The Psychological Society of Ireland (PSI) submitted the following statement to the Chair of the Oireachtas Joint Committee on Health. If the Committee extended the invitation to the PSI to present the statement, the 2019 PSI President, Ian O'Grady, would have delivered the presentation. However, due to the announcement of the 2020 General Election, and the dissolving of the 32nd Dáil, the PSI were not afforded the opportunity to present.

Psychological Society of Ireland

Opening Statement to the Oireachtas Joint Committee on Health: To address development of mental health services and workforce planning

Chairperson, members, on behalf of the Psychological Society of Ireland (PSI), I would like to thank you for the opportunity to address the Joint Committee on Health today. I am joined by my PSI colleagues, Mark Smyth & Louise Higgins.

The PSI is the learned and professional body for psychology in the Republic of Ireland. The Society is committed to maintaining professionally appropriate standards of practice in psychology and also to exploring new and innovative ways of furthering psychology as an applied science.

We welcome the opportunity to detail our concerns regarding development of mental health services and workforce planning.

Our colleagues in UCD & Jigsaw recently released the My World Survey 2 report and found that levels of depression and anxiety in adolescents and young adults increased in the 7 years from MWS-1 to MWS-2. Adolescents and young adults in MWS-2 were much less likely to be in the normal range for depression and anxiety and much more likely to be in the moderate, severe or very severe ranges for depression and anxiety than adolescents and young adults in MWS-1. Levels of protective factors related to mental health such as self-esteem, optimism and resilience have decreased. Females, in particular, indicated increased levels of anxiety and decreased levels of self-esteem, body esteem, resilience and other protective factors than males of the same age.

This is consistent with other information available which has indicated that:

a. A 2018 HSE Mental Health Workforce Planning Report notes that there are 201 Psychologists less than recommended by A Vision for Change in post (Child and Adolescent Mental Health Services (CAMHS) -118, Adult Mental Health -58, Mental Health of Older Adults – 25). These shortages are based on a 13-year-old report and with significant population increases and varying social demographics, the actual realities of the shortages are likely to be far in excess of this;
b. 3,345 adults on waiting lists for counselling appointments;
c. There were 2,523 children on the HSE CAMHS waiting list in January 2019
d. 6,300 children and teenagers were waiting for a Primary Care Psychology appointment in Ireland at the end of August 2018;
e. Disability Act Compliance -Assessments completed within timelines (3rd quarter of 2018) reached only 8.9% of target levels.

The Psychological Society of Ireland recommends that:

1. To incorporate the significant shift in what is considered best practice in mental healthcare since the original *A Vision for Change* was developed, we contend that there is a need for a complete overhaul of the original policy as opposed to the 'refresh' that the Oversight Group indicated is within their current remit. To successfully build a modern, mental healthcare system that will meet the needs of our country in the medium to long-term, we need to develop a policy that is in line with international best practice, is trauma-informed and recovery focused from start to finish.

2. The dominance of the illness model of mental healthcare in Ireland is rooted in the imbalance of power within multi-disciplinary teams, which are medically-led. Currently psychiatrists are automatically deemed leaders of CMHTs, although it is our understanding that in the CMHT, this has no legal basis. Rather, it is a policy based on medical-legal responsibility and contract-based position. This defers the conceptualisation of peoples' difficulties to one powerful group, and effectively side-lines the potential influence of other groups. This tends to result in a further cementing of illness model thinking in considering peoples' difficulties.

3. The Mental Health Commission (2010; Section 4.4.1): '*Not in keeping with current models of practice, it is inappropriate to interpret that consultant psychiatrists carry overall responsibility if they are involved, however peripherally, in the care of service users or for all referrals received. Such a centralised or 'star' model of responsibility can be perceived as crossing professional boundaries and forcing team members into 'devalued, disempowered, hand-maiden' roles'*.

4. There has been much media focus in recent months and indeed years on the difficulty in recruiting Consultant Psychiatrists for Child and Adolescent Mental Health Services (CAMHS) teams in particular. The inferences have been that in the absence of a Consultant Psychiatrist being available on a CAMHS team that it precludes the safe and effective work of all other disciplines. In the UK CAMHS have moved away from a discipline specific model of clinical leadership and instead have looked at the qualities, capabilities and competencies of clinical leadership in CAMHS (Royal College of Psychiatrists, 2011). This guidance document does not assume the primacy of any one discipline in CAMHS over another but outlines a helpful framework which emphasizes leadership at all levels of CAMHS, including service user and family leadership as well as clinical leadership. It also outlines specific programs to develop CAMHS specific leadership skills and evaluation of the impact of leadership skills. PSI strongly advocate for the concepts of leadership and clinical leadership in mental health to be brought into line with international practice. This would take the shape of developing a competency framework for clinical leadership and leadership development programs that are open to all suitable clinicians with the requisite competencies.

