policy matters. The precise membership of such committees would be a matter for discussion by health boards but, at local catchment level, they should include all the consultant staff. At health board level, the medical committee should include all the directors of local catchments plus the directors of specialty areas such as child psychiatry. The implementation of this recommendation would, the Comhairle believes, minimise the dangers inherent in the appointment of a permanent director with poor ability as leader and, at the same time, ensure participation by the senior clinicians in the formulation of policy.

2.3 The Comhairle is of the opinion that the designation of specialty areas in psychiatry in Ireland should follow international and, in particular, British practice. The Joint Committee on Higher Psychiatric Training at present recognises the following specialty areas:–

(1) General Psychiatry,
(2) Child Psychiatry,
(3) Forensic Psychiatry,
(4) Mental Sub-normality,
(5) Psychotherapy.

The Comhairle considers that, until such time as the Joint Committee recognises and introduces special training programmes in other specialty areas, consultant appointments with special interests should be confined to those listed. Arguments have been advanced for the creation of posts with a special interest in alcoholism on the grounds of the scale of the problem and the particular skills required to deal with it. However, the Comhairle believes that the majority view within the profession would at present be against this development on the ground that alcoholism should be dealt with as part of general psychiatry. However, while not favouring the formal creation of posts in general psychiatry with a special interest attached, the Comhairle would encourage the making of local arrangements under which consultants would develop special interests. In the case of alcoholism, which is too big a problem to be assigned to one individual in each health board area, a particular consultant might be encouraged to develop a special interest though not to the exclusion of other consultants. If, for example, a special unit for alcoholics is established in a hospital, all general psychiatrists working in that hospital should have access to these facilities.

3. General Considerations Relating to Consultant Manpower Needs in Psychiatry

3.1 **Classification of Patients in Mental Hospitals**: A census of Irish psychiatric hospitals carried out in 1971 (see Appendix 1) revealed that out of a total of 15,613 patients, 2,638 (16.8%) were adult mentally handicapped and 4,668 (29.9%) were over 65 years of age. Of the remaining 8,307 (53.3%) psychiatric patients, many were probably long-stay patients requiring mainly custodial care. While accepting that these three categories are not mutually exclusive, the figures do suggest that it is only a proportion of the patients in mental hospitals who are in need of the services of a consultant psychiatrist on anything like a regular and frequent basis. The Comhairle considers that the number of consultants should be related to the number of psychiatric patients who are genuinely in need of services at consultant level. In order to identify the number of such patients, a classification of the patient population in mental hospitals is required. The Comhairle understands that health boards have been asked to undertake this task but it has not yet been completed by all of them. Since it is only in the light of such information that provision can be made for the particular needs of each category of patient in an appropriate manner – including the consultant manpower requirements in psychiatry and other branches of medicine – the Comhairle strongly recommends that steps should be taken to encourage health boards to complete the classification as quickly as possible. During the course of its visits around the country, the Comhairle study group formed the impression that little was being done to identify the various categories. This, in the opinion of the Comhairle, is a matter for regret in view of the obvious benefits for all in planning and implementing a better mental health service.

3.2 **Trend towards Community Services**: In the past, the psychiatric services have been mainly based on institutional care in the mental hospitals. In more recent times, there has been an increasing emphasis on treating patients outside hospitals thus allowing them to remain in their homes and their communities. Likewise, where institutional care is unavoidable, it is increasingly regarded as important for the patient to maintain links with the community. In 1971 the number of in-patients was 15,613; in 1976, 13,408: a decrease of 2,205. The Comhairle strongly supports this trend and notes that it is an important factor to be taken into account in assessing future consultant requirements.

It is essential that highly-trained consultants should not have to undertake a large volume of routine medical duties in mental hospitals, some of which could be provided satisfactorily by other staff. However, until such time as alternative arrangements to supply such staff are made, there will not be enough consultants to devote more time to the development of community care services where their training and experience could be better utilised. It must also be borne in mind that improvements in services outside the mental hospitals may result in the recognition of more psychiatric morbidity which formerly would not have been dealt with by the psychiatric services at all.

