College of Psychiatrists of Ireland

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2017 Budget Submission

Priorities for Mental Health Services that must be addressed in Budget 2017

EAP Department

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College of Psychiatrists of Ireland - 2017 Budget Submission

The Mission of the College of Psychiatrists of Ireland is to promote excellence in the practice of Psychiatry. The College, formed in 2009, is the professional and training body for psychiatrists in the Republic of Ireland. The College supports the implementation of a **Recovery** based Mental Health Service as delineated in ***A Vision for Change***.

Priorities for Mental Health Services that must be addressed in Budget 2017:

- A working environment that attracts, trains, and retains high quality clinical staff from all necessary disciplines.
- Access to community based multi-disciplinary clinical supports for people in need 7 days a week.
- Independent oversight and transparent tracking of policy implementation based on accurate information about provisions and deficits nationally.

EXECUTIVE SUMMARY

Mental Illness causes both social and financial damage with the Mental Health Commission estimating that the cost of poor mental health is over 2% of GNP. The College is concerned that the media and public focus on suicide prevention, though important, prevents an informed discussion on the needs of those with chronic mental illness. Increased emphasis needs to be put on the meaning of recovery and ensuring adequate resources to address these needs.

The HSE issued figures in June of this year illustrating the high rate of re-admission for people with mental illness. These facts are a manifestation of the poor delivery of a basic part of the national mental health policy ***A Vision for Change*** which highlights the need for community based multi-disciplinary teams in all areas of the country for all patient age groups delivering Recovery based community supports to people with mental illness. The mental health budget remains scandalously low and inadequate for our increasingly diverse population. Moneys that are available seem, in many cases, trapped in an out of date hospital based model of financing that does not fit the community recovery vision for mental health services.

The College acknowledges that progress has been made in the last 12 months but it is patchy and basic fundamental services are lacking in many areas. Psychiatrists are key to the delivery of emergency and continuing support to people with mental illness. Many consultant posts across the country are vacant or shored up by long-term locums. The latter are often not

appropriately trained for the posts they hold. This means that patients are not getting the expert service they require and service development is not as clinically driven as it should be. The College calls for the delivery of the recommendations of the Mac Craith Report as a matter of urgency. The announcement of new clinical programmes before the establishment of basic services nationally seems an inappropriate use of funding in a country that still has may financial problems to overcome. Information on progress in policy delivery is difficult to establish and published information is open to question. The College, once again, calls for independent oversight of progress on policy delivery and for the development of an ICT system to collate appropriate accurate information which can be readily available to all.

Basic mental health services as per ***A Vision for Change*** need to be in place before any further advanced specialist services are financed and implemented. Special programmes should rest on a functioning general service, not substitute for it. Short, medium and long term phases of development and implementation need to be clearly identified and specifically funded. Information on needs nationally and the progress on the implementation of services to meet these needs, must to be readily available. This would ensure planning, accountability, learning across the system, and best use of funds for the recovery of people who present with mental illness.

The College welcomes the recent establishment of a Cross Party Committee to develop a 10 year plan for the Health Services. However there is a plan for Mental Health Services that, though already 10 years old, is still applicable. The basic tenets of ***A Vision for Change*** should be implemented before any new plans are formulated. Once this is accepted then the agenda of the proposed Cross Party Committee on Health must give equitable priority to Mental Health Service development.

MAIN ISSUES TO BE ADDRESSED:

1. The training, recruitment, and retention of frontline staff must be prioritised. In the context of Psychiatry, the implementation of the MacCraith Report and the provision of attractive training and working conditions for both Trainees and Consultant Psychiatrists (i.e. the provision of appropriately staffed teams and systems; protected educational time and resources for trainees and protected teaching/training time for trainers) need to be urgently addressed. Staff numbers and skill mix should be sufficient to ensure a Consultant delivered service with cover readily available so that no gaps are caused by leave or retirements.

