College of Psychiatrists of Ireland

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The College of Psychiatrists of Ireland

Workforce Planning Report 2013 – 2023

December 2013

Introduction:

This paper has been prepared to answer questions from HSE-MET on the number of specialists and Consultants that are required in Psychiatry in the next 5 and 10 years. It will address the policy documents and literature influencing these requirements. It will also address how mental health services are delivered into the future.

A Vision for Change (DOHC), accepted as government strategy for developing mental health services recommended setting up a workforce planning committee. It made recommendations around the number of staff required to deliver a community-based, evidence-based, and recovery focussed service. It specifically focussed on the need to deliver mental health services by Consultant-led specialist mental health teams. The number of Psychiatrists recommended was 430 Consultants and 380 Non Consultant Hospital Doctors. A persistent complaint about current mental health service is the lack of development of specialist teams, and the dissatisfaction of Service Users with seeing a different Registrar whenever they attend a clinic. (Vision for Change Implementation Group Report 2012; Annual Report MHC; Annual Report MHR, 2013). Following extensive consultation within the College of Psychiatrists of Ireland and review of the literature, this paper will recommend that we move to a mental health service with an adequate number of Consultants to both develop modern services, and be available to provide individual Consultant input for patients. **We recommend that we move to a situation where we have 800 Consultants, and the number of psychiatric trainees required to meet future manpower planning needs for these 800 Consultants.**

We are mindful of the fact that Irish mental health services have been consistently under resourced for the last ten years. Mental health problems account for 13% of the burden of disease (WHO, 2008) and yet in Ireland the budget for mental health in 2013 was 5.4% of the total health budget. There is evidence that for every £1 spent on mental health, there is a saving of £4 to the economy, (London School of Economics & Political Science, 2006) and it is based on this finding that the numbers of Consultant psychiatrists in the UK have been increased.

The Role of the Consultant Psychiatrist:

Consultant Psychiatrists are secondary care specialists competent in the assessment, diagnosis and management of mental disorders. Psychiatry is an integrative discipline which spans the evidence base from biological sciences to psychology and the social sciences. A Psychiatrist in a modern community service is required to be a brain/mind specialist and be able to practise evidence based psychiatry attuned to an individual patient's needs. The boundaries between primary and secondary care, neuroscience and social science, Psychiatrist and Psychologist, traditional healer, religious Counsellor and Psychotherapist, hospital and community all have to be traversed in both directions all the time.

Within Ireland, and within the recommendations of *A Vision for Change*, the government strategy for mental health care, the Consultant Psychiatrist provides clinical leadership to the multidisciplinary team. The Consultant contract states that each patient has a named Consultant, and that the Consultant may discharge his responsibilities through direct care, shared care, or delegation to appropriate staff, and that the Consultant shall retain a continuing overall responsibility for the care of the patient. The Consultant-led multidisciplinary team has the responsibility to develop a comprehensive service for a given catchment area. There is good evidence in Ireland and in Europe that service development has depended on effective clinical leadership from the Consultant Psychiatrist (WHO 2008). Reports from this College and from the Mental Health Commission (2012) have highlighted gaps in services including those for eating disorders, old age, child and adolescent, learning disabilities, liaison and rehabilitation services.

In recent years there have been increased demands on Psychiatrists and psychiatry. Scientific advances in neuroscience, identifying the impact of early development, and current environment on gene expression and neuroplasticity, continue to increase the complexity of psychiatry. The Psychiatrist is the only member of the multidisciplinary team who has expertise in the biological, social and psychological sciences, and it is the integration of this expertise, which makes the Psychiatrist unique within the team (Cox J. 2006).

Within Ireland the Consultant Psychiatrist has specific named duties, obligations and responsibilities under the 2001 Mental Health Act. There are also now added responsibilities under the Protection of Life in Pregnancy Bill (2013), and expected added responsibilities under the Assisted Decision Making

(Capacity) legislation, which is currently before the Oireachtas. These are statutory duties, which cannot be performed by any Psychiatrist other than a Consultant.

Consultants are identifying high levels of stress and burnout at work. There are a number of factors contributing to this including the lack of clarity on their role. Increasing expertise and autonomy of other mental health professionals, while welcomed, has not lessened the service and public's expectations of the Consultant. Clinical supervision for other disciplines has not been well developed, and in practice most Consultants provide clinical supervision for Nurses and in some areas for the other disciplines also. The increase in expectations of users and carers has also added to Consultant workload. Consultants traditionally managed their workload by providing brief consultations with large numbers of patients in an outpatient setting, often in the presence of other staff or students, and with little scheduled time available for carers. With the advent of more consumerist models of healthcare, patients and carers rightly expect more time with Psychiatrists and other staff in order to participate in decision-making as equal partners. Lack of adequate locum cover while Consultants are on leave, has led to many Consultants postponing their leave, leading to further stress. Consultant Psychiatrists are expensively trained individuals whose unique skill includes biological knowledge and psychotherapeutic communication. The Psychiatrist can maintain these skills by having ongoing professional competence, and also protected leave and support. The College believes that the lack of recognition of the need for locum cover has contributed to the stress Consultant Psychiatrists are experiencing. In the UK, these stresses have been identified and corrected by ensuring there are adequate numbers of Consultants employed.