3.3 **The Consultant in Psychiatry and Support Staff**: The Comhairle has considered whether some of the work currently undertaken by consultants in psychiatry could be carried out by suitably qualified people in other professions. The increasingly important role being played in clinical teams by psychologists, social workers, psychiatric nurses and other paramedical staff is recognised. Nevertheless, though a full range of support staff is essential to the provision of a proper service, such staff will never be able to substitute for medically qualified psychiatrists. The Comhairle is firmly of the view that all patients with mental illness should remain the clinical responsibility of the consultant. No doubt the psychologist has a very definite role to play in the assessment of such patients and in the promotion of good mental health, but his therapeutic activity has a limited scope and ought to be carried on under the supervision of a medically-qualified consultant. However, it is essential that the consultant psychiatrist should collaborate with other professionals on the basis of equality in all respects save that of final clinical responsibility.

3.4 In every branch of the mental service a team approach is now recognised as being the most useful and as such is adopted or advocated. In this situation the role of the consultant is twofold — (i) to provide the services which his medical training equips him alone to impart and (ii) to act as team leader in coordinating the different professional skills within the team. In the latter respect, a consultant who is a good leader can have an enormous influence for the better on the over-all standard of the service. On the other hand, the consultant cannot adequately provide other non-medical services (e.g. in the social field). In assessing demand for an increase in consultants, care must be taken to ensure that the needs of the situation actually warrant medical consultants and not non-medical personnel. The Comhairle believes that an increase in both the range and numbers of support staff would relieve consultants of much that is not appropriate to them and thereby secure an improvement in the services at consultant level.

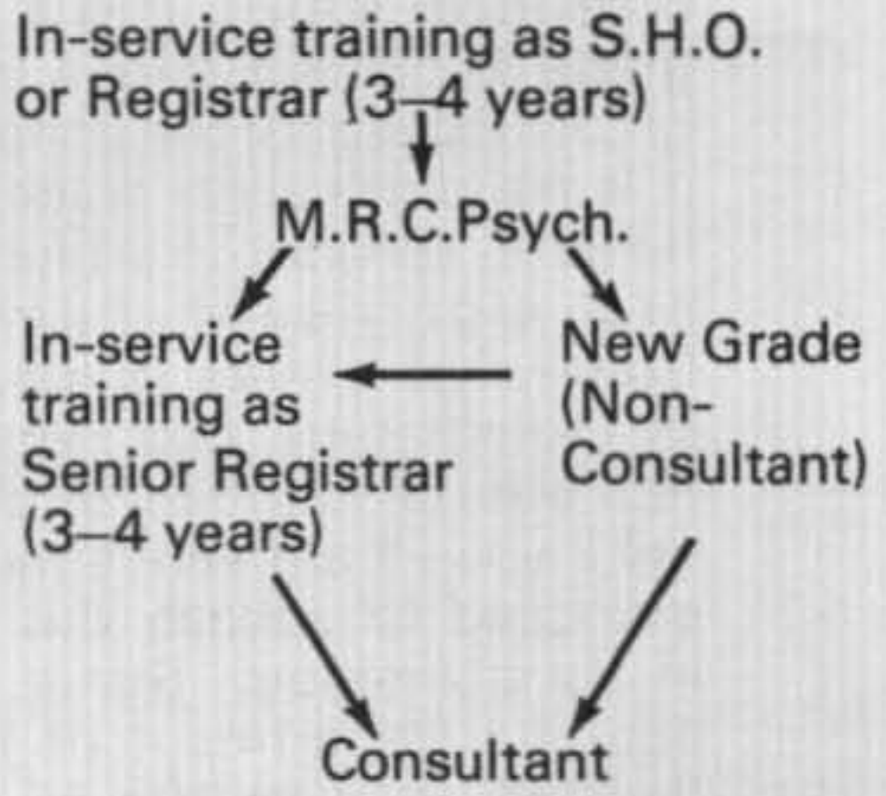
4. The Question of a Grade below that of Consultant

4.1 At the present time there exists a medical grade of "Psychiatrist" which is not of consultant status. It is a career grade as distinct from a training grade. Except for the consultant, it is the only career grade in the hospital services in which there are significant numbers. Somewhat similar grades exist in radiotherapy and rehabilitation but the numbers of personnel involved are very small. It is proposed to abolish this grade in rehabilitation. Some years ago the Department of Health decided as a matter of policy not to retain the grade of psychiatrist and over the last few years it has not created any new posts or filled existing vacancies. There were 34 appointees in the grade on 1st March 1977, many of whom have held their appointments in a temporary capacity for a number of years. The medical organisations also have expressed themselves in favour of the phased abolition of the grade of psychiatrist, subject to the position of existing temporary appointees being satisfactorily resolved.