2. The percentage of the Health budget designated for Mental Health must increase to 12%. Spending on delivery of Mental Health supports in the context of national concerns about this issue remains scandalously low at 6% both compared to other countries (e.g. UK 12%, Canada and New Zealand 11%) and compared to that proposed in ***A Vision for Change*** (8.24%). 25% of the budget should be designated to further development of Child and Adolescent Mental Health Services (CAMHS).

3. Ensure independent transparent oversight of policy implementation and service need. The last report of the Independent Monitoring Group for ***A Vision for Change*** (6th report 2012) on the implementation of ***A Vision for Change*** proposed that authority be given to the Mental Health Commission to conduct the seven year review in 2013 and to conduct yearly monitoring for the following three years. This did not happen. No seven year review occurred and there is now no independent reporting on the implementation of what is accepted by all to be national policy. Unless we delineate the deficits in the existing service we cannot hope to remedy them in a practical and practicable way.

4. Equality of access for all - address the inequitable two tiered health system. Access to specific mental healthcare inputs must be based on individual clinical need not ability to pay. An imaginative approach to enabling access to clinical inputs not available in the public sector would improve access for all. Currently people are disadvantaged by the two tier healthcare system due to geography and finance.

5. 24/7 multi-disciplinary community based services and support for people with acute mental distress and those in recovery. As stated recent HSE figures on readmission indicate that people are not getting the support they need in the community for independence and recovery. The provision of community based mental health teams for patients of all ages on a 24/7 basis beginning with immediate funding and roll out of 7 day services nationally must

be a priority if inroads are to be made into the continued morbidity and mortality due to chronic mental illness, suicide, self-harm, alcohol and substance abuse

6. Information Technology Systems. A contemporary and user friendly national IT system with appropriate patient record access needs to be provided in each local service and across the health service to ensure co-ordinated, seamless services, patient safety and to provide national data to facilitate future service planning.

7. Nurture the Mental Health of the Future Generation. Resilience education for all and support for vulnerable children must be planned and funded appropriately and for the long term. Guidance and education on mental health must be properly resourced at all levels of our education system nationally.

8. Counselling and psychological services including community based psychological therapies **for children and adolescents must be revitalised to provide ease of access based on need nationally.** This includes assessment of individual abilities and needs at an early stage.

9. Recovery model and principles to underpin service provision. All services should be funded on a Recovery model and ARI principles encouraged and integrated in services nationally. The provision of rehabilitation specialists and multi-disciplinary supports must be assured in all areas of the country.

10. Fund the development and full implementation of Clinical Programmes in Psychiatry. Designated, ring-fenced budgets for development and implementation, with time lines on staff provision and education that ensure delivery, are required for all clinical programmes both existing and planned**.**

11. Primary care counselling with ease of access nationally. Funding for the nationally based primary care counselling service must be sufficient to ensure ease of access through General Practice for people in need.

12. Budget actions (both Taxation and Spending) must support activities that reduce marginalisation and substance abuse. This means continued action on employment, housing and in support of community action group that provide settings and activities that promote community activities and reduce isolation of individuals. Such groups include sporting organisations.

13. Change from a Hospital Bed based model of funding to a Community Clinical supports model. The financing of mental health services must move from a hospital bed based model to a community based team provision model but not to the detriment of required hospital beds for emergency referrals and acute illness needs of both children and adults.

14. Access to 'Talk Therapies' must be available nationally. Therapies such as Cognitive Behaviour Therapy and Interpersonal Psychotherapy that have a proven effect for mental illness must be provided nationally.

15. Appropriate administrative support needs to be provided to each mental health team across the country. Current deficits in administration and communication with patients and with primary care, are patient safety issues.

16. The Dementia Strategy must be fully resourced.

17. Specialist services for vulnerable groups. Funding of the services needed for special groups as outlined in 'A Vision for Change' must deliver practical solutions to the needs of vulnerable groups.

18. Support for Carers. Respite services and home support for people with Intellectual Disability and dementia must receive increased levels of funding.