Within Europe the number of Consultant Psychiatrists per head of population varies from 30 per 100,000 population in Switzerland, to 1 per 100,000 in Albania and Turkey. When looking at **total** numbers of Psychiatrists (Consultant and NCHD) per 100,000 in OECD countries, Ireland at 19 per 100,000 ranks below all other northern European countries, with **Consultant** numbers at 8 per 100,000. (OECD paper 2012.) **We recommend an increase of Consultant numbers to 16 per 100,000**. **We also recommend that the number of NCHDs in Psychiatry be matched to the number required to train this number of Consultants and to provide training for future General Practitioners.**

The Specialist and the Consultant:

Following extensive consultation among the membership, and reviewing of the literature on the use of Psychiatrists, the College emphasises that all mental health services should be led by fully trained specialist Psychiatrists, who are entered on the Specialist Division of the Medical Council's Register, and who are appointed to the post of Consultant Psychiatrist. The College believes the situation since 2013, where new entrant Consultants have been paid 38% less than those already in post is an unacceptable situation. It has impacted negatively on recruitment, with several posts unfilled, and is also impacting on morale within services. **We strongly recommend this decision on salary be reversed**.

There should be Consultant Psychiatrists and Psychiatrists in training. Both Consultant posts and training posts should allow for flexible working, and career breaks. There will be certain parts of the country where recruitment may be difficult, and consideration should be given to incentives, (such as for posts where there is excess travel involved).

The College can see no role for a staff grade psychiatrist. Psychiatrists should be fully trained specialists, and therefore employed as Consultants, or in training. Any introduction of a middle grade undermines the training required to reach specialist level. The unique expertise of the Consultant Psychiatrist as team leader, and the named person under the Mental Health Act, identifies psychiatry as one specialty where staff grade posts would not be appropriate.

There are a group of registrars who are currently on the General Division of the Medical Council's Register. Some of these doctors have completed some training in Psychiatry and some possess the Membership in Psychiatry but many do not. We recommend that these doctors re-enter training to reach specialist level. There will be a need for more flexible training posts to accommodate these individuals.

Policy Impacting Staffing:

A Vision for Change, as the strategy document for Mental Health services in Ireland, published in 2006, remains very relevant today and will continue to be relevant for those entering training. It anticipated having a smaller number of NCHDs, and made recommendations that services would be reconfigured, with less reliance on hospital beds and use of staff in Community teams. It recommends moving inpatient facilities to one regional area, in keeping with recommendations for manpower planning under the Hanly Report (2003). It describes the greater development of sub-specialties, and the development of multidisciplinary team working, where other disciplines would be taking on work previously carried out by Psychiatrists. It emphasises the role of the Psychiatrist as team leader (DOHC, 2006). It was recommended that it would take 10 years to implement this strategy. There has been much dissatisfaction at the slow pace of implementing the recommendations of *A Vision for Change*. Where progress has been made in developing improved services, local Consultants have been credited with bringing about this change (Annual Report of Mental Health Commission 2011). While many service users express dissatisfaction with mental health services, a consistent finding among surveys of service users' views has been the very high satisfaction with input from Consultant Psychiatrists, once the person has access to a Consultant (de Burca et al 2010; MHC, NSUE Second Opinion 2012). The College now believes the most cost effective means of introducing a quality mental health service is to increase the number of Consultants per head of population to 16/100,000 (800).

Allowing for flexible working, including part time Consultants the actual number needed will be 840 individual Consultants.

Clinical Programmes:

Inconsistent funding of our mental health services has made the introduction of any national programmes difficult. Traditionally, funding in Irish mental health services tended to follow historical and political agendas rather than what was needed. Well-resourced services tended to be those which had the old asylums up to the 1980s, and although the asylums closed, many services retained the same staffing. Funding for mental health services has gradually reduced as a percentage of the overall health spend. In the 1960s when there were a large number of residents in the asylums, 25% of the health budget was on mental health, by the mid-1980s this was down to 13%, and in 2012 it was 5.2%. While there has been talk of extra mental health professionals for the Clinical Programmes, to date there have been no extra Consultant posts. If we were to deliver the current Clinical Programmes in mental health, the College would recommend an increase in Consultant posts, for Early Intervention in Psychosis, for Eating Disorders, and for Self Harm presentations.

Demographics:

In 2006, the population of Ireland was 4,239,848. In 2011 the population was 4,588,252. (www.cso.ie) and the projection ranges from 4.6 million to 5.2 million by 2020. 13% of the population is over 65 years, and 44% of the population is between 25 and 54 yrs. The age ranges vary from area to area in the country, and so in planning the workforce for a catchment area of the country these variations need to be taken into account. Services for children, adults and older people will need to be planned per head of population in that age range, i.e. 1 Consultant per 10,000 children under 18 years, 1 Consultant per 25,000 adults, and 1 Consultant per 10,000 persons over 65 yrs.