4.2 As the grade of psychiatrist is not of consultant status, strictly speaking, it does not fall within the ambit of the Comhairle's regulatory functions. However, as the retention or abolition of the grade has obvious implications for the staffing of the psychiatric services at consultant level, the issue is of direct interest to the Comhairle. Although it is here considering and advising on the future of this grade, the Comhairle, of course, fully accepts the fact that the final decision on its future will rest with the Minister and the Department of Health.

4.3 In view of the trends mentioned at par. 4.1, the original Comhairle sub-committee on psychiatric services saw no alternative to discontinuing the grade of psychiatrist. However, the sub-committee pointed out to the Comhairle, when it reported in 1975, that the disappearance of the grade was creating problems and that there was little evidence that these problems were being faced. They relate first to the practical problem of who will undertake the day-to-day running of the services and, second, to an emerging problem of job opportunities. The sub-committee noted that, in the psychiatric field in particular, there is a large element of custodial care which does not require the services of highly-trained consultant psychiatrists. Moreover, in psychiatry, as in other areas of medicine, there is going to be a number of doctors who will not achieve consultant status. As higher training programmes are developed, there will be fewer and fewer opportunities, for those who do not achieve consultant status, to find suitable jobs. The sub-committee thought that there was a problem here for the medical profession generally.

4.4 On the other hand, the Comhairle study group which visited and consulted widely, found at local level considerable support, among both the hospital managements and the consultants, for the retention of a non-consultant grade similar to the existing grade of psychiatrist. The support for this type of post stemmed from their recognition of the need for a suitable type of person to take care of the day-to-day management of patients. Such a grade was seen as necessary to provide the continuity of treatment which is essential for proper psychiatric care and to assist in generating increased therapeutic and occupational activity within the psychiatric hospitals. Many of those with whom the study group spoke believed that without such a grade, the services currently being provided would be placed in jeopardy and the patients would, consequently, suffer. In the light of the weight of opinion at local level in favour of a non-consultant grade, the study group proposed the introduction of a medical grade between that of consultant and registrar. The study group considered that it was of paramount importance that the grade should be established as a career grade with proper standards of entry. The holders of posts in the grade should be capable of assuming clinical responsibility for patients (e.g. they would admit and discharge). They would function as members of the psychiatric team but would not be eligible to be team leaders – this function should be reserved for the consultant grade. It should be possible, the group thought, for a person to advance to consultant status through this non-consultant grade, provided he has undergone senior registrar training or its equivalent. The following diagram illustrates how the group envisaged the career structure in psychiatry and the place which this new grade might occupy:–



4.5 The minimum qualifications for entry to the new grade, it was suggested, should include the possession of the M.R.C.Psych. and at least 3–4 years satisfactory experience in psychiatry. The question of a title for the proposed new grade would have to be given careful consideration – in this context, the proposed introduction of specialist registration under the E.E.C. Directives might be of relevance.

4.6 The Comhairle has discussed at some length the concept of a medical career grade of the type described above. In doing so, the members recognised that this concept has relevance not only for psychiatry but for many, perhaps all, of the other branches of medicine as well. The main arguments advanced for and against are summarised as follows:–

(a) Arguments for :–

(i) There is a need and a place in the psychiatric services in Ireland for the person who does not wish to undertake the full clinical responsibility appropriate to a consultant. Such individuals can undertake a considerable range of clinical duties in the context of a team headed by a consultant.

(ii) In non-teaching hospitals in particular, such a grade can (in fact does) take some of the heavy workload from consultants and, at the same time, provides a continuity of service which is important for patients but which cannot be achieved by the use of the training grades alone.