19. Plan and provide for the mental health needs of Refugees & Asylum Seekers.The European response to the international refugee crisis means extra responsibilities for Ireland. Planning for healthcare, including mental healthcare, must be in place to ensure the special needs of displaced people are met appropriately.

20. Plan and resource to ensure the physical health of those with long term severe mental illness who die on average 17 year earlier than the general population.

INTRODUCTION

The College of Psychiatrists of Ireland was formed in 2009. It is the professional body for Psychiatrists in the Republic of Ireland.

The Mission of the College is to promote excellence in the practice of psychiatry.

The College fulfils its mission through the following actions:

1. Education and Training of psychiatrists
2. Provision of lifelong learning for psychiatrists
3. Advocacy for resources to support best practice in the delivery of mental health services.
4. Promoting best practice in education, training, and research in psychiatry.
5. Public education in issues related to psychiatric illness, psychiatric services and mental health promotion.

The College supports the delivery of mental health services in line with the recovery model and supports the delivery of the national policy on mental health services ***A Vision for Change***.

The College of Psychiatrists of Ireland is the sole body recognised by the Medical Council and the HSE for the training of doctors to become specialists in psychiatry and for the continuing assurance of the career long competence of specialists in psychiatry.

The College of Psychiatrists supports the principle that the Health Provision in the Annual National Budget ensures that vulnerable people get the support they need to be active members of Irish society. People with acute or chronic mental illness are among the most vulnerable in our society. The College proposes certain key issues that must be addressed to reduce the impact of mental illness on Irish citizens and Irish society.

The Percentage of the Irish Health Budget that has been dedicated to Mental Health (circa 6%) falls far short of that of other countries (e.g. UK 12%, Canada and New Zealand 11%) even though advocates in those countries also criticise the level of investment.

This is a human rights issue and should be seen as a scandal by anyone who cares about the health of our nation.

The Irish national policy on mental health, 'A Vision for Change', proposed that the 8.24% of the national health budget (based on 2005 figures) should be dedicated to mental health. A case can be made that the changes in Irish society wrought by the economic deterioration after 2005 have caused mental health morbidity to increase and this means that the proportion of the health budget needed for Mental Health Services is now larger. Even taking a cold and practical view that leaves aside the

damage to society and to individuals in society caused by mental ill health all international research shows the major negative effect on GNP of untreated mental health problems. Mental health problems account for 13% of the burden of disease (WHO 2008). Research from the UK shows that for every £1 spent on Mental Health there is a saving of £4 to the Economy. There is no reason to doubt that the same applies in the Republic of Ireland. The Mental Health Commission's report 'The Economics of Mental Health Care in Ireland' (2008) gives an estimate of €3 Billion for the cost to Ireland of poor mental health (2% of GNP).

The case for investment is multi-faceted and impossible to deny. The Mental Health Commission's Report states that "the evidence examined suggests that the individual and social returns from judicious investment in mental health in Ireland is likely to be high and sustained". Research from the UK indicates that the damage wrought to mental health service provision by the departure of experienced staff and the focus on an inpatient model of investment also needs changes in organisational and professional culture. Service delivery and professional training must be based on a Recovery model delivered mostly in the community. Though this is national policy and exemplars exist we are far from achieving this nationally. Difficulties in recruitment of staff, and reluctance to support continued professional development for all staff with the resources to provide cover for leave and retirements, and the call for existing staff to "do more with less" does not permit the development of reflective community based practice.

Delivery of modern health services cannot occur in a piecemeal fashion. The problems highlighted by advocates and service providers such as deaths due to unavailability of inpatient beds; the lack of crisis intervention except through understaffed A & E Departments; over reliance on pharmacological treatments and the lack of community based clinical services all are part of a cycle of poor integration and lack of consolidation of investment across the country. A review carried out by the HRB in 2013 highlighted that 67% of all admissions were readmissions (Activities of Irish Psychiatric Units; Daly & Walsh). Recent HSE figures showing show that there were almost 13,100 admissions for people with mental health difficulties last year with a readmission rate within 12 months of 66 % suggest that people with mental health problems are not getting the supports they need to pursue recovery in their own communities. A review exploring traditional, hospital-based service compared to a service providing home treatment and 5-day-a-week day hospital support found that the latter was able to reduce re-admissions to 58% compared to 72% in the traditional service (Value for Money: A comparison of cost and quality in two models; Gibbons et al; HSE; 2012).