Prevalence of Illness:

At any given time, approximately 10% of adults are experiencing a current mental disorder, and 25% will develop one at some point during their lifetimes. Mental disorders are found in all, women and men, at all stages of life, among the rich and poor, and in both rural and urban settings. Mental disorders account for 13% of the burden of disease, and this figure will rise to nearly 15% by 2030. Depression alone is likely to be the second highest contributor to the global burden of disease by that date. Mental disorders also are associated with more than 90% of the one million suicides

worldwide that occur annually. People with mental disorders have a heightened risk of suffering from physical illnesses because of diminished immune function, poor health behaviour, poor adherence to medical treatments, and social barriers to obtaining treatment. In Ireland in 2012 the spend on mental health was 5.2% of the total health spend. This compares with 12% in the UK, where mental health has been prioritised in the last five years, and the number of Consultant Psychiatrists per head of population has increased to 16 per 100,000. (OECD 2013).

Subspecialisation and Consultant Numbers:

Within Psychiatry there are four specialties recognised by the Medical Council. Within each of these specialties there are sub-specialties. Specific issues related to each specialty are discussed below.

Adult Psychiatry:

Catering for those between the ages of 18 and 65 years, this group accounts for 44% of the population. The recommendation from *A Vision for Change* is that each area of 50,000 has 2 Consultants in Community Psychiatry. Out of each year a Consultant has six weeks annual leave and two weeks study leave for continuous professional development. Hence, for every five Consultants employed, one more Consultant is needed to provide cover when the Consultants are on leave. This will require 220 Consultants for Adult Psychiatry in 2013, and 240 in 2020.

Rehabilitation psychiatry, for those who have disabilities secondary to long term mental illness, requires one Consultant per 100,000 population, equivalent to 54 Consultants and 60 Consultants for 2013 and 2020 respectively (allowing 6 for each 5 Consultants to ensure cover during leave.) There is evidence from Irish and international studies that well-developed rehabilitation services will save money and improve outcomes (Lavelle, E, 2010 MHC and Killaspy et al 2011).

Additional Adult Consultants will be needed for general liaison, neuropsychiatry, eating disorders, forensic, early intervention in psychosis, and perinatal psychiatry. One Consultant per 350,000 will be required in each of these areas, adding 100 Consultants to the number. For perinatal psychiatry this may be an over-estimate. There are 13 maternity units in the country, many small. These have not been studied in detail. All units should have specialist sessions but apart from the 3 Dublin hospitals, part time sessions may be appropriate (Preliminary estimate: 3 fulltime, 4 half time, and 6

with 2 or 3 sessions). In addition, 1 Consultant per million population will be required for Intensive Care Rehabilitation Units, requiring 5 and 6 Consultants in 2013 and 2020 respectively.

In a country with a high misuse of alcohol the College has repeatedly called for an increase in services for addiction. 40% of Community Mental Health Teams' caseload have problem alcohol or drug use, and this group are at a high risk of suicide. The NACD Dual Diagnosis 2004 report recommended "closer collaboration between addiction psychiatry and general psychiatry." Addiction Services will require 30 Consultants, an increase from the current level of 8.

Old Age Psychiatry:

The Psychiatry of Old Age is a relatively young psychiatric speciality. The first services were developed in the early 1960s 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. 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.

A Vision for Change recommends 1 old age Psychiatrist per 100,000 total population but this is based on 10% of the population being over 65 years. Currently the percentage across the country varies from 11% to 18% so to provide equity the recognised proportion for old age psychiatry is 1 Consultant per 10,000 people over the age of 65. In very rural areas the proportion should be 1 per 8,000 over the age of 65 years (to allow for travel requirements for predominately home-based services). The older population by percentage will continue to increase over the coming years. It is expected to double by 2036. (CSO Projected Population 2026 = 5,300,000 of which 16.5% (about 860,000) will be over 65 years.

A Vision for Change omitted entirely the need for liaison old age psychiatry or other specialist old age psychiatry services. The evidence for this service is overwhelming. Greater than 60% of patients in general hospitals are over 65 years. Note *'Who Cares Wins'* (2005) from the Royal College of Psychiatrists, UK and the provisional results from the Irish National Dementia Audit (2013) both highlight the large number of older people on antipsychotics who do not have these reviewed by a Consultant Old Age Psychiatrist. Recommended numbers are 0.5 WTE Consultant per general hospital with 350 beds. The development of hospital groups will highlight the issues around chronic disease and the cost of managing dementia in hospital.

The National Dementia Strategy, which is in development, will note the increasing numbers of people with dementia in this country, from 41,740 to 140,000 in 2030 (EuroCoDe age/gender specific dementia prevalence rates and the 2006 Census of Population in Ireland). The strategy will highlight the need for dementia clinics that will require input from old age psychiatry services. While we cannot forecast their recommendations it will be in the order of 2 clinical sessions per 10,000 older people. Early onset dementia services – for this population (currently about 4,000 of these people live in Ireland) the recommendation is that they require the care of specialists in dementia care, especially with regards behavioural and psychological symptoms, namely Consultants in Old Age Psychiatry. The recommended number is 0.5 Consultant per 250,000 population (Cahill, S. et al, 2012).