(iii) It is the view of a sizeable number of consultants in mental hospitals that there is a need for the grade because the services, particularly in the rural areas, cannot be maintained solely by consultants and trainees.

(iv) The Royal College of Psychiatrists in a memorandum of evidence to the Royal Commission on the National Health Service in Great Britain has recommended:–

'That the psychiatric services be strengthened by the establishment of specialist posts with independent clinical responsibility but not entailing the full range of duties required of a consultant. These posts would have security of tenure, could be full-time or part-time and would be appropriate for psychiatrists who had completed higher training but who did not wish (or were not able) to enter the consultant grade".

(v) Because of the nature of the services and the volume of demand, the medical organisational requirements in the psychiatric services are different from most other specialties. The large volume of routine medical care in the psychiatric hospitals requires the continuous presence of sufficiently qualified personnel. This grade would facilitate the maintenance of a unified medical policy which is essential within a large psychiatric institution.

(vi) If a proper standard of entry (including a higher qualification in psychiatry) was set, the grade would have the necessary status to attract good quality candidates.

(vii) Formal postgraduate training at senior registrar level will tend to be based on the main teaching hospitals. It will become increasingly difficult for other hospitals to attract support staff with higher qualifications unless such a grade as this is established as a career grade.

(viii) The existence of a medical career grade of the type proposed would facilitate the return to hospital practice of married women doctors at the stage when their children are reared.

In view of the growing number of female medical graduates, the problem of providing such outlets will assume greater proportions in the future.

(b) Arguments against:–

(i) The introduction of a career grade below that of consultant would place this country out of step with the United Kingdom where the practice now is to discontinue all grades below consultant level apart from the training grades. In 1969, a British report entitled "The Responsibilities of the Consultant grade" (H.M.S.O. 1969) came down very firmly against the concept of a career grade below consultant level. (Nevertheless, permanent staff at this level continue to be employed and recruited there).

(ii) The continuation of the grade of psychiatrist or the introduction of a similar grade is undesirable as such grades do not exist in the other branches of medicine. Psychiatry is already somewhat isolated from the other medical specialties. To have such a grade perpetuates the impression that exists that psychiatry is different and set apart from the rest of the profession. Furthermore, if the grade was confined to psychiatry, it might tend to be a refuge for doctors who had failed to achieve consultant status in other specialties.

(iii) If the grade required a higher qualification for entry, it would be difficult to distinguish between it and the consultant grade. The difference would tend to be more administrative than professional. It would be preferable to increase the number of consultants rather than to have a grade below consultant.

4.7 Having considered the arguments, the Comhairle is in favour of a career grade below that of consultant for the psychiatric service. However, it recognises not only that this is a matter which falls to the Minister for Health to decide upon, but also that it is of great importance to the hospital services in general and to the medical profession. Indeed, it seems to the Comhairle that there is a need for consideration of the question of career grades below that of consultant throughout the hospital services. Recent developments in training at higher levels are going to have a profound effect upon the supply of registrars for service work and upon the demand for jobs by those who, for one reason or another, do not get to consultant level but are not able to move into other areas of medicine as has been possible in the past before the advent of higher training in virtually all branches of medicine. Again, the coming into existence of the "specialised doctor" grade under EEC directives with the freedom for such "specialists" to establish in Ireland precipitates the need to consider urgently the relationship of "specialist" to "consultant". These are matters for consideration by the medical organisations, the professional

training bodies and those responsible for the provision of services to the public. The Comhairle suggests that it would be appropriate for the Minister to take the initiative in promoting such discussions. The Comhairle would be pleased to take part in them for its statutory duties give it an immediate interest in their outcome.