To illustrate what is meant, if a person in distress can go to their GP and access a community mental health team as needed then they will not need to go to A & E thus not occupying the time of A & E staff and they may not need admission thus freeing out hospital based resources for those in need of such a model of intervention. If treated in the community their recovery may be quicker thus returning them to active participation in their community and freeing out resources for other people. Parallel with such an example if a person has recovered from an acute illness and has regular follow up to support them in

maintain their treatment and associated plans they are much less likely to relapse and require readmission. The subsequent positive effects on the individual, the community, health services and the GNP are obvious.

The benefits of a national community based mental health service for all ages will not happen without investment both Financial and Philosophical. The annual Budget is an opportunity for the Government to propose a pathway to underpin mental health by investment of money and by policies that support the mental health of vulnerable individuals through investment in social policies and taxation that promotes community inclusion and discourages unhealthy activities. Investment in services should be in community based models not in hospital based ones. This will indicate support for modern philosophies and give practical and moral support to patients, those in recovery, and the staff who work with them

The Irish public is concerned at the effect issues such as suicide, self-harm, alcohol abuse and chronic mental ill health are having on our communities throughout the country. These issues are important but the needs of people with chronic mental illnesses may get lost if these are the main focus of attention. As stated people with chronic mental illnesses can live fulfilled lives and the humanitarian and financial long-term cost to individuals and the nation can be minimised with appropriate interventions and supports. The College of Psychiatrists of Ireland has proposed certain measures that it sees as priorities for the development of a mentally healthy nation. In continuing to advocate for these measures under separate headings the College reiterates that it is vital that the mental health services and allied supports develop in a unitary cohesive fashion as piecemeal delivery will be ineffective and wasteful. In circumstances of financial drought however certain issues must be prioritised and can form a sound base for future investment as the economic picture improves.

People with mental illness have much higher rates of morbidity and premature mortality and are particulary disadvantaged by the two tier Irish Health System. It has been shown that those who are financially secure have better access to healthcare. Research also demonstrates that those with chronic mental health problems have increased physical morbidity and are less proactive in looking after their physical health. A health service with access based on clinical need not financial means would address access for those with mental health problems who are a particularly vulnerable group disadvantaged by the two tier system.

The nature of public funding of healthcare generally militates against long term planning. It is impossible to plan in a system that is funded on a yearly basis with little provision of long-term funds for sustainable service developments. The College call for a minimum five year budget and implementation plan with an adequate percentage of the overall health budget rising to 12%. The historic piecemeal approach with annual budgeting militates against delivery of cohesive national planning and must change.

THE KEY ISSUES

In financially straitened times the College proposes that resource allocation in Psychiatry be on the basis of community based treatment and not on hospital beds.

The priority must be to have functioning specialist assessment and intervention systems in place nationally for children, adolescents, adults, and the elderly available on a daily basis. These allied to the Clinical Programmes (see below) will have a major impact on current issues of public concern such as self-harm and chronic mental illness. The template for the community teams is delineated in ***A Vision for Change***. There are examples of such teams in practice in the Adult Mental Health Services but nationally major gaps remain with major deficits in Child and Adolescent, Old Age, and Intellectual Disability Mental Health Services. The lack of such teams leads to unfortunate situations highlighted in the media where people with acute exacerbations of chronic mental illness present to A & E departments causing further distress to themselves and others.

TRAINING AND STAFFING

Recruitment

Recruitment processes seem ponderous and not fit for purpose. Conditions of employment including pay and the lack of provision of a modern multi-disciplinary working environment continue to adversely affect recruitment at all levels in all disciplines. This allied to insufficient training places in many disciplines and the lack of ring fenced time for trainers to train and trainees to learn continues to discourage high quality candidates. Other countries seem to provide a more attractive working environment for mental health professionals especially doctors.