Recent presentations have highlighted the need for specialist Forensic and Addiction Old Age psychiatry services. It is unclear what the population requirements would be but may approximate 0.5 Consultant per ISA.

The majority of people in nursing homes have dementia and many have co-existent mental disorder. Nursing homes have in reality become what were once the back-wards in psychiatric asylums. This is an expanding area and requires consideration to be given to the number of specialists in Old Age Psychiatry that will be required to meet the needs of a group of patients that can be challenging in their care needs

As with Adult Psychiatry, additional posts will be required to provide for Consultant leave.

	No of Consultant WTE Posts Needed	No of posts currently
Core Psychiatry Old Age Work	86	40 approx
Liaison	20	0.5
Under 65	11.5	0
Memory Clinic	17 approx	0
Specialist Old Age Posts	8	0

Forensic Psychiatry:

There are currently 8 Consultants in Forensic Psychiatry in Ireland at the Central Mental Hospital, representing an increase since 2000 when there were 3, but approximately half of the fifteen recommended in the *A Vision for Change* policy document. The area remains under-resourced in terms of requirements. The current proposal is for a requirement of 18 Consultants.

A new Central Mental Hospital is scheduled to open in 2017 with an increased inpatient complement of 120 beds. The hospital currently has 93 beds, with teams providing for:

1. Remand Prisoners (currently 1 Consultant: Requirement for at least 2 currently)
2. Acute admissions (currently 2 Consultants: Requirement for 4 by 2017)
3. Medium Secure placement (currently 2 Consultants: Requirement for 4 by 2017)
4. Rehabilitation and Community Forensic Psychiatry (currently 2 Consultants: Requirement for 4 by 2017).

The increase in beds with the opening of the new Central Mental Hospital will require the recruitment of a further 4 Consultant Forensic Psychiatrists, not including Consultants in the areas of Intellectual Disability and CAMHS (see below).

Forensic-Intellectual Disability:

The new Central Mental Hospital is also scheduled to have a 10 bed unit for persons with intellectual disability. This will require 2 Consultant posts. One post is expected to be filled during 2014.

Forensic-CAMHS:

The new Central Mental Hospital is also scheduled to have a 10 bed Forensic CAMHS unit. This will require 2 Consultant posts.

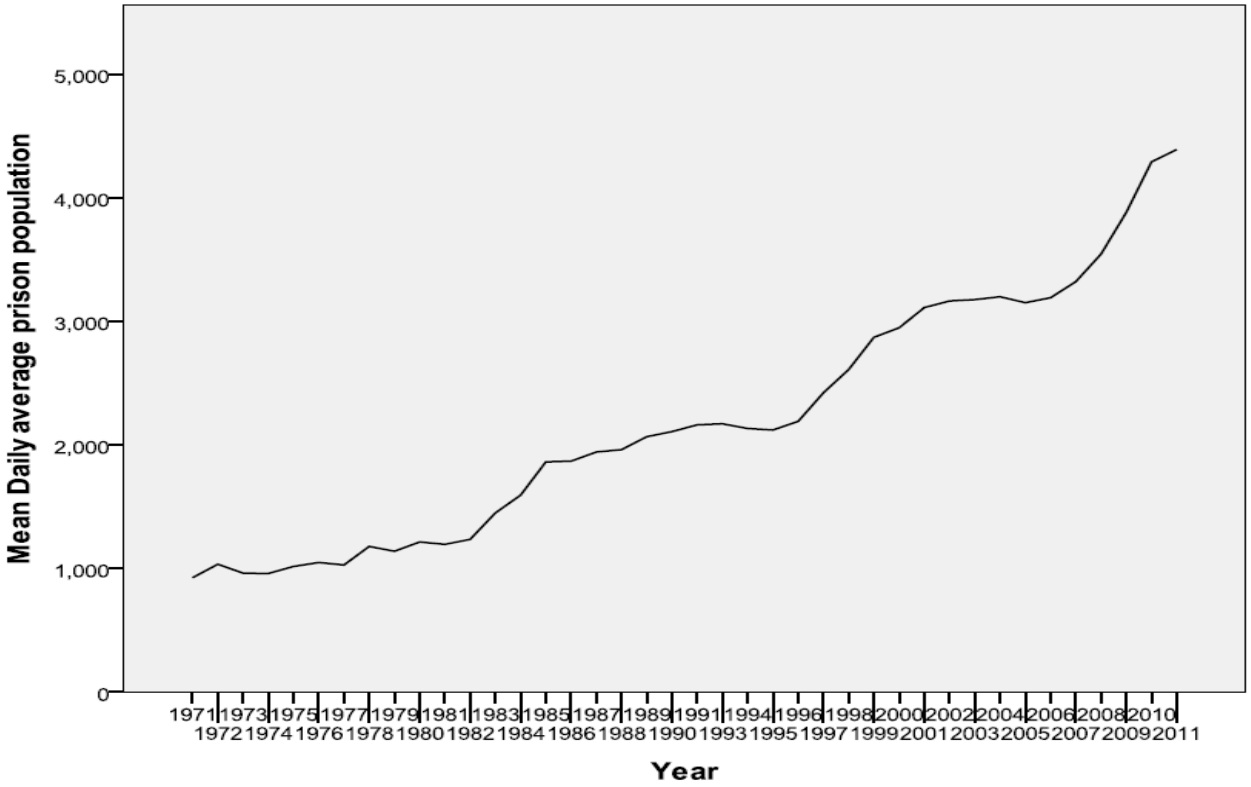
Prisons:

Other than Cloverhill Prison, there are no full-time appointments for delivery of Multidisciplinary care to persons with major mental illness in prisons. Since the publication of *A Vision for Change*, the prison population (in which persons with major mental illness are markedly overrepresented) has

almost doubled, with international estimates and local research indicating that the proportion with major mental illness remains unchanged (approximately 4% of sentenced and up to 8% of remands having psychotic illnesses). There is a need for Consultant-led teams to provide enhanced in-reach for this group (currently delivered on a sessional basis). There is likely to be a need for approximately 4 Consultant Forensic Psychiatry posts to provide for this changing level of need (at least 1 extra post for remand prisoners and 3 for sentenced prisoners).

Please note that the above does not include staffing requirements for proposed ICRU (Intensive Care Rehabilitation Units) as recommended in *A Vision for Change.*

Below is a graph showing the significant increases in the prison population in Ireland in recent decades.



Child and Adolescent Psychiatry:

A Vision for Change identifies the following posts in Child Psychiatry, and was aware of the need for direct Consultant work in Child Psychiatry.

Community / Liaison	107
Substance Misuse	4
Mental Health Intellectual Disability	15
Forensic	2
Eating Disorder Specialist	1
Inpatient* (? Include in Community)	9
Total Posts	**138**

Allowing as before for 6 posts for every 5, to ensure there is adequate cover at all times, brings this number to 165 Consultants.

There is also a need for Consultant numbers to reflect the regional variation in the percentage of the population who are under 18 years.

Learning Disability Psychiatry:

The high prevalence of mental health problems in people with an Intellectual Disability is well established and described in depth in *A Vision for Change*. The delivery of Learning Disability Psychiatry services has historically been patchy or poorly developed in Ireland and in the eight years since *A Vision for Change* was published, 2 of the 3 admission centres mentioned have been de-designated and the third (St. Joseph's Intellectual Disability Service) remains an approved centre but has halved in terms of admission capacity and has no functioning acute admission beds. A number of individuals are currently receiving services outside of the state. With adequate staffing these people could be provided treatment at home. We recommend 5 Consultants to staff regional inpatient beds.

A Vision for Change recommended providing 2 Consultant led multidisciplinary teams per 300,000 population, however we also recommend other factors are taken into account to include the following: Inner city vs. rural (reflecting density of population, ethnicity, deprivation indices and transient populations); Local group homes (Are difficult-to-manage people placed outside catchment area or brought into catchment area? – this is a phenomenon we have definitely seen in Ireland since budgetary and other considerations have resulted in the repatriation of a number of patients placed in specialist services overseas. However, private providers have most likely catered for a significant proportion of this group); Previous institutions can improve local resources and skills base but also increase local case-loads (this is an important point as having a legacy of an old institution in a catchment area is a significant issue. If the area has previously been without a service the unmet need can be very substantial. In any event the legacy of an old institution distorts the staffing requirements and increases them beyond the basic catchment area requirement of 2 Consultants per 300,000 population); Proximity to local support networks and academic hubs for continuing professional development; Local organisations active in providing quality services (mixed housing projects offering appropriate and good quality support to those with challenging behaviour, for dementia care, autism, sensory impairment); The type of services provided on the ground by other organizations and types of agencies that an MHID team can collaborate with; Degree of local intellectual disability employment, day service and availability of other supported activities.

Also, the number of Consultants required reflects the local configuration of services. Factors include the expectations and roles of other mainstream mental health services. Are all patients with mild intellectual disability seen in mainstream? Are there autism roles outside of learning disability services? Are there age boundaries or lifespan services; Are there well-resourced supporting teams including other medical staff, secretarial and other allied professions: community nurses, speech and language therapists, occupational therapists, dieticians, psychologists and physiotherapists; Are specialist teams available? (e.g. epilepsy, challenging behaviour, dementia, autism, forensic); Out-of-area/private placement quality assurance roles commissioners may require assessment and management of clients placed out of area.