5. Consultant Manpower in Psychiatry

5.1 Statistics of consultant manpower at 1st May, 1977, compiled by the Comhairle revealed an establishment of 161 posts, of which 20 were vacant. (Details are given in Appendix III). The figures indicate a ratio of one consultant per 19,400 population. From the information which the Comhairle has been able to obtain from other countries, the position is as follows:–

Year	Country	Population per Consultant Psychiatrist
1975	England/Wales	39,800
1975	Scotland	27,300
1973	Finland	26,500
1980 (target)	Northern Ireland	24,000
1976	Denmark	23,600
1986 (target)	New Zealand	15,000
1972	Sweden	14,000
1976	Norway	11,200
1980 (target)	Canada	11,000

5.2 While international comparisons are extremely difficult because of the different medical systems and the varying circumstances (including support staff) from country to country – Ireland seems to be generously supplied with consultant psychiatrists compared with her immediate neighbours in the United Kingdom. The reasons for this are likely to include the following factors:–

(a) There is a higher rate of admissions to mental hospitals in Ireland than in the United Kingdom. However, though more people are admitted to psychiatric hospitals, it has yet to be shown conclusively that the incidence of psychiatric illnesses is greater in Ireland than in other countries. Such little evidence as is available

suggests that the incidence *may* be greater but it is inconclusive. There is, however, firm evidence that there are more people suffering from serious mental illness in this country than in the United Kingdom. Poorer social and economic conditions in Ireland (against a background of large-scale emigration in the past) coupled with an expectation of service availability on a par with the United Kingdom; the lack of adequate community services coupled with the availability of institutional accommodation (much of doubtful quality), are factors which combine to bring about a large number of admissions to institutions and an inability to effect early discharge. While improvements may be made over the coming years, the Comhairle thinks that the present situation is unlikely to alter significantly in the near future.

(b) There is a greater number of people in mental hospitals in this country who are known not to be suffering from mental illness of a degree necessitating hospital care and who ought to be accommodated in more appropriate institutions. In particular, there are many old people who are "geriatric" rather than "psychiatric" cases. In addition, 17% of patients in mental hospitals are mentally handicapped adults, most, if not all, of these could be better dealt with in a different setting.

(c) The lack of back-up facilities and support staff, such as social workers, in the community often prevents the discharge of patients from mental hospitals. In some cases where these facilities and staff exist, they are not fully utilised. In some cases, because of emigration, patients have no families to which they could return.

(d) Many problems have been experienced in relation to nursing in the psychiatric hospitals which have resulted in an insufficient emphasis on the rehabilitation of patients. It is not within the ambit of the Comhairle's functions to comment on psychiatric nursing.

(e) The proportion of psychiatric morbidity dealt with by family practitioners in the United Kingdom is 90%–95%. There is no figure available for this country, but it is generally reckoned to be lower. The family doctor in Ireland tends to refer patients with psychiatric problems to a consultant psychiatrist much more readily than his U.K. counterpart.

(f) Socio-economic factors make it difficult to bolster the staffing of Irish mental hospitals by the recruitment of family doctors on a part-time basis. The Comhairle considers that, in the future development of psychiatric services, there should be a greater emphasis on the role of family doctors in the treatment of psychiatric illnesses. Closer contact between family doctors and the psychiatric hospitals should be encouraged.

5.3 The distribution of consultant manpower in psychiatry is far from satisfactory from the point of view of the numbers in each of the specialty areas. At present it is as follows:–

General Psychiatry	—	144
Child Psychiatry	—	14
Forensic Psychiatry	—	3
Psycho-therapy	—	—

The Comhairle understands that there are, in addition about ten consultants in mental handicap. However, as these are usually based in "homes" as distinct from "hospitals", they do not fall within the purview of the Comhairle.

5.4 Save in general psychiatry, not only is the total number of consultants in the country below the requirements for a population of three million but the situation is further aggravated by the unsatisfactory geographical spread of available consultants in these specialty areas.

5.5 In general, the Comhairle accepts that the psychiatric needs of this country would warrant a higher level of consultant staffing than that which exists in many others. The difficult question to determine is precisely what level of staffing would be appropriate for this country. In the course of many discussions around the country, the Comhairle study group did not see or hear any evidence to support the view that, in general, there is a need to increase the overall consultant manpower in psychiatry. The majority opinion was that there was probably a sufficient number of consultants available. However, the view was strongly expressed to the study group that what was needed was more psychiatrically orientated general practitioners and consultant physicians.