The College is aware of many services without the requisite team members either due to recruitment problems or to key professionals being on long term sick leave. This has a major effect on continuity of care and on waiting lists. This, in turn, leads to patients presenting in crisis which could have been avoided with the availability of appropriate community mental health staff. The deficits in staffing also put increasing stress on those who remain. This perpetuates a cycle of low morale and further staff indisposition leading to further problems in service provision. The overall deficits in Mental Health Professional numbers must be corrected as a matter of urgency and the relevant professional groups consulted as to how this can be done.

Training, Retention and Career Planning

The remit of the College is the training and ongoing education of Psychiatrists. In this regard the recommendations of the MacCraith Committee (Strategic review of Medical Training and Career Structure: Final Report; Department of Health, June, 2014) must be implemented in full to encourage

both Irish and overseas medical graduates to train and then work as Consultants in Ireland. Our current system of service provision is dependent on a certain number of junior/trainee doctors and is at risk of collapsing without them.

There are ongoing problems in recruitment. Among the issues highlighted by MacCraith is the working environment, career progression and pay. The provision of attractive training and working conditions for both Trainees and Consultant Psychiatrists, (i.e. the provision of appropriately staffed teams and systems; protected educational time and resources for trainees, and protected teaching/training time for trainers), need to be urgently addressed.

The College recommends that the national budget sets aside the funding necessary to implement the actions proposed by MacCraith to ensure a system is in place nationally to attract, develop, and retain sufficient trainees to provide for the pubic need in Psychiatry in the future.

Consultant Manpower

Patients are entitled to a Consultant delivered service but current employment practices and recruitment practice militate against this. The College has published a Manpower Planning Document (College of Psychiatrists of Ireland, Workforce Planning Report 2012-2013) which delineates the Consultant numbers necessary to deliver such a service and the trainee places necessary to provide for such numbers in the future. Sufficient numbers of Consultants must be in place to ensure continuity of service delivery allowing for acceptable on-call rotas, leave, training, and retirement of consultants. Numbers must also ensure a critical mass of expertise in each specialty area thus making posts more attractive to high quality candidates.

SERVICE PROVISION

Community Based Teams

The template for Psychiatric Service Provision in Ireland is in ***A Vision for Change***. Unfortunately the proposals of that document in acute assessment and intervention and in rehabilitation and recovery have not been implemented nationally and retirements and recruitment embargos and other recruitment problems have depleted existing teams of Specialist Psychiatrists, Trainee Doctors, Specialist Nurses and Allied Health Professionals (see Training and Staffing below).

The College strongly recommends that the budget allocates funding for the delivery of multi-disciplinary assessment and intervention teams nationally that are available every day of the week to those in need. There is a continued argument that there is a dearth of appropriate candidates for posts and this means that budgets cannot be used and so the appropriate disciplines are not present in every team.

However the lack of complete teams with sufficient numbers to cover leave militates against attracting high quality candidates for posts. Imaginative answers to this conundrum incorporating available information and plans must be used or the situation will not change.

Hospital Based Care and Emergencies

Community based teams and seven day access to support and services must not be to the detriment of beds required for emergency situations and in acute wards. A significant proportion of emergencies, including first presentation of severe mental illness, present to hospital Emergency Departments in the first instance. Recovery in hospital with the appropriate treatment plan and supports are needed for a functioning mental health service and to enable a person when discharged to engage with the community teams. Liaison mental health services need to be adequately resourced to provide appropriate care and support to those presenting to hospital.

Between 10% and 40% of inpatients in general hospitals will have psychiatric comorbidities or presentations attributable to psychiatric/psychological pathology. It is imperative that a standardised resourcing of integrated mental health care across all general hospitals according to activity levels and levels of medical complexity managed in hospital is planned for and resourced.