At a national level there are few fully developed catchment area based multidisciplinary MHID teams and most likely at this time there are none which precisely meet the specifications set out in *A Vision for Change.* Given these reservations the number of Consultants required will be between 40 and 45. For services for children with a learning disability who require mental health services the recommendations include that all new Consultant appointments be delivered as joint appointments with a commitment to both generic and intellectual disability services. This would help to minimize professional isolation which can occur with those Consultant groups that are in a minority. It would also lend itself to cross fertilisation of skills between the generic, child and adolescent mental health services and the intellectual disability child and adolescent mental health services. It would facilitate joint training of child psychiatrists with a special interest in intellectual disability. (CPsychI, 2013).

The following tables identify the Consultants required and identify the requirement for 800 Consultants which is 16 per 100,000.

SUB SPECIALTIES OF ADULT CONSULTANT	A Vision for Change	Number needed in 2013 (College recommends)	Number recommended in 2020	Current number (HSE at 30th Sept. 2013)
General Adult Psychiatrist	156	220	240	179
Early intervention Psychiatrists	2	18	20	0
Liaison, Eating Disorder Psychiatrist	4	18	20	1
Adult Liaison	13	18	20	12
Neuropsychiatry	2	6	7	1
Perinatal – see text above	1	18	20	3 x 0.5
Rehabilitation Psychiatry	39	54	60	16
Co morbid Substance Misuse and Mental illness	13	30	33	6
Forensic General	15	18	20	9
Intensive Care Rehabilitation Psychiatry	4	5	6	0
Medical Psychotherapist	0	18	20	2
Psychiatrists with the Homeless	4	5	6	3 x 0.5
Total	**242**	**428**	**492**	**232**

SUB SPECIALTIES OF CHILD PSYCHIATRY	A Vision for Change	Number needed in 2013	Number recommended in 2020	Current Number (HSE at 30th Sept. 2013)
Child and Adolescent Psychiatrists	95	165	180	82
Total	**95**	**165**	**180**	**82**

SUB SPECIALTIES OF LEARNING DISABILITY	A Vision for Change	Number needed in 2013	Number recommended in 2020	Current Number (HSE at 30th Sept. 2013)
Inpatient Units		5	5	
Community Mental Health Team Psychiatrists.	26	30	33	28
Children and Adolescents (need dual training and so counted twice.)	13	13*	22	11
Total	**39**	**50**	**60**	**39**

SUB SPECIALTIES IN OLD AGE PSYCHIATRY	A Vision for Change	Number needed in 2013	Number recommended for 2020	Current Number
General Old Age Psychiatry	39	86	90	41
Liaison	0	20	22	0.5
Under 65 with dementia.	0	11.5	14	0
Total	**39**	**117.5**	**126** *Consider additional posts for Old Age psychiatry sub-specialties (see table page 11 above)*	**41.5**

SPECIALTY	ADULT	CHILD	LEARNING DISABILITY	OLD AGE	Total
Numbers in Vision for Change (2006)	242	95	39	52	428
Numbers Needed in 2013 (College)	428	165	50	117.5	760.5
Numbers recommended in 2020	**492**	**180**	**60**	**126**	**858**
Numbers in post currently	233	82	21	41	377

Number of Specialists (IMC report 2013)	Number of Consultants in HSE @ 30th Sept. 2013	Number of Consultants in Independent Sector	Number of Consultants as recommended by College 2013	Number of Consultants as recommended by College 2020
715	388	?	760.5	858

Please note: Numbers currently in post are approximate. Information has been gathered from the HSE, but individual College Faculties have not concurred with the numbers given.

Psychiatry Training and Numbers of Trainees needed to plan for 700-800 Consultants:

Undergraduate Psychiatry training and Intern posts are currently delivered by the Universities, as recommended by the Fottrell Report (2006).

Postgraduate training in Psychiatry has been developed by the College of Psychiatrists of Ireland, since the College was first formed in 2009, and it follows the recommendations of the Buttimer Report (2006). The College of Psychiatrists of Ireland is responsible for all aspects of postgraduate training in psychiatry in Ireland. It aims to provide the best possible training for qualified doctors at both basic and higher 'Specialist' level in psychiatry.

Training occurs in two specialist stages - Basic Specialist Training (BST) followed by Higher Specialist Training (HST). Ordinarily this is a 7 year process (Foundation Year = 1 year; Basic Specialist Training [BST] = 3 years; Higher Specialist Training [HST] = 3 years) based on the achievement of learning outcomes. The completion of BST requires success at the Exam **PLUS** success at continuous assessment [Annual Review of Progress or ARP] for BST 3. Completion of HST requires success at the ARP for HST 3. Satisfactory completion of Specialist Training confers eligibility for inclusion on the Specialist Division of the Medical Register maintained by the Medical Council.

The overall length of training in Psychiatry is similar to the other medical disciplines (other than General Practice) except that BST is relatively longer (a trainee completing BST in Psychiatry is expected to have similar skills to a trainee completing BST in general medicine PLUS the skills to be a Psychiatrist) and HST is relatively shorter. This reflects the overlap of skills across the 4 psychiatric specialties and their sub-specialties. It also reflects the complex role of the doctor compared to other members of the CMHT with responsibilities for physical health, prescribing, risk assessment, leadership, and team management-governance.