5.6 **General Psychiatry**:– During the course of its visits and discussions, the Comhairle study group canvassed opinion amongst consultants on what they would regard as a reasonable consultant/population ratio in general psychiatry. It emerged from these discussions that most consultants would accept a norm of one consultant per 25,000 to 30,000 population as being reasonable provided support staff was available in increased numbers. The Comhairle has decided to adopt this overall ratio as a general guideline in reaching decisions on applications for consultant appointments. In doing so, the Comhairle wishes to stress the importance of increasing the level of support staff available to the psychiatric services in general. It must also be stressed that this is a national norm. It is to be expected that, within this norm, there will be regional variations related to local circumstances e.g. age structure, density of population, distance and terrain. Of the present total establishment of 161 consultant posts in psychiatry, 144 are in general psychiatry – a consultant/population ratio of 1/22,000 based on the latest population estimates. The implementation of a norm of 1/25,000 would result in a reduction to 125 posts. The actual reduction is likely to be less, certainly in the short-term, since the norm will be applied as opportunities arise e.g. retirements, deaths or resignations.

In any case, it will be off-set to a considerable extent by population growth and increased numbers of consultants in the other specialty areas of psychiatry.

5.7 **Child Psychiatry**:– The Royal College of Psychiatrists recommend one team (which includes one consultant) per 100,000 population. It should be noted that there is evidence to indicate that urban child populations have increased morbidity and, therefore, higher service requirements. There is at present an establishment of fourteen child psychiatrists in this country – a consultant population ratio of 1/223,000. A suggestion was made to the Comhairle that the scope for preventive services is greatest in the field of child psychiatry. However, the Comhairle has not been able to find any evidence to indicate that there is a direct relationship between the incidence of psychiatric disorders in children and in adults. There is, however, evidence that child psychiatry is tending to become more concerned with the family situation. If so, it should become more closely associated with general practitioners and the social services. It is clear, however, that the present level of consultant staffing in child psychiatry is inadequate in the country as a whole. The Comhairle considers that more child psychiatrists should be recruited. Initially, the new entrants should be based on the large centres of population, but should have a commitment to provide a consultation service for provincial areas.

5.8 **Forensic Psychiatry**:– The number of forensic psychiatrists recommended by the Royal College of Psychiatrists is two per one million population. This would indicate a need for six forensic psychiatrists in this country. The present establishment is three who are all based in Dublin. Perhaps of greater importance than the precise number of consultants required is the question of the development of a proper structure for forensic psychiatry. There needs to be close linkages between the forensic psychiatrist and general psychiatrists in other psychiatric units. In addition, it is essential that adequate back-up facilities should be available to enable the forensic psychiatrist to function effectively. The Comhairle accepts the need for an increase in the number of consultants in this specialty area and a more equitable distribution to cope with the needs outside the Dublin area. The creation of additional posts, however, should be in the context of a planned development of the service on the lines mentioned above.

5.9 **Mental Handicap**:– Although the Comhairle is not directly involved in the provision of services for the mental handicap field, it has a lively interest in the much-needed development of services in this area since this would have an effect upon manpower needs in the psychiatric services generally. The Comhairle wishes to stress the necessity to develop separate appropriate services (including more qualified staff) and accommodation for the adult mentally handicapped many of

whom are at present accommodated in psychiatric hospitals. This problem, in the Comhairle's view, deserves much greater attention than it has received in the past.

5.10 **Psychotherapy**:– The scope for psychotherapy is very wide. It is reasonable to expect that this specialty will develop and that demand will grow with the increasing emphasis being placed on community care. However, until such time as norms are established and the size of the need is clearly defined, the Comhairle thinks that it would not be advisable to make recommendations on the number of consultants who might be needed in this country.

6. Arrangements for Linking the Various Psychiatric Services at Consultant Level

6.1 The Comhairle has considered what links between the various services are needed at consultant level. Links of two sorts are involved here:–

(a) between the various branches of psychiatry (e.g. adult psychiatry/child psychiatry), and
(b) with other related services (e.g. acute units in general hospitals, long-stay units and community care services).

The commission of Inquiry on Mental Illness (1966) stressed that there should be formal links between the different psychiatric services in the acute, long-stay and community field. The Comhairle agrees with their recommendation and thinks that the appropriate authorities should seek to implement it. Because of the variety of circumstances which exist in different parts of the country, it is not possible for the Comhairle to be more precise in regard to the form these linkages might take. Arrangements will have to be made with due regard to local circumstances.