Recovery

Recovery is the philosophy that underpins modern mental health service development. The Recovery Model is based on the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms. To support this service users need access to multi-disciplinary community based clinical supports where and when they require them. The philosophy of Recovery must underpin all mental health service interventions. In addition Rehabilitation Psychiatric Services to support those with longer term illness towards Recovery are needed nationally. The requirements are as designated in ***A Vision for Change***.

Information Technology and Administrative Support

To help plan and deliver these services a National Mental Health Information Technology System is needed. ***A Vision for Change*** indicated that this was a priority but no progress seems to have been made. The system would enable audit and review. The HSE has pointed to this as a problem for planning. Such a system should also facilitate communication between mental health professionals (both Psychiatry and Primary Care) and between the system and service users. The College knows of

many examples where Clinicians are answering phones or writing letters which is a poor use of clinical time. The difficulties posed where information about service users is not available to the professionals supporting them when needed due to the lack of a modern IT infrastructure is a major safety concern. An IT system with appropriate administrative support is needed nationally as a matter of urgency.

Clinical Programmes in Psychiatry

Clinical Programmes aim to improve and standardise patient care throughout the HSE by bringing together clinical disciplines together with service user input and thereby developing innovative solutions based on sound evidence to deliver greater benefits. Five National Clinical Programmes in Mental Health are being developed. The Programmes are based on three main objectives: to improve the quality of care delivered in the public mental health services in Ireland; to ensure equitable access to services and to improve cost effectiveness. The Clinical Programmes in Psychiatry are:

- *Assessment and Management of Self-Harm Presentations in Emergency Departments.*
  Twenty eight Clinical Nurse Specialists funded through the Programme for Government funding in 2013 were recruited to this Clinical Programme. It was implemented in December 2014 and officially launched jointly by the College and the HSE in March 2016. At the launch, data on the first full year of operation of the Clinical Programme was presented.

- *Eating Disorders*
  The first draft of the Working Group's document is now ready. It outlines the need to develop regional specialist eating disorders teams for children and for adults which will be co-located. The funding for these teams is essential with services for adults in particular being poorly developed. Training has commenced with staff trained in Family Based Therapy for children and adolescents and Cognitive Enhanced Behaviour Therapy for adults, for both of which there is a supervisory structure in place. The aim is to build up the skills and competencies of staff to treat eating disorders.

- *Early Intervention for Psychosis*
  The strategy document produced by the College Working Group and a recent review commissioned by the College are now being collated by a HSE Working Group together with a College Clinical Advisory Group.

  In the meantime, recruitment of staff for the Independent Placement Scheme required for this Clinical Programme is underway. Training in Behaviour Family Therapy for First Episode Psychosis has been completed. There is a robust supervision structure in place and on-going training.

- *Two new Clinical Programmes 2016*
  - Comorbid Mental Illness and Substance Misuse (Dual Diagnosis)
  - National Clinical Programme for Attention Deficit Hyperactivity Disorder in Adults

These Clinical Programmes are in the early stages of development. Each Clinical Programme was chosen as it targets a clinical area requiring an improved service response e.g. where a dual diagnosis of substance misuse and comorbid mental illness exists, and likewise management of ADHD in adults.

The College strongly proposes that the budget should indicate ongoing ring-fenced funding for complete development, resourcing, training and implementation of these programmes, and audit carried out to monitor how and when they are embedded in services.

In addition the Mental Health section of the Older Persons Programme needs to be actively dealt with.

'Talk' Therapies

There is much evidence to show that in certain circumstances, for certain conditions therapies such as Cognitive Behaviour Therapy (CBT) are as good as or better than pharmacotherapy. There is also evidence that such therapies used in conjunction with pharmacotherapy improve recovery from illness. Unfortunately availability of such interventions is limited in the public health service. Action on provision of trained staff nationally in the public service must be accelerated. Staff must be freed up to get further training in such therapies. The Budget can support this by setting aside finds to ensure that staff get support financial and otherwise to get such training. Investment here would benefit service users and also attract candidates to work in posts where such training is available.