Recruitment and retention:

The Buttimer Report commented that Psychiatrists often enter training later, and that a higher percentage of Consultant Psychiatrists are women, compared with other specialties, on average Consultants remain in post for 30-35 years. A recent UK paper on recruitment in Psychiatry (Goldacre et al, 2013) indicates Psychiatrists are now no longer older on entering training, and women are no longer selectively choosing Psychiatry.

Recruitment into Psychiatry has presented a challenge for some time. The reasons for this are many, doctors do not see Psychiatry as a true branch of medicine, they do not believe psychiatric illnesses are treatable, and they are often advised by their tutors to follow what has been described by non-Psychiatrists as a more worthwhile career. In practice Psychiatry is one of the most complex and demanding of medical specialties, and recovery rates for most mental illnesses are greater than for other illnesses. Despite major advances in neurosciences and the integration of social sciences and biological science, recruitment to Psychiatry remains at around 4-5% of medical students, and it has remained so for some time (Goldacre et al, 2013). The factors influencing recruitment are experience as a student, or an opportunity to work in Psychiatry as an intern, or in foundation year. The College of Psychiatrists of Ireland has produced a Careers Booklet for medical students, and has run Summer Schools in Dublin and Galway in order to increase recruitment. Intern posts have been used in recent years. Trainees have identified poor resources in mental health services and the reduction in remuneration as reasons for not remaining in Psychiatry in Ireland.

With approximately 725 medical students qualifying each year, 4% of those entering psychiatric training would provide 29 new entrants to BST each year. However, in recent years up to 50% of graduates have left the country on completion of the intern year. Assuming that this rate is no different in those considering Psychiatry compared to other specialties we could expect to recruit 15 new entrants to BST each year. If there was to be 100% retention of these trainees (not likely) for the duration of the 4 years of BST then 60 of the 400 current NCHDs at this level could be expected to be provided by graduates of Irish Medical Schools. Therefore, government policy of being self-sufficient in the provision of specialist trainees is not currently realistic for Psychiatry.

At present, at BST level, there are 205 doctors in training for Psychiatry and another 56 are completing psychiatry placement as part of GP training.

1. **Can you provide us with your general view of how your specialty area should be developed to fit with changes in health service delivery? This might include for example, changes in team structures, task sharing, productivity levels or any other work systems within your specialty area and the supporting multidisciplinary team.**

European Working Time Directive:

The commitment of the government to ensure the introduction of the EWTD by 2014, will mean that services will be put under pressure. This measure will need to be preceded by reducing the number of Emergency Departments and further amalgamation of smaller units around the country.

Hospital Groups:

While mental health services are largely delivered in the community, the Hospital Groups will mean there will be a reduction in Emergency Departments. *A Vision for Change* identified reconfiguring inpatient mental health services, to move to a smaller number of units. This will reduce the on-call requirements, and make it possible for the service to manage with 348 NCHDs, if all other posts were in place. NCHDs in Psychiatry are currently needed in each Emergency Department. Until the number of Emergency Departments is reduced, NCHD numbers will need to be higher. The College believes mental health patients should have the same access to expertise as those with physical illness, and so once an Emergency Department is open 24 hours, it will require Psychiatry on-call 24 hours.

Team Structure within Psychiatry:

It is important to note here the unique role of the Psychiatrist within the mental health team. Psychiatry is clearly a medical specialty, with the Psychiatrist's expertise being the knowledge, skills and attitudes required to ensure the integration of biological, social and psychological components of illness. No other discipline has this breadth or depth of knowledge. The Psychiatrist is the clinical lead on the multidisciplinary team, and is named in the Mental Health Act with specific duties. Nursing education has developed further and there are now a number of Clinical Nurse Specialists and Advanced Nurse Practitioners working in mental health services, many of whom are carrying out work of chronic illness management that was identified