6.2 Most health boards have been developing general psychiatric services on the basis of psychiatric teams (including one or more consultants) catering for particular local populations within their administrative areas and with the ultimate aim of providing comprehensive services and facilities at these local levels. In general, the Comhairle supports this approach. However, until such time as the necessary physical facilities for acute, long-stay and community care services are available locally, formal linkages will be necessary to ensure that each individual consultant has access to all the necessary facilities to enable

him to become involved in all three aspects of the services. In particular, the establishment of an acute psychiatric unit at a voluntary hospital will give rise to the necessity for formal arrangements to link such unit into the appropriate local area services provided by the health board concerned.

6.3 Child psychiatry and forensic psychiatry units require a much bigger population than general psychiatry and cannot, therefore, be organised in the same way. Hence the need for formal linkages between these specialty areas and the general psychiatric services. At present, linkage arrangements are being evolved in the Dublin area, e.g. the child psychiatry unit at the Mater Hospital has made good arrangements with outside agencies. However, in general, such arrangements, where they exist, are only in their infancy and they need to be developed further.

6.4 The making of formal links is primarily a management function which falls within the responsibility of the hospital authorities. As far as the Comhairle is concerned, it will expect such arrangements to be reflected in the structuring of consultant appointments. The onus rests upon the hospital authorities to describe these when submitting applications for consultant appointments to the Comhairle. The object of the Comhairle in considering a request for an appointment will be to ensure that it fits into a total service with formal linkage arrangements. The Comhairle will expect to have a specific statement of what the appointee's responsibilities are in an acute psychiatric unit, a long-stay unit and also the community care services.

7. Training of Psychiatrists at Senior Registrar Level

7.1 The Joint Committee on Higher Psychiatric Training in its first report (1975), has recommended that before proceeding to higher training (senior registrar level) in one of the five branches of psychiatry, a trainee should normally have completed at least three years general professional training. This time will usually have been spent in psychiatric posts, though a period of up to one year may be spent in other relevant medical work including general practice, general medicine, neurology, paediatrics, appropriate research etc. The period in general professional training will include experience in general psychiatry with at least two different consultant teams and, if possible, the trainee should also have had additional experience in one or more of the other branches of psychiatry and instruction in the psychotherapeutic skills which are essential for all psychiatrists. On completion of training at this general professional level, the trainee would normally obtain a higher qualification in psychiatry (e.g. membership of the Royal College of Psychiatrists).

7.2 The Joint Committee has laid down that, upon completion of general professional training, a period of four years of higher training is required for those wishing to become consultants in psychiatry. As yet, no programmes have been set up and no posts of Senior Registrar approved as suitable for higher training in this country. The Comhairle understands that it is hoped to establish programmes of higher training on a regional basis involving participation by a number of hospitals judged suitable for training purposes. It is urgently necessary that programmes be established and posts created because there are already candidates available who have completed their general professional training but who are unable to proceed to accreditation in this country. The danger is that if they go abroad to complete the final four years of training, they may not return to work in Ireland.

7.3 On the basis of consultant numbers (see Appendix II), it appears to the Comhairle that only a limited number of senior registrar posts can be justified and many of these should be in the specialty areas at present under-staffed at consultant level. It follows, therefore, that of those undergoing general professional training (109 on 1st March, 1977) only a proportion can expect to obtain a senior registrar post. The number in training at the moment does, of course, include doctors intending to go into general practice. Nevertheless, a problem arises as to what will happen to a considerable number of people who will not be able to go on to higher training. The question of the introduction of a career medical grade (discussed at section 4 of this document) is relevant to this problem.