Access to appropriate Mental Health supports from Primary Care must include national resourcing of regulated counselling services. Figures for 2014 indicate that at the end of November 2014 there were 248 people waiting for counselling for 3 to 6 months and approximately 80 patients had waited for longer than six months (*A Vision for Change Nine Years On,* Mental Health Reform, 2015).

SPECIAL GROUPS

People with Developmental Disabilities and related needs

Certain groups of people have specialist support needs that should not necessarily be within the remit of mental health services. Unfortunately due to the lack of such services they present to mental health services often when carers have burnt out after years of unsupported unrecognised maintenance of their loved one. These groups include people with intellectual disability, people with developmental disorders (e.g. Autism), people with head injuries and people with dementia. These groups need community support from trained carers, appropriate vocational and recreational support and education, and appropriate respite.

People with developmental disabilities also need specialist psychiatric clinical services from time to time. They are also more likely to be prescribed psychotropic medication especially if they have behaviour problems. This is a national scandal caused by the lack of appropriate environments and activities and a lack of specialist input when it is needed. Funding must be provided for community supports to ensure such vulnerable people lead meaningful lives.

The College asks for funding for this as a matter of national duty and that resources are allocated also to ensure specialist mental health services are available nationally, for all these groups, as proposed in ***A Vision for Change***.

Care of the Carers

More than 50% of people caring for someone have a significant mental health issue (Irish College of Psychiatrists and the Carers Association 2009). Carers have indicated that they need more support including respite and home help. These needs continue. The College joins other groups in asking for greatly increased funding for carer support in the next budget.

Dementia Care

It is estimated that there are approximately 50,000 people with dementia in Ireland today (Irish National Dementia Strategy: 2014; Department of Health). These numbers are expected to increase to over 140,000 by 2041 as the number of older people in Ireland increases. It has been estimated that the average annual cost per person with dementia in Ireland is €40,500 with the bulk of care for people with dementia being provided free of charge by family caregivers, many of whom are adult children and spouses.

The value of informal care for those with dementia is estimated to be €807 million per annum. Thus the burden on families and other informal care givers is huge and provides an under heralded benefit to the State.

The College endorses the Government's undertaking to provide dedicated funding for the Dementia Strategy and calls for this to be copper fastened in the forthcoming budget. . People with dementia often require home care packages that can increase their time at home but home care needs significant investment. People with dementia are more likely to go to nursing homes than people without so the onus of the 'Fair Deal' is heavier on them. It is also unfair that if a person with dementia requires a specialised dementia unit they will be charged more than an individual with a physical health problem. This does not apply in other area of the health service such as Cancer Care and must change.

Finally, as stated already, Carers of people with dementia need increased and equitable access to respite and other services regardless of the age or presentation of their loved one with dementia.

Peri-Natal Mental Health Services

The discussion of the Protection of Life in Pregnancy Act has highlighted the lack of Peri-natal Psychiatrists nationally. The College supports the introduction of specialist Peri-natal Psychiatry Services nationally.

Refugees and Asylum seekers

The plight of refugees has rightly led to a supportive response from the Irish Government. 4,000 refugees are due in Ireland before the end 2106 and the figure is possibly similar for 2017. Practice and research (The Mental Health Service Requirements for Asylum Seekers and Refugees in Ireland; CPsychI; 2009) have shown that the experiences of refugees lead to increased mental health issues compared to the indigenous population and that for many reasons they need specialist support.

Research shows that refugees resettled in western countries have been shown to be about ten times more likely to have Post traumatic Stress Disorder, PTSD compared with age-matched general populations in those countries. International research reveals that 30–60% of all refugees in Europe have experienced torture and other forms of serious violence. The research goes on to explain that it is possible that the under-detection of trauma and under-diagnosis of PTSD are the case not only in the outpatient mental health clinics represented in this study but also in services nationwide. The College is happy to help in planning for the needs of newly arrived refugees but warns that existing services are not sufficient and delivery of extra resources in the areas where refugees will live is a matter of urgency. Simply directing refugees with mental health needs to catchment area services where they are placed will not meet their needs and will further dilute the general effectiveness of existing services. A mental health needs assessment of individuals must be carried out prior to arrival in Ireland. Based on the findings placement of people with a definite need for mental health services should be made to communities where appropriate services exist and have the capacity to support them. Some special groups such as those who were victims of torture should be placed so that they have ease of access to the inputs they need.