5. All our mental health Key Performance Indicators (KPIs) are exclusively output focused, with no regard at all for outcome. Quality healthcare service has to be efficient and efficiency is the optimal balance between output and outcome. If you just focus on output, you become inefficient because, although you will put a large number of people through your service, their outcomes are poor. If you just focus on outcomes, you become very inefficient because, although your patients' outcomes will be very good, you will put a huge amount of resources into seeing each patient and so you will see very few patients. At present, all mental health service metrics and KPI's are output focused which is very inefficient Therefore, unless we start becoming more outcome focused and includes outcome metrics in our KPI's, we will never have a quality mental health service.

6. The number of children who have been prescribed psychiatric medication has increased by nearly 500% over the past decade from 1,150 in 2009 to just under 6,500 in 2018. In a system where €400 million euro per year is spent on psychotropic medication, we need to ensure there is increased access to high quality psychosocial interventions and evidence-based psychological therapies as a first line of intervention if we are to begin to redress the imbalance in our system and move away from the medical model of mental health care and long-term dependence on pharmacological intervention.

7. PSI recommend a minimum number of qualified WTE psychologists per head of population (adjusted for deprivation) are employed across primary, secondary and tertiary mental health care services. The agreed number of WTEs should be evidence based; at a minimum it should allow all service users in mental health services access to Psychological assessment and intervention. The post-code lottery of access to timely evidence based psychological intervention is inequitable and needs to end.

8. There needs to be a fundamental shift within the Health Service Executive, from a medical model of mental health care to one that is predominantly psychosocial in nature. This requires changes in the current service delivery model so that social and psychological interventions are the first line of treatment considered when a person presents with psychological distress. Acknowledging and addressing the centrality of psychological and social issues (including trauma, poverty, family problems, relationships, inequality etc) in the development and maintenance of mental health difficulties and providing collaborative, person-centred, evidence-based interventions that will help address these issues is crucial.

9. PSI supports the need for 24/7 mental health services in the community. However, the nature of the services provided needs to be considered carefully. It is crucial that the support received is primarily psychosocial in nature and that in addition to receiving a comprehensive and therapeutic assessment when presenting in crisis, individuals can be provided with intervention to address the psychosocial difficulties that led to their crisis and psychological distress. Assessments and interventions should be both collaborative and evidence based. Staff need to be trained in evidence-based approaches for addressing suicidality and have easy access to necessary interventions such as Psychology/Social Work/Family Therapy to address the underlying difficulties contributing to the service user's distress/suicidality. To ensure the shift in culture and practise required to achieve a psychosocial model of mental health care, it is crucial that 24/7 teams are multidisciplinary in nature. Currently all crisis care is provided by medical staff (Psychiatry, Nursing, GPs) which is perpetuating the dominance of the medical model within mental health. Given their expertise in mental health, assessment and psychological interventions, psychologists should play a central role in designing and delivering 24/7 mental health care services.

10. There are gaps in how children and young people access supports across the health services when needed. This relates to a number of children and young people with complex clinical presentations who require the supports of more than one service (e.g., disability team and CAMHS). While there is a HSE joint working protocol developed (2017) this is not consistently implemented. In addition, the development of specific CAMHS-ID teams and MHID teams to support those individuals with a moderate/severe intellectual disability and moderate/severe mental health difficulties, are only in their infancy with gaps in many areas nationally.

11. The World Health Organisation (WHO) (2008) has highlighted that increased access to psychological therapies for service users are associated with positive outcomes in terms of physical and mental health, while guidelines from the National Institute for Health and Care Excellence (NICE) recommend psychological therapies as the first-line intervention of choice for clients suffering from mild to moderate depression and generalised anxiety disorder.

12. A Vision for Change (DoHC, 2006) emphasised the need for a comprehensive range of psychological therapies to meet the increasing demand from service users for alternatives to medication in providing intervention for mild to moderate mental health difficulties. Nationally, services that focus on the provision of psychological therapies are an imperative. Demand for psychological assessment and intervention for a range of mental health difficulties and developmental disorders has grown over the past decade in line with increases in our population.

13. PSI recommends the following to improve recruitment and retention of Psychologists who can deliver high quality and evidence based mental health care:
    a. A full independent review of the current National Recruitment Services which in the view of PSI is directly contributing to difficulties in the appropriate recruitment of Psychologists. PSI is happy to input into this review;
    b. Provision of individually allocated Continuous Professional Development (CPD) budgets for Psychologists working in the Civil / Public Service;
    c. A commitment to fund the Doctorate in Counselling Psychology training programme;
    d. A commitment to fund the Doctorate in Educational Psychology training programme;
    e. An expansion of the number of funded places in Doctorate in Clinical Psychology training programme places.

I wish to thank members of the Committee for inviting us here this morning. We would be happy to answer any questions you may have.