Comhairle na n-Ospidéal
March 1978

Appendix I

IRISH PSYCHIATRIC HOSPITAL CENSUS 1971*
NUMBERS

	TOTAL	MENTAL HANDICAP	65 YEARS & OVER
St. Brigid's Hospital, Ardee	399	58	123
St. Brigid's Hospital, Ballinasloe	1,524	232	514
St. Patrick's Hospital, Castlerea	396	74	145
St. Dympna's Hospital, Carlow	343	58	137
St. Mary's Hospital, Castlebar	941	129	301
St. Luke's Hospital, Clonmel	624	104	200
Our Lady's Hospital, Cork	1,057	78	199
Our Lady's Hospital, Ennis	664	115	190
St. Senan's Hospital, Enniscorthy	470	127	170
St. Brendan's Hospital, Dublin **	3,022	606	783
St. Canice's Hospital, Kilkenny	423	66	139
St. Finan's Hospital, Killarney	745	115	181
St. Conal's Hospital, Letterkenny	578	110	207
St. Joseph's Hospital, Limerick	835	95	236
St. Davnet's Hospital, Monaghan	685	135	202
St. Loman's Hospital, Mullingar	941	244	309
St. Fintan's Hospital, Portlaoise	549	99	180
St. Columba's Hospital, Sligo	706	111	233
St. Otteran's Hospital, Waterford	506	72	182
Newcastle Hospital, Wicklow	73	10	13
St. Stephen's Hospital, Sarsfieldcourt	74	0	11
St. Joseph's Hospital, Clonmel	41	0	12
St. Anne's Hospital, Skibbereen	17	0	1
St. James's Hospital, Dublin	17	0	1
All Local Authority Hospitals	15,630	2,638	4,669
All private hospitals	1,031	42	

** including St. Ita's, Portrane & St. Loman's, Ballyowen.

*Source – Department of Health.

Appendix II

DEPARTMENT OF HEALTH, 1976.

District and Auxiliary Mental Hospitals. Patients on Register on 31st December.

	TOTAL
Eastern Health Board	
St. Brendan's (including Vergemont, St.. Dympna's Unit, Drug Unit, Dundrum St. Loman's St. Ita's	2,394
Newcastle, Co. Wicklow	84
Norther-Eastern Health Board	
St. Brigid's, Ardee	297
St. Davnet's, Monaghan	544
South-Eastern Health Board	
St. Dympna's, Carlow	332
St. Canice's, Kilkenny	406
St. Luke's, Clonmel (including St. Joseph's Admission Unit)	603
St. Otteran's, Waterford	448
St. Senan's, Enniscorthy	417
Midland Health Board	
St. Fintan's, Portlaoise	494
St. Loman's, Mullingar	906
North-Eastern Health Board	
St. Conal's, Letterkenny	544
St. Columba's, Sligo	666
Western Health Board	
St. Brigid's, Ballinasloe	1,277
St. Mary's, Castlebar	777
St. Patrick's, Castlerea	340
Mid-Western Health Board	
Our Lady's, Ennis	589
St. Joseph's, Limerick	804
Southern Health Board	
Our Lady's, Cork St. Stephen's, Sarsfieldscourt St. Anne's, Skibbereen St. Raphael's, Youghal*	774
St. Finan's, Killarney	712
TOTAL	13,408
All Private Hospitals	1,065

*Closed 1972

Appendix III

COMHAIRLE NA N-OSPIDÉAL
CONSULTANT MANPOWER STATISTICS AS AT 1st MAY, 1977

Psychiatry (excluding Mental Handicap)

Health Board Area	Mid Western	Southern	Eastern	Midland	North Eastern	South Eastern	North Western	Western	National
Establishment*	9	23	70	12	8	14	8	17	161
No. of vacant Posts	—	3	5	2	3	1	1	5	20
Population per Consultant (000's)	25.1	21.2	14.9	21.6	22.8	30.6	23.5	18.4	19.4
% Distribution of Consultants	5.6	14.3	43.5	7.5	5.0	8.7	5.0	10.6	100
% Distribution of Population	9.0	15.6	34.3	5.8	8.3	11.0	6.0	10.0	100
Retirals (at 65 years of age)									
Age 66 or over	—	—	3	1	—	—	—	—	4
1977–1981	—	2	4	2	—	2	1	1	12
1982–1986	1	2	3	2	—	5	1	2	16
1987–1991	4	3	12	2	—	3	—	1	25
1992–1996	2	3	17	1	3	2	1	2	31
1997 +	2	10	26	2	2	1	4	6	53

*Establishment = Number of consultants in practice plus the number of vacant posts approved by the Comhairle.