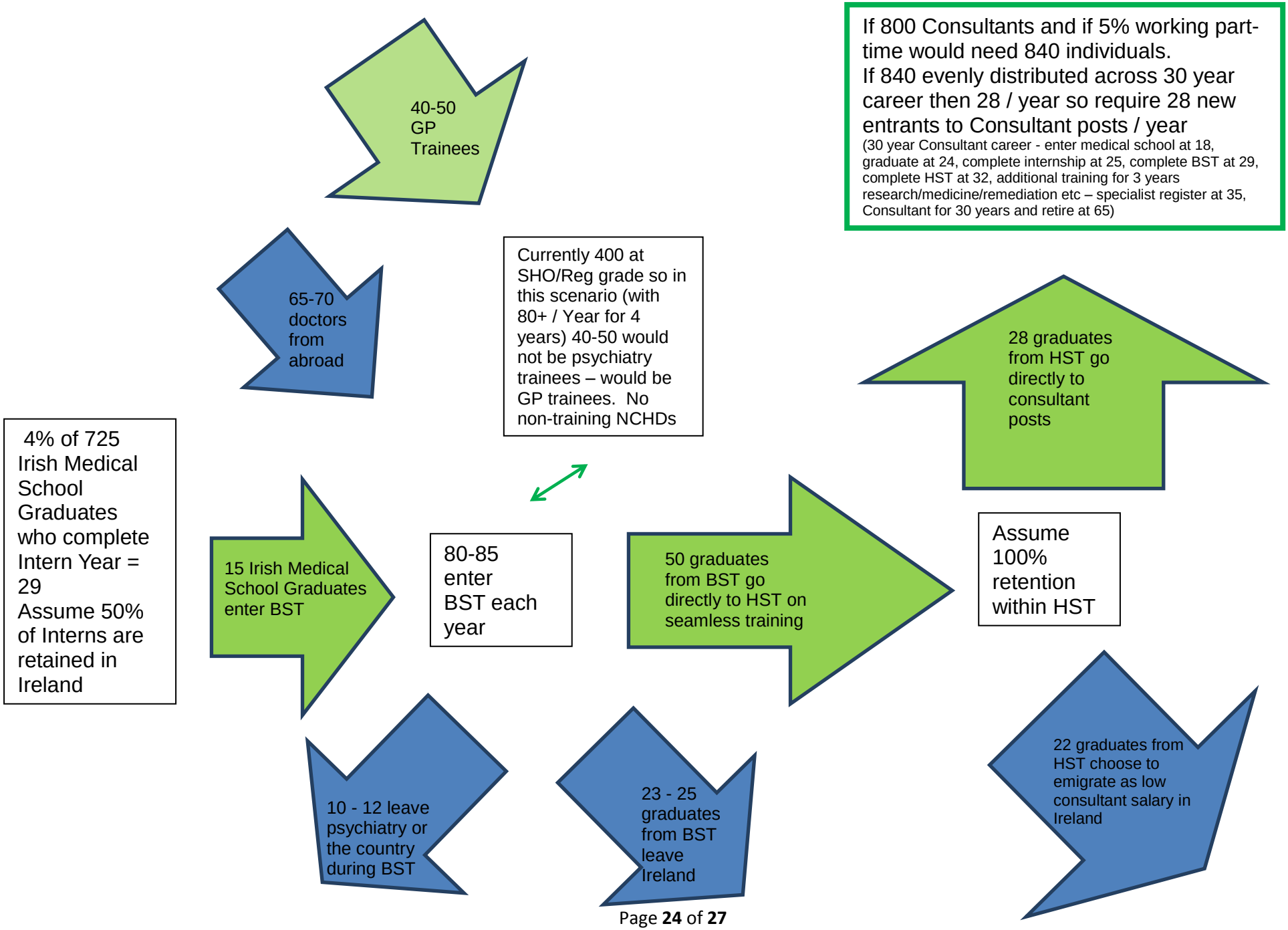
for nursing staff in *A Vision for Change.* While some tasks can be carried out by nursing specialists, many Consultants have found this has increased their workload in the need for greater supervision.

Doctors recruited from abroad and "International Medical Graduates":

Mental Health services have benefited over the years from the input of medical graduates from foreign medical schools. As discussed above, despite the increase in Irish medical students, with 4% choosing Psychiatry, it is unlikely that Ireland will be training enough Psychiatrists for domestic need. Under those circumstances we will need both Consultants and NCHDs graduating from foreign medical schools.

The term "International Medical Graduates" – we have to be careful of the term which has been taken up by the Medical Council and HSE-MET to have a specific meaning related to 2 year contracts on the Medical Council's Supervised Division for doctors who are on an educational programme agreed by an Irish postgraduate training body and a training body in their country of origin. These doctors must return to their country of origin and cannot contribute to the Consultant workforce.

These doctors could contribute to filling the gap between the number of Trainees needed to meet Consultant manpower requirements and the number of NCHDs required for service delivery but they would be unlikely to fill this gap.


If 800 Consultants and if 5% working part-time would need 840 individuals.
If 840 evenly distributed across 30 year career then 28 / year so require 28 new entrants to Consultant posts / year
(30 year Consultant career - enter medical school at 18, graduate at 24, complete internship at 25, complete BST at 29, complete HST at 32, additional training for 3 years research/medicine/remediation etc – specialist register at 35, Consultant for 30 years and retire at 65)
40-50 GP Trainees
65-70 doctors from abroad
Currently 400 at SHO/Reg grade so in this scenario (with 80+ / Year for 4 years) 40-50 would not be psychiatry trainees – would be GP trainees. No non-training NCHDs
28 graduates from HST go directly to consultant posts
4% of 725 Irish Medical School Graduates who complete Intern Year = 29
Assume 50% of Interns are retained in Ireland
15 Irish Medical School Graduates enter BST
80-85 enter BST each year
50 graduates from BST go directly to HST on seamless training
Assume 100% retention within HST
10 - 12 leave psychiatry or the country during BST
23 - 25 graduates from BST leave Ireland
22 graduates from HST choose to emigrate as low consultant salary in Ireland

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