PROMOTING MENTAL HEALTH

Alcohol

The College welcomes the Public Health (Alcohol) Bill 2015 and supports all five measures contained therein.

Alcohol abuse remains a major factor in occurrences of self-harm. The National Registry of Self Harm shows that 45% of men and 37% of women use or misuse alcohol at the time of their self-harm act (*Saving Lives and Reducing Harmful Outcomes: Care Systems For Self-harm and Suicidal Behaviour: National Guidelines for the Assessment and Management of Self-harm* 2012). In Irish psychiatric units and hospitals, 1,318 individuals were admitted with a primary diagnosis of alcohol disorder to an inpatient unit in 2014, representing 28.7 per 100,000 population and 7.4% of all admissions (*HRB Activities of Psychiatric Units and Hospitals;* 2014).

The College is part of the Alcohol Health Alliance and support the proposal that any measures which control the ready availability of alcohol in circumstances that are outside normal social interaction and control are welcome. (See 'Calling Time on Alcohol Advertising and Sponsorship in Ireland': Supporting a Ban on Alcohol Advertising in reland, Protecting Children and Adolescents; A Policy Paper prepared by the Faculty of Addiction Psychiatry of the Irish College of Psychiatrists; 2008)

The College asks that Government makes the Public Health (Alcohol) Bill a priority legislative action in the lifetime of this Dáil.

Education

8% of Irish children have a moderate to severe mental health difficulty and that 2% of children at any point in time will require specialist mental health intervention (Irish College of Psychiatrists; 2005: *A Better Future Now: Position Statement on Psychiatric Services for Children and Adolescents in Ireland*).

Training for children from an early age addressing mental health promoting activities has been shown to reduce the occurrence of mental ill health in later life in those who have such programmes from an early age (*Better Outcomes, Brighter Futures*; Department of Children and Youth Affairs; 2014 & *Well-Being in Primary Schools - Guidelines for Mental Health Promotion; 2015; Departments of Health, Department of Education & Skills and HSE.*). Early and prompt recognition of pupils with specific educational support needs is vital to reduce suffering in vulnerable children and adolescents.

Following on from this provision of appropriate educational supports to those with specific learning problems and social problems has also been shown to reduce psychiatric morbidity. Individual counselling for pupils in distress and appropriate referral pathways for those in need of more intense input allowing early intervention are also important in decreasing morbidity from substance abuse, self-

harm and mental illness. In the past few years financial cut backs have led to a reduction in Psychological assessments and supports in schools nationally.

The College asks that major steps be taken in the Education budget to reverse these cuts.

Community Activities

The College supports any national or local activities that promote inclusion of all in local communities. Isolation and marginalisation are major factors in mental ill health and, for those who suffer mental ill health, major barriers to recovery. Any budgetary measures that support organisations that increase local community integration are to be welcomed. The College is aware that currently community recreational organisations are subject to rates and allied taxes. A simple measure to help these organisations would be to end their tax liabilities thus decreasing their expense base and cost and freeing funds for practical local community promoting actions.

CONCLUSION

Ireland's Mental Health Policy ***A Vision for Change*** has proved a theoretical ideal internationally. The fact that ten years from its announcement it is not implemented is shameful. The College of Psychiatrists of Ireland remains concerned that the Recovery based approach to Mental Health Services as delineated in ***A Vision for Change*** is not seen as a priority. A patchwork approach to service implementation based on responses to local or national public noise seems to remain the default position.

The College holds that unless a systematic transparent implementation plan for ***A Vision for Change*** is developed and financed nationally then resources will be wasted, professionals will leave, and service users, their carers and the National Interest will suffer.